Your PEBB benefits for

2026

PEBB Retiree Enrollment Guide

HCA | Health Care Authority
Public Employees Benefits Board

HCA 51-0205 (8/25)

Who to contact for help

Contact the health plans for help with:

- Benefit questions
- ID cards
- Checking if your provider or pharmacy is in the plan's network
- Appeals
- Making sure your prescriptions are covered
- Claims

Contact the PEBB Program for help with:

- Eligibility and enrollment
- Making changes to your account (due to Medicare enrollment, divorce, etc.)
- Updating your name, address, or phone number
- Enrolling or removing dependents
- Finding downloadable forms
- Premium surcharge questions
- Eligibility complaints or appeals

Visit HCA's website at **hca.wa.gov/pebb-retirees** for information updates and downloadable forms.

Call the PEBB Program toll-free at 1-800-200-1004 (TRS: 711), Monday through Friday, 8 a.m. to 4:30 p.m. Other business activities may result in the phones being unavailable at times.

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

Fax documents to us at 360-725-0771.

Write to us at:
Health Care Authority
PEBB Program
PO Box 42684
Olympia, WA 98504-2684

Visit our office at:
Health Care Authority
626 8th Avenue SE
Olympia, WA 98501

Experiencing a mental health or substance use crisis?

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

For a life-threatening emergency: Call 911.

For 24-hour suicide prevention or a mental health crisis: Call or text 988.

For substance use, problem gambling, or mental health support: Call the Washington Recovery Help Line at 1-866-789-1511 or the mental health crisis line in your area.

Updates to this guide

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

Medical plans

Kaiser Permanente NW CDHP, Classic, or Senior Advantage with Part D
kp.org/wa/pebb
Medicare members: 1-877-221-8221 (TRS: 711)
Non-Medicare members: 1-800-813-2000 (TRS: 711)

Kaiser Permanente WA CDHP, Classic, SoundChoice, Value, or Medicare Advantage with Part D
kp.org/wa/pebb
Medicare members: 1-888-901-4600 (TRS: 711)
Non-Medicare members: 1-888-901-4636 (TRS: 711)

Premera Blue Cross Medicare Supplement Plan G
blue.premera.com/pebb
1-800-817-3049 (TRS: 711)

Uniform Medical Plan (UMP) Classic Medicare with Part D (PDP) Administered by Regence BlueShield and ArrayRx
Medical services (Regence BlueShield):
ump.regence.com/pebb
1-888-849-3681 (TRS: 711)

Prescription drugs (ArrayRx):
arrayrxsolutions.com/UMP
1-833-599-8539 (TRS: 711)

UMP CDHP, Classic, or Select
Administered by Regence BlueShield and ArrayRx
Medical services (Regence BlueShield):
ump.regence.com/pebb
1-888-849-3681 (TRS: 711)

Prescription drugs (ArrayRx):
ump.regence.com/pebb/benefits/prescriptions
1-888-361-1611 (TRS: 711)

UnitedHealthcare PEBB Balance and PEBB Complete
retiree.uhc.com/wapebb
1-855-873-3268 (TRS: 711)

Dental Plans

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

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

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

Vision services for UMP Classic Medicare with Part D (PDP) members

Vision Service Plan
vsp.com
1-844-299-3041
TTY: 1-800-428-4833

Vision plans for non-Medicare retirees

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

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

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

Additional contacts

Auto and home insurance: Liberty Mutual Insurance Company
libertymutual.com/pebbretirees
1-800-706-5525 (TRS: 711)

Health savings account (HSA): HealthEquity, Inc.
Kaiser Permanente members:
1-877-873-8823 (TRS: 711)
UMP members: 1-844-351-6853 (TRS: 711)

Retiree term life insurance: Metropolitan Life Insurance Company (MetLife)
metlife.com/wshca-retirees
1-866-548-7139 (TRS: 711)

Voluntary wellness program: SmartHealth
smarthealth.hca.wa.gov
1-800-947-9541 (TRS: 711)

Voluntary Employees' Beneficiary Association (VEBA) Plan
K-12, community and technical colleges
veba.org
1-888-828-4953

VEBA Medical Expense Plan (MEP)
State agencies and higher education
veba.org
1-888-828-4953

HRA VEBA Plan
Cities, counties, special purpose districts, etc.
hraveba.org
1-888-659-8828

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

Contents

2026 PEBB Retiree Monthly Premiums

Effective January 1, 2026

The amounts shown are the monthly costs for PEBB medical, dental, vision and life insurance coverage. These premiums do not include your Medicare Part B premium. Uniform Medical Plan (UMP) is administered by Regence BlueShield and ArrayRx. The term "spouse" is interchangeable with "state-registered domestic partner."

Special requirements for Medicare

To qualify for the Medicare premium, at least one member on the account must be enrolled in Medicare Part A and Part B. Medicare premiums have been reduced by the state-funded contribution, up to the lesser of $183 or 50 percent of the plan rate per Medicare enrolled retiree per month. Medicare plans that include Part D are not available to members who permanently live outside of the U.S. or its territories. You must provide a physical address to enroll or remain enrolled in a Medicare plan.

