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

To continue PEBB health plan coverage, you must complete the enclosed form(s) and follow the instructions. The PEBB Program must receive your election form(s) no later than 60 days from the date PEBB health plan coverage ended or the mailing date on this booklet, whichever is later. To continue life insurance, MetLife must receive your completed application no later than 31 days (or 60 days, if you are retiring) after your employer-paid coverage ends.
For more information

This notice does not fully describe your rights for continuation coverage. You can find more information in the PEBB Initial Notice of COBRA and Continuation Coverage Rights 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 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
P.O. Box 42684
Olympia, WA 98504-2684

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

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

Where to find PEBB laws and rules

You may find the Public Employees Benefits Board’s law 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.

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).
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This booklet contains important information about your and your family members’ right to continue Public Employees Benefits Board (PEBB) health plan 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](http://www.wahbexchange.org) or 1-855-923-4633 (TTY: 1-855-627-9604)
- Outside Washington State: Health Insurance Marketplace  
  [www.healthcare.gov](http://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 insurance coverage.

Please read the information in this notice very carefully before making a decision.

- To elect COBRA or PEBB Continuation Coverage (Leave Without Pay), 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 the mailing date on this booklet, whichever is later.
- To continue your life insurance under portability or conversion, complete the form sent to you by MetLife. MetLife must receive your completed form no later than 31 days (or 60 days, if you are retiring) after your employer-paid coverage ends.

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 family member(s) stop being eligible. If elected, COBRA or PEBB Continuation Coverage begins the first day of the month after the date your other coverage ended.

To help process your enrollment faster, you should send your first premium payment (and any applicable premium surcharges) with your election form. However, your first premium payment (and any applicable premium surcharges) are due to the HCA no later than 45 days after the PEBB Program receives your election form.

You can find important information about payment for continuation coverage under “When and how do I make payments?” on page 11. If you do not make your premium payment (and any applicable premium surcharges) by the deadline, you forfeit your right to enroll in continuation coverage.

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

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

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

What continuation coverage options are available?

The PEBB Program offers one or more ways for you and your family members, if eligible, to continue PEBB health plan coverage.

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

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

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

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

- The employee’s spouse or state-registered domestic partner may elect continuation coverage, even if the employee does not.

- The employee or their eligible spouse or state-registered domestic partner may elect continuation coverage for one, several, or all eligible dependent children. Certain newborns, newly adopted children, and children identified under a court order or National Medical Support Notice may also be eligible for continuation coverage.

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

Who can elect continuation coverage?

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

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

How do I elect continuation coverage?

To elect continuation coverage, your completed form(s) from Appendix A or B of this booklet must be received by the PEBB Program no later than 60 days from the date PEBB health plan coverage ended or the mailing date on this notice, whichever is later.

If the PEBB Program does not receive your completed form(s) by the required deadline, your

(continued)
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 COBRA or PEBB Continuation Coverage?

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

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

What is the Health Insurance Marketplace?

The Marketplace offers “one-stop shopping” to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing (your out-of-pocket costs for deductibles, coinsurance, and copays).

You can see what your premium, deductibles, and out-of-pocket costs will be before you enroll. Through the Marketplace, you’ll also learn if you qualify for free or low-cost coverage from Medicaid (called Apple Health in Washington state) or the Children’s Health Insurance Program (CHIP).

You can access the Marketplace for your state at www.healthcare.gov. (Washington State residents can access it at www.wahbexchange.org.)

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

When can I enroll in Marketplace coverage?

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

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

Can I switch between COBRA coverage and the Marketplace?

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

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

Can I enroll in another group health plan?

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

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

What factors should I consider when choosing coverage options?

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

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

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

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

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

- **Where you live.** Some plans limit their benefits to specific service or coverage areas. If you move to another area of the country, you may not be able to use your benefits. You may want to see (continued)

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 WAC.

- **Retiring employees,** including employees applying for a disability retirement, 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 and retirees, as described in WAC 182-12-180 and 182-12-265.

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

- **At** [www.hca.wa.gov/pebb-retirees](http://www.hca.wa.gov/pebb-retirees).

- **By calling** the PEBB Program at 1-800-200-1004 and selecting option 5 to request a **Retiree Enrollment Guide**.

To enroll in or defer enrollment in PEBB retiree insurance coverage, your form(s) must be received by the PEBB Program 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 appointed official as described in WAC 182-12-180(1).
if your plan has a service or coverage area, or other similar limitations.

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

**What if I decline COBRA or PEBB Continuation Coverage?**

If you reject or decline continuation coverage before the due date, you may change your mind as long as your completed form(s) are received by the PEBB Program no later than 60 days from the date of this notice, or the end of your PEBB health plan coverage, whichever is later.

**How long can I remain on continuation coverage?**

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

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

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

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

(2) **When the covered employee becomes entitled to Medicare within 18 months**

**before their termination of employment or reduction in hours, it affects both the employee and their dependents**

**Employees**

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

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

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

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

**Dependents**

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

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

This special Medicare extending rule for a spouse and dependent child is available only if the covered employee becomes entitled to Medicare **18 months or less** before termination of employment or reduction of hours.
(3) When an employee is on approved leave or when employment ends due to a layoff

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

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

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

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

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

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

(c) For an employee awaiting hearing of a dismissal action, PEBB Continuation Coverage (LWOP) generally can last until the dismissal is upheld or overturned for up to 29 months as described in WAC 182-12-148.

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

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

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

- Medical
- Dental
- Life insurance

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

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

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

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

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

(d) 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 if you meet the procedural and eligibility requirements in WAC 182-12-180 and 182-12-265.

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

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

(a) Disability

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

The disability must have started before the 61st day after the covered employee's termination of employment or reduction in hours and must last at least until the end of the 18-month continuation coverage period. The disability extension is available only if you notify the PEBB Program in writing and submit a 2018 COBRA Election/Change (Continuation Coverage) form and a copy of the disability award letter from the Social Security Administration no later than 60 days after the last of the following events:

- The date of the covered employee's termination of employment or reduction of hours.
- The date the qualified beneficiary loses (or would lose) coverage under PEBB rules as a result of the covered employee's
termination of employment or reduction of hours.

- The date the PEBB Program mails a PEBB Continuation Coverage Election Notice to the qualified beneficiary, informing the beneficiary of his or her responsibility and the procedures to notify the PEBB Program.

- The date of the Social Security Administration’s disability determination.

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

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), he or she may be entitled to receive up to an additional 18 months of continuation coverage, for a maximum of 36 months of continuation coverage.

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

- Occur during the initial continuation coverage period resulting from termination of employment, reduction of hours, or the retiree’s loss of PEBB retiree insurance 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 his or her termination of employment or reduction of hours. However, the employee and covered dependents may remain enrolled in COBRA for the duration of the COBRA coverage period.

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

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

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

- The date of the second qualifying event.
- The date the qualified beneficiary would lose

(continued)

*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.

**Also, termination of a state-registered domestic partnership is considered a second qualifying event for these state-registered domestic partners and their children.
coverage under PEBB 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 (LWOP) counts toward your maximum COBRA coverage period

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

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

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

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

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

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

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

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

2) Medicare entitlement or other group health coverage

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

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

After electing COBRA or PEBB Continuation Coverage, 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 coverage.

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

Note: Qualified beneficiaries who are entitled to elect COBRA or PEBB Continuation Coverage may do so even if they have other group coverage or are entitled to Medicare benefits before the date on which COBRA or PEBB Continuation Coverage is elected.
(3) **A qualified beneficiary stops being disabled**

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

(4) **Request to cancel coverage**

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

PEBB Program  
Health Care Authority  
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 notice. If your written notice is received on the first day of the month, coverage will end on the last day of the previous month.

**How much does continuation coverage cost?**

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

You will also pay the tobacco use premium surcharge and/or spouse or state-registered domestic partner coverage premium surcharge in addition to your medical plan premium if they apply to you. For more information, see “Premium Surcharges” on pages 16–17.

**When and how do I make payments?**

(1) **First payment for continuation coverage**

Your first payment (and any applicable premium surcharges) are due to the HCA **no later than 45 days** after the date the PEBB Program receives your election form.

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

You must make sure the amount of your first payment is correct. To confirm the amount due, call 1-800-200-1004 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 payment.**

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

You must mail or bring your **first payment** to:

**Mail to:**

Health Care Authority  
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 the Health Care Authority.

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

**Mailing address**

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

(continued)
To request electronic debit service, call 1-800-200-1004 and select option 4 to speak with PEBB Accounting.

(3) When payments are considered made
We consider your payment made on the date it was mailed or hand delivered to the Health Care Authority at one of the addresses under (2) above, or received via electronic debit service (see the Electronic Debit Service Agreement form at www.hca.wa.gov/erb under Forms and publications). Payment will not be considered made if your check is returned due to insufficient funds or for any other reason.

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

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

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

(5) Grace period for monthly premium payments
You will be allowed a 30-day grace period from the date that your premium (and any applicable premium surcharges) become delinquent to pay the unpaid premium balance or premium surcharges. If your monthly premium (and any applicable premium surcharges) remain 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 surcharges) were paid.

A monthly premium (and applicable premium surcharges) are considered delinquent (unpaid) if:

• The HCA doesn't receive payment for your monthly premium (or applicable premium surcharges) for 30 days after the original due date; or
• The 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 surcharges) remain underpaid for 30 days after the original due date.

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

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

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

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

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

Once you are terminated from COBRA or PEBB Continuation Coverage, you cannot reenroll.
2018 PEBB Continuation Coverage (Leave Without Pay) and COBRA Monthly Premiums

Effective January 1, 2018

Special Requirements

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

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

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

### Non-Medicare Medical Plan Premiums

<table>
<thead>
<tr>
<th>For members not eligible for Medicare (or enrolled in Part A only)</th>
<th>Subscriber Only</th>
<th>Subscriber and Spouse*</th>
<th>Subscriber and Child(ren)</th>
<th>Full Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaiser Permanente NW Classic**</td>
<td>$692.66</td>
<td>$1,380.30</td>
<td>$1,208.39</td>
<td>$1,896.03</td>
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<tr>
<td>Kaiser Permanente NW CDHP**</td>
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<tr>
<td>Kaiser Permanente WA (formerly Group Health) Classic</td>
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<td>Kaiser Permanente WA (formerly Group Health) CDHP</td>
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<td>$1,167.37</td>
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<tr>
<td>Kaiser Permanente WA (formerly Group Health) SoundChoice</td>
<td>$607.11</td>
<td>$1,209.20</td>
<td>$1,058.68</td>
<td>$1,660.77</td>
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<tr>
<td>Kaiser Permanente WA (formerly Group Health) Value</td>
<td>$633.52</td>
<td>$1,262.02</td>
<td>$1,104.90</td>
<td>$1,733.40</td>
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<tr>
<td>UMP Classic</td>
<td>$657.86</td>
<td>$1,310.70</td>
<td>$1,147.49</td>
<td>$1,800.33</td>
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<tr>
<td>UMP CDHP</td>
<td>$588.91</td>
<td>$1,166.83</td>
<td>$1,036.93</td>
<td>$1,556.52</td>
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<tr>
<td>UMP Plus-PSHVN</td>
<td>$600.56</td>
<td>$1,196.10</td>
<td>$1,047.22</td>
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<tr>
<td>UMP Plus-UW Medicine ACN</td>
<td>$600.56</td>
<td>$1,196.10</td>
<td>$1,047.22</td>
<td>$1,642.76</td>
</tr>
</tbody>
</table>

*or state-registered domestic partner

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

(continued)
### Medicare Medical Plan Premiums

<table>
<thead>
<tr>
<th>For members enrolled in Medicare Part A and Part B</th>
<th>Subscriber Only</th>
<th>Subscriber and Spouse*</th>
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<tbody>
<tr>
<td>1 Medicare eligible</td>
<td>1 Medicare eligible</td>
<td>2 Medicare eligible</td>
<td>1 Medicare eligible</td>
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<tr>
<td>Kaiser Permanente NW Senior Advantage**</td>
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<td>Kaiser Permanente WA (formerly Group Health) Medicare Plan</td>
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<td>Kaiser Permanente WA (formerly Group Health) SoundChoice</td>
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<td>N/A †</td>
<td>$776.97</td>
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<td>Kaiser Permanente WA (formerly Group Health) Value</td>
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<td>$953.90</td>
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<td>$796.78</td>
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<td>$1,136.48</td>
<td>$962.26</td>
<td>$973.27</td>
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</table>

* Or state-registered domestic partner

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

† If a Kaiser Permanente WA (formerly Group Health) member is enrolled in Medicare Part A and Part B and other enrolled family members are not eligible for Medicare, the non-Medicare family 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 family members are not eligible for Medicare, the non-Medicare family 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.
**Medicare Supplement Plan F Premiums (administered by Premera Blue Cross)**
Available for COBRA and PEBB Continuation of Coverage members (not enrolled in Leave Without Pay) only.

<table>
<thead>
<tr>
<th></th>
<th>Subscriber Only</th>
<th>Subscriber and Spouse*</th>
<th>Subscriber and Child(ren)</th>
<th>Full Family</th>
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</thead>
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<tr>
<td></td>
<td>1 Medicare eligible</td>
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<td>2 Medicare eligible: 1 retired, 1 disabled</td>
<td>2 Medicare eligible</td>
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<tr>
<td>Plan F</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Age 65 or older, eligible by age</td>
<td>$212.38</td>
<td>$870.24</td>
<td>$573.41</td>
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<td>Plan F</td>
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<td>$1,018.89</td>
<td>$573.41</td>
<td>$722.06</td>
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</table>

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

---

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

For more guidance on whether these surcharges apply to you, see the 2018 Premium Surcharge Help Sheet at [www.hca.wa.gov/erb](http://www.hca.wa.gov/erb).

---

**Dental Plan Premiums**

### 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.**

<table>
<thead>
<tr>
<th></th>
<th>Dental Plan Premiums</th>
<th>Dental Plan Premiums</th>
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</thead>
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<td></td>
<td>DeltaCare, administered by Delta Dental of Washington</td>
<td>DeltaCare, administered by Delta Dental of Washington</td>
</tr>
<tr>
<td></td>
<td>Uniform Dental Plan, administered by Delta Dental of Washington</td>
<td>Uniform Dental Plan, administered by Delta Dental of Washington</td>
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<tr>
<td></td>
<td>Willamette Dental of Washington, Inc.</td>
<td>Willamette Dental of Washington, Inc.</td>
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<table>
<thead>
<tr>
<th></th>
<th>Subscriber Only</th>
<th>Subscriber and Spouse*</th>
<th>Subscriber and Child(ren)</th>
<th>Full Family</th>
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<td>$39.53</td>
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<td>$79.06</td>
<td>$91.64</td>
<td>$84.74</td>
<td>$193.30</td>
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</table>

**Or state-registered domestic partner**
These premium surcharges apply to PEBB benefits-eligible subscribers who:

- Are enrolled in a PEBB medical plan.
- AND
- Do not have Medicare Part A and Part B as their primary coverage (excluding PEBB Continuation Coverage [Leave Without Pay] subscribers).

**Tobacco use premium surcharge**

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

- You or any family member age 13 or older enrolled on your PEBB medical coverage attests to using a tobacco product in the past two months (whether your enrolled family member lives with you or not).
- OR
- You do not respond whether the tobacco use surcharge applies no later than 60 days after the mailing date on this booklet.

To determine whether the tobacco use premium surcharge applies to your account, use the 2018 Premium Surcharge Help Sheet (found on page 49) and respond by completing the 2018 COBRA Election/Change (Continuation Coverage) form or the 2018 Continuation Coverage Election/Change (for Leave Without Pay) form. The PEBB Program must receive the form by the required deadline.

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

- You have a spouse or state-registered domestic partner enrolled on your PEBB medical, and your spouse or state-registered domestic partner has elected not to enroll in other employer-based group medical that is comparable to Uniform Medical Plan (UMP) Classic. (This is regardless of whether you enroll in UMP Classic.)
- OR
- You have a spouse or state-registered domestic partner enrolled on your PEBB medical, and you do not respond on the form whether the spouse or state-registered domestic partner coverage surcharge applies no later than 60 days after the mailing date on this booklet.

If you enroll a spouse or state-registered domestic partner on your PEBB medical plan, use the 2018 Premium Surcharge Help Sheet (found on page 49) to determine whether the spouse or state-registered domestic partner coverage premium surcharge applies to your account. Then respond by completing the 2018 COBRA Election/Change (Continuation Coverage) form or 2018 Continuation Coverage Election/Change (for Leave Without Pay) 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 if you enroll a
spouse or state-registered domestic partner on your PEBB medical and you are:

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

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

To report a change

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

• When there is 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 2018 COBRA Election/Change (Continuation Coverage) form or 2018 Continuation Coverage Election/Change (for Leave Without Pay) form.

To change your current attestation (without adding or removing your spouse or state-registered domestic partner from PEBB medical), complete and submit a 2018 Premium Surcharge Change Form (found at www.hca.wa.gov/erb) to the PEBB Program. You must also submit proof of the qualifying event with your completed form within 60 days of the qualifying event.

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

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

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

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

Who is eligible to participate?

All subscribers, except those who are 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 2019 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 2019).

How do I qualify for the financial wellness incentives?

To qualify for the $25 financial wellness incentives, 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, 2018.

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

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

To qualify for the incentive in 2019, the subscriber must still be enrolled in a PEBB medical plan in 2019.

If a subscriber qualifies for the $125 wellness incentive in 2018, and enrolls in Medicare Part A and Part B while enrolled in a PEBB medical plan after January 1, 2019, he or she will still receive the incentive in 2019.

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 qualify for and claim the $25 Amazon.com gift card wellness incentive is December 31, 2018.

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, 2018**.

• 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 his PEBB medical effective date is July 1, 2018. Sam’s deadline to complete his SmartHealth activities and earn his financial wellness incentive is October 29, 2018.*

• If your PEBB medical effective date is in September through December, your deadline is **December 31, 2018**.
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 dog guide 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...

<table>
<thead>
<tr>
<th>Organization</th>
<th>Health Care Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaiser Foundation Health Plan of the Northwest</td>
<td>Division of Legal Services, Attn: HCA Compliance Officer</td>
</tr>
<tr>
<td>Kaiser Foundation Health Plan of Washington (formerly Group Health Cooperative)</td>
<td>Quality GNE-D1E-07</td>
</tr>
<tr>
<td>Kaiser Foundation Health Plan of Washington Options, Inc. (formerly Group Health Options, Inc.)</td>
<td></td>
</tr>
<tr>
<td>Washington State Rx Services (for discrimination concerns about prescription-drug benefits for Uniform Medical Plan [UMP])</td>
<td></td>
</tr>
<tr>
<td>Premera Blue Cross (for discrimination concerns about Medicare Supplement Plan F and the Center of Excellence Program for UMP Classic and UMP CDHP members)</td>
<td></td>
</tr>
</tbody>
</table>

### You can file a grievance with:

- Kaiser Foundation Health Plan of the Northwest
- Kaiser Foundation Health Plan of Washington
- Kaiser Foundation Health Plan of Washington Options, Inc.
- Washington State Rx Services
- Premera Blue Cross

HCA 57-401 (6/18)
If you believe this organization has failed to provide language access services or discriminated in another way...

<table>
<thead>
<tr>
<th>You can file a grievance with:</th>
</tr>
</thead>
</table>
| **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](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf) (to submit complaints electronically)
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 PEB Division Benefits Services at 1-800-200-1004. (TRS: 711).
**Appendix A:**
**COBRA and PEBB Continuation Coverage**

**Complete the 2018 COBRA Election/Change (Continuation Coverage) form if the qualifying event is one of the following:**

**Employee:**
- Your employment ended for any reason other than gross misconduct.
- Your hours of employment were reduced 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 under Leave Without Pay (LWOP), which may allow a longer coverage period and different benefits.

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

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

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

**State-registered domestic partner’s children**
- 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 (the employee’s) hours of employment are reduced.
- Your parent’s state-registered domestic partner (the employee’s) employment ends for any reason other than gross misconduct.
- Your eligibility for PEBB health plan coverage as a dependent child ends.

**Retiree:**
- You are a retiree and your employer group ends participation in 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.
Medical and dental benefits
You may elect to continue coverage you were enrolled in on the day before the qualifying event occurred (medical coverage only, dental coverage only, or both medical and dental coverage) by self-paying the premiums. Unless you make separate elections, eligible dependents you elect to cover will be enrolled in the same plans you elect. To enroll, complete the enclosed 2018 COBRA Election/Change (Continuation Coverage) 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 within 60 days from the date your PEBB health plan coverage ended or the mailing date on this booklet (whichever is later), PEBB coverage will end on the last day of the month you and your family member(s) stop being eligible for your original PEBB coverage.

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

Note: If you are enrolled in a PEBB Medical Flexible Spending Arrangement (FSA) and your employment ends, you may be eligible to continue making contributions to your Medical FSA through Navia Benefit Solutions until the end of the plan year by electing 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 mailing date on Navia’s COBRA election notice, whichever is later. You can find more information in the 2018 PEBB Medical Flexible Spending Arrangement Enrollment Guide at http://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 this plan terminates, you will have an opportunity to continue group term coverage (“portability”) under a different policy, subject to plan design and state availability. Premiums will be based on the experience of the group enrolled in portability coverage and MetLife will bill you directly. Premiums may be higher than your current premiums. To take advantage of this feature, you must have coverage of at least $10,000.

Portability is also available on coverage you’ve selected for your spouse or state-registered domestic partner and dependent child(ren). The maximum amount of coverage for your spouse or state-registered domestic partner is $250,000; the maximum amount of coverage for your dependent child is $25,000. Increases, decreases, and maximums are subject to state availability. Generally, there is no minimum time that you must be covered by the plan before you can take advantage of the portability feature. Please see your certificate for specific details. MetLife will send portability information to you which will include instructions on how to continue coverage.

Conversion coverage
You can generally convert your group term life insurance to an individual whole life insurance policy if your coverage terminates in whole or in part due to your retirement, termination of employment, or eligibility for employer-sponsored coverage ends. Conversion is available on all group life insurance coverages. Please note that conversion is not available on AD&D coverage. MetLife will send conversion information to you which will include instructions on how to continue coverage.
# 2018 COBRA Election/Change (Continuation Coverage)

- 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 the HCA receives your election form. Premiums and applicable premium surcharges are due back to the date your other coverage ended.
- List eligible family members you wish to cover or remove from coverage. This form replaces all COBRA Election/Change forms previously submitted.
- If adding a dependent with a disability age 26 or older, or an extended dependent, you must also include the applicable required dependent certification form(s).

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

<table>
<thead>
<tr>
<th>Employee or retiree information only</th>
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<tbody>
<tr>
<td>Employee or retiree name</td>
</tr>
<tr>
<td>Employee or retiree Social Security number</td>
</tr>
<tr>
<td>Date employer coverage ended (mm/dd/yyyy)</td>
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</table>

## Section 1: Subscriber Information

<table>
<thead>
<tr>
<th>Social Security number</th>
<th>Last name</th>
<th>First name</th>
<th>Middle initial</th>
<th>Sex</th>
<th>Street address</th>
<th>Apt./unit number</th>
<th>City</th>
<th>State</th>
<th>ZIP Code</th>
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</tbody>
</table>

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

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

**Continue coverage:** (select one)

- Medical and dental
- Medical only
- Dental only

You may elect to continue coverage you were enrolled in on the day your employer-sponsored coverage ended. If you have life insurance and wish to port or convert, contact MetLife at 1-866-548-7139.

If you are enrolled in a Medical Flexible Spending Arrangement and would like to continue it, contact Navia Benefit Solutions at 1-800-660-3539. 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.

**Cancel coverage:** (select one)

- Medical and dental
- Medical only
- Dental only

If cancelling coverage, include reason ____________________________ Cancel date _______________

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

- Are you covered by another group medical plan? Yes No
- If yes, effective date ____________________________

- Are you covered by another group dental plan? Yes No
- If yes, effective date ____________________________

- Are you disabled under Title II (OASDI) of the Social Security Act? Yes No
- If yes, effective date ____________________________

- Are you disabled under Title XVI (SSI) of the Social Security Act? Yes No
- If yes, effective date ____________________________

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

- Enrolled in Part(s) A and/or B of Medicare?
  - Part A (hospital) Yes No
  - Part B (medical) Yes No

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

HCA 50-245F (7/18) (continued)
Tobacco Use Premium Surcharge

The PEBB Program requires a monthly $25-per-account surcharge in addition to your premium if you are not enrolled in Medicare Part A and Part B, and you or a family member (age 13 or older) enrolled on your PEBB medical coverage uses a tobacco product. Tobacco use is defined as any use of tobacco products within the past two months except for religious or ceremonial use. See the 2018 Premium Surcharge Help Sheet at www.hca.wa.gov/pebb for instructions on how to respond. If you check YES below or leave this section blank, you will pay the surcharge.

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

- I am enrolled in Medicare Part A and Part B. The premium surcharge does not apply.
- YES, I am subject to the $25 premium surcharge. I have used tobacco products in the past two months.
- NO, I am not subject to the $25 premium surcharge. I have not used tobacco products in the past two months, or I have used the tobacco cessation resources noted in the 2018 Premium Surcharge Help Sheet.

Section 2: Spouse or State-Registered Domestic Partner Information

List an eligible spouse or state-registered domestic partner, as defined by Washington Administrative Code 182-12-260(2), you wish to cover or remove from coverage. Family members cannot be enrolled in two PEBB medical or dental accounts at the same time. If adding a state-registered domestic partner, you must provide proof of eligibility (dependent verification documents) within PEBB 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/pebb.

Relationship to subscriber

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

Covered by another group medical plan?

- Yes
- No

Covered by another group dental plan?

- Yes
- No

Disabled under Title II (OASDI) of the Social Security Act?

- Yes
- No

Disabled under Title XVI (SSI) of the Social Security Act?

- Yes
- No

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?

<table>
<thead>
<tr>
<th>Part A (hospital)</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part B (medical)</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

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

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 premium surcharge does not apply.
- YES, I am subject to the $25 premium surcharge. My spouse or state-registered domestic partner has used tobacco products in the past two months.
- NO, I am not subject to the $25 premium surcharge. My spouse or state-registered domestic partner has not used tobacco products in the past two months, or has used the tobacco cessation resources noted in the 2018 Premium Surcharge Help Sheet.

(continued)
### 2018 COBRA Election/Change

**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 other employer-based group medical that is comparable to Uniform Medical Plan Classic. See the 2018 Premium Surcharge Help Sheet and the 2018 Spousal Plan Calculator at [www.hca.wa.gov/pebb](http://www.hca.wa.gov/pebb). To change your attestation, use the 2018 Premium Surcharge Change Form. If you check YES below or leave this section blank, you will pay the monthly surcharge.

Does the spouse or state-registered domestic partner coverage 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 2018 Premium Surcharge Help Sheet and completed the 2018 Spousal Plan Calculator online.
- [ ] NO, I am not subject to the $50 premium surcharge. I used the 2018 Premium Surcharge Help Sheet and, if needed, completed the 2018 Spousal Plan Calculator online.

Which questions, if any, on the 2018 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 2018 Spousal Plan Calculator for the PEBB Program to determine.

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

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

<table>
<thead>
<tr>
<th>A</th>
<th>Relationship to subscriber</th>
<th>Disabled? Check only if age 26 or older</th>
<th>Sex</th>
<th>Social Security number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Extended dependent validated by court order?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Last name</td>
<td>First name</td>
<td>Middle initial</td>
<td>Date of birth (mm/dd/yyyy)</td>
</tr>
<tr>
<td></td>
<td>Street address (only if different from subscriber)</td>
<td>Apt./unit number</td>
<td>City</td>
<td>State</td>
</tr>
</tbody>
</table>

- [ ] Continue coverage: (select one)
  - [ ] Medical and dental
  - [ ] Medical only
  - [ ] Dental only
- [ ] Add coverage: (select one)
  - [ ] Medical and dental
  - [ ] Medical only
  - [ ] Dental only
- [ ] Cancel coverage: (select one)
  - [ ] Medical and dental
  - [ ] Medical only
  - [ ] Dental only

If cancelling coverage, include reason for cancellation.

<table>
<thead>
<tr>
<th>Covered by another group medical plan?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, effective date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered by another group dental plan?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If yes, effective date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disabled under Title II (OASDI) of the Social Security Act?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If yes, effective date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disabled under Title XVI (SSI) of the Social Security Act?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If yes, effective date</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you and your enrolled dependents may be eligible for additional months of coverage.

<table>
<thead>
<tr>
<th>Enrolled in Part(s) A and/or B of Medicare?</th>
<th>Part A (hospital)</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, effective date</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part B (medical)</td>
<td>Yes</td>
<td>No</td>
<td></td>
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<tr>
<td>If yes, effective date</td>
<td></td>
<td></td>
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</table>

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

**Tobacco Use Premium Surcharge—if enrolling in medical coverage**

Does the tobacco use premium surcharge apply to this family member? *(Response required for family members 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 premium surcharge does not apply.
- [ ] YES, I am subject to the $25 premium surcharge. This family member has used tobacco products in the past two months.
- [ ] NO, I am not subject to the $25 premium surcharge. This family member has not used tobacco products in the past two months, or has used the tobacco cessation resources noted in the 2018 Premium Surcharge Help Sheet.

-----

(continued) 3
Section 3: Family Member Information (continued)

B Relationship to subscriber

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

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

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

Financial State of the Family Member:

□ Yes
□ No
If yes, effective date ______________________

Extended dependent validated by court order? □ Yes □ No

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

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

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

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

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 family member’s Social Security Disability Award letter. You and your enrolled dependents may be eligible for additional months of coverage.

Tobacco Use Premium Surcharge— if enrolling in medical coverage

Does the tobacco use premium surcharge apply to this family member? (Response required for family members 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 premium surcharge does not apply.

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

□ NO, I am not subject to the $25 premium surcharge. This family member has not used tobacco products in the past two months, or has used the tobacco cessation resources noted in the 2018 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 ______________________

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

□ Remove dependent(s) from coverage. In most cases, when removing a dependent from coverage, the change will occur prospectively. If removing due to loss of eligibility (divorce, dissolution of state-registered domestic partnership, death, or other loss of eligibility under PEBB Program rules), we must receive this form no later than 60 days after the dependent is no longer eligible. Coverage will be cancelled 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
Section 4: Changes to an Existing Account (continued)

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

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

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/pebb.

- 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 his or her employer-based group health plan.

- Subscriber’s dependent has a change in his or her own employment status that affects his or her eligibility for the employer contribution under his or her employer-based group health plan.

- A court order or National Medical Support Notice requires the subscriber or any other individual to provide insurance coverage for an eligible child of the subscriber.

- 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 his or her dependent for a specific condition or ongoing course of treatment (requires approval by the PEBB Program).

Are you or any eligible dependents enrolled in PEBB insurance coverage under another account?  □ Yes  □ No
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
3 Kaiser Permanente NW Senior Advantage

Kaiser Foundation Health Plan of Washington  
1 Kaiser Permanente WA (formerly Group Health Cooperatives)
2 Kaiser Permanente WA (formerly Group Health) Classic
3 Kaiser Permanente WA (formerly Group Health) Medicare Plan
4 Kaiser Permanente WA (formerly Group Health) SoundChoice
5 Kaiser Permanente WA (formerly Group Health) Value

Kaiser Foundation Health Plan of Washington Options Inc.  
1 Kaiser Permanente WA (formerly Group Health Options Inc.)
2 Kaiser Permanente WA (formerly Group Health) Consumer-Directed Health Plan

Medicare Supplement Plan F, administered by Premera Blue Cross

Uniform Medical Plan, administered by Regence BlueShield

1 UMP Classic
2 UMP Consumer-Directed Health Plan
3 UMP Plus—Puget Sound High Value Network
4 UMP Plus—UW Medicine Accountable Care Network

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

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

3 These plans are available only to members not enrolled in Medicare. If you cover a dependent enrolled in Medicare, you must cancel your dependent’s PEBB 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/pebb 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 (formerly Group Health) 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.

Section 6: Dental Plan Selection  
Check only one.

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

Preferred Provider Organization
You can choose any dental provider and change providers at any time.

☐ Uniform Dental Plan (Group #3000), administered by Delta Dental of Washington

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

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

☐ Willamette Dental of Washington, Inc. (Group WA82)
   Call Willamette Dental of Washington at 1-855-433-6825 to verify your provider is in the Willamette Dental Group network.
Section 7: Signature Required

I have received and read the PEBB Continuation Coverage Election Notice, including any appendices. By signing this form, I declare that the information I have provided is true, complete, and correct. If it isn’t, or if I do not update this information within the timelines in PEBB Program rules, to the extent permitted by federal and state laws, I must repay any claims paid by my health plan(s). My family members and I may also lose PEBB 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 family members. If we do not qualify, I will receive a refund.

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

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

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

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

Subscriber’s signature __________________________________________________________
Date ____________________

Please sign and date this form.

<table>
<thead>
<tr>
<th>Mail to:</th>
<th>If payment is enclosed, make it payable to Health Care Authority and mail to:</th>
<th>Or hand-deliver to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Washington State Health Care Authority</td>
<td>Washington State Health Care Authority</td>
<td>Washington State Health Care Authority</td>
</tr>
<tr>
<td>PO Box 42684</td>
<td>PO Box 42691</td>
<td>626 8th Ave. SE</td>
</tr>
<tr>
<td>Olympia, WA 98504-2684</td>
<td>Olympia, WA 98504-2691</td>
<td>Olympia, WA 98501</td>
</tr>
</tbody>
</table>

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

### 2018 PEBB Program Medical Contractors

- **Kaiser Foundation Health Plan of Washington**
  (formerly Group Health Cooperative)
  601 Union Street, Suite 3100, Seattle, WA 98101
  1-888-901-4636 or TTY 1-800-833-6388

- **Kaiser Foundation Health Plan of Washington Options, Inc.**
  (formerly Group Health Options Inc.)
  601 Union Street, Suite 3100, Seattle, WA 98101
  1-888-901-4636 or TTY 1-800-833-6388

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

- **Premera Blue Cross**
  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

### 2018 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).
2018 Medicare Advantage Plan Election Form
Please fill in all information requested. Be sure to read and sign the back of this form.

### Section 1: Retiree information

<table>
<thead>
<tr>
<th>Medical effective date (mm/dd/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security number</td>
</tr>
<tr>
<td>Permanent residential address (required)</td>
</tr>
<tr>
<td>Mailing address (if different than above)</td>
</tr>
<tr>
<td>County of residence</td>
</tr>
<tr>
<td>Retiree Medicare claim number from Medicare card</td>
</tr>
</tbody>
</table>

#### 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)

| Entitled to Part A (hospital)  □ Yes  □ No  
If yes, effective date _______________________
| Entitled to Part B (medical)  □ Yes  □ No  
If yes, effective date _______________________

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

#### Spouse or state-registered domestic partner’s Medicare claim number from Medicare card

### Section 3: Plan choice

Kaiser Foundation Health Plan of Washington (formerly Group Health Cooperative)  
□ Kaiser Permanente WA (formerly Group Health) Medicare Advantage

Kaiser Foundation Health Plan of the Northwest  
□ Kaiser Permanente NW Senior 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

---

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

(continued)
Section 4: Medical information

<table>
<thead>
<tr>
<th>Question</th>
<th>Retiree Yes/No</th>
<th>Spouse or state-registered domestic partner Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you currently have end-stage renal disease (kidney disease)?</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>2. Do you have any health insurance other than Medicare?</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>If yes, through which company?</td>
<td></td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Do you intend to discontinue this policy?</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

Note: Your answers to questions 3 and 4 below will not affect your eligibility to enroll in a Medicare Advantage plan.

<table>
<thead>
<tr>
<th>Question</th>
<th>Retiree Yes/No</th>
<th>Spouse or state-registered domestic partner Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Do you live in an institution?</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>If yes, name of institution:</td>
<td></td>
<td>Date of admission:</td>
</tr>
<tr>
<td>Address</td>
<td></td>
<td>Phone number:</td>
</tr>
<tr>
<td>4. Are you currently receiving Medicaid?</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>If yes, Medicaid number:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature and authorization

By signing this form, I declare that the information I have provided is true, complete, and correct. If it isn’t, or if I do not update this information within the timelines in PEBB Program rules, to the extent permitted by federal and state law, I must repay any claims paid by my health plan(s) or premiums paid on my behalf. My family members and I may also lose PEBB benefits as of the last day of the month we qualified. To the extent permitted by law, the PEBB Program may retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility, or do not fully pay premiums when due. In addition, I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, and denial of PEBB 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/pebb.

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

Signature of applicant 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 he or she resides) 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 applicant

Address Phone

HCA is committed to providing equal access to our services.
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 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.

#### 2018 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 TTY: 711

**Kaiser Foundation Health Plan of Washington**  
601 Union St., Suite 3100, Seattle, WA 98101-1374  
1-888-901-4636 or TTY: 1-800-833-6388 or 711
Appendix B: PEBB Continuation Coverage (Leave Without Pay)

Complete this *2018 Continuation Coverage Election/Change (for Leave Without Pay)* form if you are an employee who will lose your PEBB employer-based coverage because of one of the following events:

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

*You may also be entitled to continue long-term disability coverage. See pages 39-40 for information on continuing LTD coverage while on USERRA or approved educational leave.
Medical and dental benefits
You may elect to continue coverage you were enrolled in on the day before the qualifying event (medical, dental, or both) by self-paying the premiums. Your enrolled eligible dependents will be enrolled in the same plans that you elect. If you do not elect PEBB Continuation Coverage (LWOP), your family members may not enroll independently as they do not have independent election rights to PEBB Continuation Coverage (LWOP). To enroll, complete the enclosed 2018 Continuation Coverage Election/Change (for Leave Without Pay) form and submit it to the PEBB Program at the address shown at the end of the form.

If the PEBB Program does not receive your completed form within 60 days from the date your PEBB health plan coverage ended or the mailing date on this booklet (whichever is later), PEBB coverage will end on the last day of the month you and your family member(s) stop being eligible for your original PEBB coverage.

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

Note: If you are enrolled in a PEBB Medical Flexible Arrangement (FSA) and your employer-based coverage ends, you can elect to continue your Medical FSA if you are eligible to enroll in PEBB Continuation Coverage (Leave Without Pay). You must contact Navia Benefit Solutions at 1-800-669-3539 or customerservice@naviabenefits.com no later than 60 days after the mailing date on this booklet. You can find more information in Navia Benefits Solutions’ 2018 PEBB Medical Flexible Spending Arrangement Enrollment Guide at http://pebb.naviabenefits.com.

Life insurance benefits
You may choose to continue all or part of your life insurance coverage while on PEBB Continuation Coverage (LWOP). If you choose to continue any part of your optional life coverage, you must also continue the $35,000 Basic Life Insurance and $5,000 Basic Accidental Death & Dismemberment (AD&D) Insurance at a cost of $3.96 per month.

If you do not continue your life insurance and wish to reenroll when you return to work, you may need to submit a 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 continued during PEBB Continuation Coverage (LWOP) cannot exceed 50 percent of the Employee Optional Life Insurance coverage in force.

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

1. You can use agency-approved annual or military leave to maintain a minimum of eight hours’ pay status each month. Employer-sponsored Basic Life 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 2018 Continuation Coverage Election/Change (for Leave Without Pay) form. Payments are due 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, 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 LWOP, your employee coverage will be reinstated when you return to work without evidence of insurability.

- If you choose not to pay for optional coverage during LWOP, complete the *MetLife Enrollment/Change Form*. Your enrollment may require a Statement of Health depending on the coverage you elect.

**Long-term disability insurance benefits**

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

**If you continue LTD coverage while on USERRA or educational leave**

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

**Reinstatement requirements**

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

(continued)
### USERRA or educational leave only

<table>
<thead>
<tr>
<th>You discontinued LTD coverage during PEBB Continuation Coverage (LWOP)</th>
<th>You self-paid for LTD coverage during PEBB Continuation Coverage (LWOP) and you return to active work immediately following your leave period</th>
<th>You self-paid for LTD coverage during PEBB Continuation Coverage (LWOP) but did not return to active work immediately following your leave period</th>
<th>You were not eligible to continue LTD coverage during PEBB Continuation Coverage (LWOP)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>To apply for optional LTD insurance, your employing agency must receive your completed Long Term Disability Enrollment/Change Form and Standard Insurance Company must receive your completed Long Term Disability Evidence of Insurability Form no later than 31 days after you regain eligibility for the employer contribution. Your insurance would not become effective until approved by Standard Insurance Company.</strong></td>
<td><strong>If you become eligible for the employer contribution immediately following your leave during the first 29 months, your LTD insurance does not end. You do not have to complete and submit any forms to continue the amount of coverage you had during PEBB Continuation Coverage (LWOP).</strong></td>
<td><strong>If you do not immediately return to work after your approved leave period and your insurance ends—You are eligible to reinstate your basic and optional LTD insurance the first day of the month you regain eligibility for the employer contribution as a new subscriber. Your employing agency must receive your completed Long Term Disability Enrollment/Change Form no later than 31 days of becoming eligible for benefits. After 31 days of becoming eligible for benefits, follow these steps for requesting changes to your waiting period:</strong></td>
<td><strong>Your basic and optional LTD insurance 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 (LWOP). You do not have to complete and submit any forms.</strong></td>
</tr>
<tr>
<td><strong>If you wish to increase your waiting period for optional LTD coverage—Your employing agency must receive your completed Long Term Disability Enrollment/Change Form no later than 31 days after you regain eligibility for the employer contribution.</strong></td>
<td><strong>If you wish to increase your waiting period for optional LTD coverage—Your employing agency must receive your completed Long Term Disability Enrollment/Change Form no later than 31 days after you regain eligibility for the employer contribution.</strong></td>
<td><strong>If you wish to increase your waiting period for optional LTD coverage—Your employing agency must receive your completed Long Term Disability Enrollment/Change Form no later than 31 days after you regain eligibility for the employer contribution.</strong></td>
<td><strong>If you wish to increase your waiting period for optional LTD coverage—Your employing agency must receive your completed Long Term Disability Enrollment/Change Form no later than 31 days after you regain eligibility for the employer contribution.</strong></td>
</tr>
<tr>
<td><strong>If you wish to decrease your waiting period for optional LTD coverage—Your employing agency must receive your completed Long Term Disability Evidence of Insurability Form after you regain eligibility for the employer contribution. The decreased waiting period would not become effective until approved by Standard Insurance Company. Otherwise, you will continue to be enrolled in the same level of basic and optional LTD insurance you had during PEBB Continuation Coverage (LWOP).</strong></td>
<td><strong>If you wish to decrease your waiting period for optional LTD coverage—Your employing agency must receive your completed Long Term Disability Evidence of Insurability Form after you regain eligibility for the employer contribution. The decreased waiting period would not become effective until approved by Standard Insurance Company. Otherwise, you will continue to be enrolled in the same level of basic and optional LTD insurance you had during PEBB Continuation Coverage (LWOP).</strong></td>
<td><strong>If you wish to decrease your waiting period for optional LTD coverage—Your employing agency must receive your completed Long Term Disability Evidence of Insurability Form after you regain eligibility for the employer contribution. The decreased waiting period would not become effective until approved by Standard Insurance Company. Otherwise, you will continue to be enrolled in the same level of basic and optional LTD insurance you had during PEBB Continuation Coverage (LWOP).</strong></td>
<td></td>
</tr>
</tbody>
</table>
2018 Continuation Coverage
Election/Change (for Leave Without Pay)

- 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 the HCA receives your election form. Premiums and applicable premium surcharges are due back to when your other coverage ended.
- List eligible family members you wish to cover or remove from coverage. This form replaces all Continuation Coverage Election/Change (for Leave Without Pay) forms previously submitted.
- If adding a dependent with a disability age 26 or older, or an extended dependent, you must also include the applicable required dependent certification form.

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

### Qualifying Event for Leave Without Pay Coverage

- 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

<table>
<thead>
<tr>
<th>Social Security number</th>
<th>Last name</th>
<th>First name</th>
<th>Middle initial</th>
<th>Sex</th>
<th>Street address</th>
<th>Apt./unit number</th>
<th>City</th>
<th>State</th>
<th>ZIP Code</th>
<th>Mailing address (if different from above)</th>
<th>Apt./unit number</th>
<th>City</th>
<th>State</th>
<th>ZIP Code</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

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

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.

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

Include reason ___________________________________________________________________

Cancel date __________________

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

Visit our website at www.hca.wa.gov/pebb (continued)
Section 1: Subscriber Information

Tobacco Use Premium Surcharge

The PEBB Program requires a monthly $25-per-account surcharge in addition to your premium if you or a family member (age 13 or older) enrolled on your PEBB medical coverage uses a tobacco product. Tobacco use is defined as any use of tobacco products within the past two months except for religious or ceremonial use. See the 2018 Premium Surcharge Help Sheet at www.hca.wa.gov/pebb for instructions on how to respond. If you check YES below or leave this section blank, you will pay the surcharge.

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

☐ YES, I am subject to the $25 premium surcharge. I have used tobacco products in the past two months.
☐ NO, I am not subject to the $25 premium surcharge. I have not used tobacco products in the past two months, or I have used tobacco cessation resources noted in the 2018 Premium Surcharge Help Sheet.

Section 2: Spouse or State-Registered Domestic Partner Information

List an eligible spouse or state-registered domestic partner, as defined by Washington Administrative Code 182-12-260(2), you wish to cover or remove from coverage. Family members cannot be enrolled in two PEBB medical or dental accounts at the same time. If adding a state-registered domestic partner you must provide proof of eligibility (dependent verification documents) 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/pebb.

Relationship to subscriber

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

Social Security number | Last name | First name | Middle initial | Sex |
------------------------|-----------|------------|----------------|-----|

Street address (only if different from subscriber) | Apt./unit number | City | State | ZIP Code | Date of birth (mm/dd/yyyy)

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

If cancelling coverage, include reason ____________________________ Cancel date ______________

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

Tobacco Use Premium Surcharge—If enrolling 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 used tobacco cessation resources noted in the 2018 Premium Surcharge Help Sheet.

Spouse or State-Registered Domestic Partner Coverage Premium Surcharge

The PEBB Program requires a monthly $50 surcharge in addition to your premium if your spouse or state-registered domestic partner is enrolling in medical coverage and has elected not to enroll in other employer-based group medical insurance that is comparable to Uniform Medical Plan Classic. See the 2018 Premium Surcharge Help Sheet and the 2018 Spousal Plan Calculator at www.hca.wa.gov/pebb. To change your attestation, use the 2018 Premium Surcharge Change Form. If you check YES below or leave this section blank, you will pay the monthly surcharge.

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

☐ YES, I am subject to the $50 premium surcharge. I used the 2018 Premium Surcharge Help Sheet and completed the 2018 Spousal Plan Calculator online.
☐ NO, I am not subject to the $50 premium surcharge. I used the 2018 Premium Surcharge Help Sheet and, if needed, completed the 2018 Spousal Plan Calculator online.

Which questions, if any, on the 2018 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 2018 Spousal Plan Calculator for the PEBB Program to determine.
### Section 3: Family Member Information

(such as child) **Use additional forms for more members.**

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

<table>
<thead>
<tr>
<th>A</th>
<th>Relationship to subscriber</th>
<th>Disabled?</th>
<th>Sex</th>
<th>Social Security number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Extended dependent validated by court order?</td>
<td>Yes</td>
<td>M</td>
<td>Social Security number</td>
</tr>
</tbody>
</table>

Last name | First name | Middle initial | Date of birth (mm/dd/yyyy) | Street address (only if different from subscriber) | Apt./unit number | City | State | ZIP Code |
|-----------|------------|---------------|---------------------------|---------------------------------------------------|------------------|------|--------|---------|

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

If cancelling coverage, include reason ____________________________ Cancel date ________________

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

- YES, I am subject to the $25 premium surcharge. This family member has used tobacco products in the past two months.
- NO, I am not subject to the $25 premium surcharge. This family member has not used tobacco products in the past two months, or has used the tobacco cessation resources noted in the 2018 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**  
  - Name change  
  - Address change  
  - Cancel medical coverage  
  - Cancel dental coverage

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

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

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

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

All changes become effective January 1 of the following year.
**Section 4: Changes to an Existing Account (continued)**

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

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

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/pebb.
- 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 his or her employer-based group health plan.
- Subscriber’s dependent has a change in his or her own employment status that affects his or her eligibility for the employer contribution under his or her employer-based group health plan.
- A court order or National Medical Support Notice requires the subscriber or any other individual to provide insurance coverage for an eligible child of the subscriber.
- 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 his or her dependent for a specific condition or ongoing course of treatment (requires approval by the PEBB Program).

Are you or any eligible dependents enrolled in PEBB insurance coverage under another account?  Yes  No
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 Classic²
- ☐ Kaiser Permanente NW Consumer-Directed Health Plan²

**Kaiser Foundation Health Plan of Washington (formerly Group Health Cooperative)**¹
- ☐ Kaiser Permanente WA (formerly Group Health) Classic
- ☐ Kaiser Permanente WA (formerly Group Health) SoundChoice
- ☐ Kaiser Permanente WA (formerly Group Health) Value³

**Kaiser Foundation Health Plan of Washington Options, Inc. (formerly Group Health Options Inc.)**¹
- ☐ Kaiser Permanente WA (formerly Group Health) Consumer-Directed Health Plan

**Uniform Medical Plan, administered by Regence BlueShield**
- ☐ UMP Classic
- ☐ UMP Consumer-Directed Health Plan
- ☐ UMP Plus–Puget Sound High Value Network¹
- ☐ UMP Plus–UW Medicine Accountable Care Network¹

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1. These plans have a specific service area. If you move out of the service area, you may need to change your plan. You must notify the PEBB Program no later than 60 days after you move.
2. Kaiser Foundation Health Plan of the Northwest, with plans offered in Clark and Cowlitz counties in WA, and the Portland, OR, area
3. 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 (formerly Group Health) Medicare Plan.

Section 6: Dental Plan Selection  Check only one.

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

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

**Managed-Care Plans**
You must choose a provider from the dental plan network. Before you select a managed-care plan, be sure to call the dental plan to verify your provider is in their network.
- ☐ DeltaCare (Group #3100), administered by Delta Dental of Washington
  - Call DeltaCare at 1-800-650-1583 to verify your provider accepts the specific plan network and plan group.
- ☐ Willamette Dental of Washington, Inc. (Group WA82)
  - Call Willamette Dental of Washington at 1-855-433-6825 to verify your provider is in the Willamette Dental Group network.

(continued)
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)
  - [ ] 30-Day
  - [ ] 60-Day
  - [ ] 90-Day
  - [ ] 120-Day
  - [ ] 180-Day
  - [ ] 240-Day
  - [ ] 300-Day
  - [ ] 360-Day

- Optional coverage (select a waiting period)
  - [ ] 30-Day
  - [ ] 90-Day
  - [ ] 180-Day
  - [ ] 300-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)
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 family members 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 family members. If we do not qualify, I will receive a refund.

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

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

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

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

Please sign and date this form.

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

If payment is enclosed, make it payable to Health Care Authority and mail to:
Washington State Health Care Authority
PO Box 42691
Olympia, WA 98504-2691

Or hand-deliver to:
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.
2018 Premium Surcharge Help Sheet

- Use the information below to attest on your 2018 enrollment form or the 2018 Premium Surcharge Change Form whether the surcharges apply.
- The surcharges do not apply to subscribers and any family members enrolled in PEBB dental coverage only.
- The surcharges do not apply to retirees, COBRA, or continuation coverage subscribers enrolled in Medicare Part A and Part B.
- The tobacco use surcharge does not apply to any enrolled family members ages 12 and younger.

Tobacco use premium surcharge

What are “tobacco products”? Tobacco products means any product made with or derived from tobacco that is intended for human consumption, including any component, part, or accessory of a tobacco product. This includes, but is not limited to, cigars, cigarettes, pipe tobacco, chewing tobacco, snuff, and other tobacco products.

Tobacco products do not include:
- E-cigarettes.
- Tobacco cessation aids approved by the FDA, such as:
  1. Over-the-counter nicotine replacement products.
     - All over-the-counter tobacco cessation products for adults ages 18 and older.
     - All over-the-counter tobacco cessation products for children under age 18 if recommended by a doctor.
   Examples of over-the-counter nicotine replacement products include:
     - Skin patches—generic (nicotine film), private label, or brand-name (Habitrol or Nicoderm).
     - Chewing gum (also called nicotine gum)—generic (nicotine polacrilex or Thriave), 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 (bupropion hydrochloride) or brand name (Chantix or Zyban).

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

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

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

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

You can change your attestation online using My Account at www.hca.wa.gov/pebb or submit a 2018 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 the family member(s) started or stopped using tobacco products). If that day is the first of the month, the change to the surcharge begins on that day. Changes that result in removing a premium surcharge will begin the first day of the month following receipt of the attestation. If that day is the first of the month, the change to the surcharge begins on that day.

(continued on next page)
**Spouse or state-registered domestic partner coverage premium surcharge**

**Will the spouse or state-registered domestic partner coverage premium surcharge apply to me?**

If you don’t have a spouse or state-registered domestic partner enrolled on your PEBB medical plan, you don’t need to complete this questionnaire—this surcharge doesn’t apply to you. If you have a spouse or state-registered domestic partner enrolled on your 2018 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 2018 enrollment/change form or 2018 Premium Surcharge Change Form.

<table>
<thead>
<tr>
<th>Questions</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are you covering your spouse or state-registered domestic partner in Public Employees Benefits Board (PEBB) medical plan under your account in 2018?</td>
<td>![✓]</td>
<td></td>
</tr>
<tr>
<td>2. Will your spouse or state-registered domestic partner be eligible for medical coverage through his or her employer in 2018? (If your spouse or state-registered domestic partner will not be employed in 2018, answer NO.)</td>
<td>![ ]</td>
<td></td>
</tr>
<tr>
<td>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 2018?</td>
<td>![ ]</td>
<td></td>
</tr>
<tr>
<td>4. Has your spouse or state-registered domestic partner elected not to enroll in his or her employer’s medical in 2018?</td>
<td>![ ]</td>
<td></td>
</tr>
<tr>
<td>5. Will the coverage offered by your spouse’s or state-registered domestic partner’s employer in 2018 NOT be through the PEBB Program or TRICARE?</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
<tr>
<td>• Answer YES if your spouse’s or state-registered domestic partner’s employer does not offer PEBB coverage or TRICARE.</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
<tr>
<td>• Answer NO if your spouse’s or state-registered domestic partner’s employer does offer PEBB coverage or TRICARE.</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
<tr>
<td>6. Will your spouse’s or state-registered domestic partner’s share of the medical premium through his or her employer be less than $106.41 per month in 2018?</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
</tbody>
</table>

If you answered NO to ANY of these questions, check NO on your 2018 enrollment form or 2018 Premium Surcharge Change Form. You will not have to pay the surcharge.

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

1. Your spouse or state-registered domestic partner should ask his or her employer for a 2018 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 $106.41 per month for the employee.

2. Use the 2018 Summary of Benefits and Coverage (SBC) information to answer the questions in the 2018 Spousal Plan Calculator online tool at www.hca.wa.gov/pebb.

   Or, you can download a paper version of the 2018 Spousal Plan Calculator from the website and submit it with your 2018 enrollment form or your 2018 Premium Surcharge Change Form.

If you don’t have access to the Internet, you may request a paper version of the 2018 Spousal Plan Calculator from your employer (if an employee). Retirees, COBRA, and continuation coverage subscribers only may call the PEBB Program at 1-800-200-1004 to request a paper copy.

If using the online 2018 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 2018 enrollment form or 2018 Premium Surcharge Change Form.

If using a paper version of the 2018 Spousal Plan Calculator:

- Provide all the information requested by the form.
- Check “Employer or PEBB Program to determine.”
- Include a copy of the 2018 Spousal Plan Calculator (not this Help Sheet) when you submit your 2018 enrollment form or 2018 Premium Surcharge Change Form.

- Your employer (for employees) or the PEBB Program (for non-Medicare retirees, COBRA, and continuation coverage subscribers only) will determine whether your spouse’s or state-registered domestic partner’s employer-based group medical is comparable to UMP Classic.
You are receiving this booklet because your Public Employees Benefits Board (PEBB) health plan coverage recently ended. This booklet explains how you and your dependents can continue your PEBB health plan coverage.

To continue PEBB health plan coverage, you must complete the enclosed form(s) and follow the instructions. The PEBB Program must receive your election form(s) no later than 60 days from the date PEBB health plan coverage ended, or the mailing date on this booklet, whichever is later. To continue life insurance, MetLife must receive your completed application no later than 31 days (or 60 days, if you are retiring) after your employer-paid coverage ends.