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

Medicare medical plan premiums (for members enrolled in Medicare Part A and Part B)

The table below shows the monthly medical premiums based on the number of Medicare-eligible members enrolled in the plan. If a Kaiser Permanente NW Medicare plan is selected, the non-Medicare members will be enrolled in Kaiser Permanente NW Classic. If a Kaiser Permanente WA Medicare plan is selected, the non-Medicare members may enroll in Classic, SoundChoice, or Value. If a Premera, UMP, or UnitedHealthcare Medicare plan is selected, the non-Medicare members will be enrolled in UMP Classic.

If you have more Medicare-eligible members than are shown here, contact the PEBB Program at 1-800-200-1004 (TRS:711) for your rate.

	Managed Care Plans					Preferred Provider Organization (PPO)		
	Kaiser Permanente NW	Kaiser Permanente WA				Uniform Medical Plan	UnitedHealthcare	
	Senior Advantage with Part D	Classic	Medicare Advantage with Part D	SoundChoice	Value	Classic Medicare with Part D (PDP)	PEBB Balance	PEBB Complete
Subscriber only								
1 eligible	$174.44	N/A	$220.61	N/A	N/A	$337.67	$172.83	$220.18
Subscriber and spouse								
1 eligible	$1,250.32	$1,181.61	N/A	$1,142.77	$1,190.53	$1,302.35	$1,137.51	$1,184.86
2 eligible	$343.13	N/A	$435.47	N/A	N/A	$669.59	$339.91	$434.61
Subscriber and children								
1 eligible	$981.35	$941.36	N/A	$912.23	$948.05	$1,061.18	$896.34	$943.69
2 eligible	$343.13	N/A	$435.47	N/A	N/A	$669.59	$339.91	$434.61
3 eligible	$511.82	N/A	$650.33	N/A	N/A	$1,001.51	$506.99	$649.04
Subscriber, spouse, and children								
1 eligible	$2,057.23	$1,902.36	N/A	$1,834.39	$1,917.97	$2,025.86	$1,861.02	$1,908.37
2 eligible	$1,150.04	$1,156.22	N/A	$1,127.09	$1,162.91	$1,393.10	$1,063.42	$1,158.12
3 eligible	$511.82	N/A	$650.33	N/A	N/A	$1,001.51	$506.99	$649.04
4 eligible	$680.51	N/A	$865.19	N/A	N/A	$1,333.43	$674.07	$863.47

Medicare supplement plan premiums

	Premera Blue Cross			
	Medicare Supplement Plan F (closed to new members)		Medicare Supplement Plan G	
	Age 65 or older, eligible by age	Under age 65, eligible by disability	Age 65 or older, eligible by age	Under age 65, eligible by disability
Subscriber only				
1 Medicare eligible	$143.14	$289.90	$122.42	$219.43
Subscriber and spouse				
1 Medicare eligible	$1,107.82	$1,254.58	$1,087.10	$1,184.11
2 Medicare eligible: 1 retired, 1 disabled	$427.29	$427.29	$336.10	$336.10
2 Medicare eligible	$280.53	$574.05	$239.09	$433.11
Subscriber and children				
1 Medicare eligible	$866.65	$1,013.41	$845.93	$942.94
Subscriber, spouse, and children				
1 Medicare eligible	$1,831.33	$1,978.09	$1,810.61	$1,907.62
2 Medicare eligible: 1 retired, 1 disabled	$1,151.55	$1,151.55	$1,060.36	$1,060.36
2 Medicare eligible	$1,004.04	$1,297.56	$962.60	$1,156.62

Non-Medicare medical plan premiums (for members not enrolled in Medicare)

	Managed Care Plans					
	Kaiser Permanente NW		Kaiser Permanente WA			
	Classic	CDHP	Classic	CDHP	SoundChoice	Value
Subscriber only	$1,081.63	$889.16	$966.75	$855.84	$927.91	$975.67
Subscriber & spouse	$2,157.51	$1,771.31	$1,927.75	$1,704.67	$1,850.07	$1,945.59
Subscriber & children	$1,888.54	$1,565.36	$1,687.50	$1,507.05	$1,619.53	$1,703.11
Subscriber, spouse, & children	$2,964.42	$2,389.18	$2,648.50	$2,297.55	$2,541.69	$2,673.03

Non-Medicare medical plan premiums (continued)

	Preferred Provider Organization (PPO) Plans		
	Uniform Medical Plan		
	Classic	CDHP	Select
Subscriber only	$970.43	$887.83	$907.50
Subscriber & spouse	$1,935.11	$1,768.65	$1,809.25
Subscriber & children	$1,693.94	$1,563.03	$1,583.81
Subscriber, spouse, & children	$2,658.62	$2,385.52	$2,485.56

Medical premium surcharges (for members not enrolled in Medicare)

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

- A monthly $25-per-account medical premium surcharge will apply if you or any dependent (age 13 or older) enrolled in PEBB medical uses tobacco products.
- A monthly $50 medical premium surcharge will apply if you enroll a spouse or state-registered domestic partner, and they have chosen not to enroll in another employer-based group medical plan that is comparable to UMP Classic.

Visit the HCA website at **hca.wa.gov/pebb-retirees** under *Surcharges* for more information.

Dental plan premiums

You must enroll in medical coverage to enroll in dental.

	Managed Care Plans		Preferred Provider Organization (PPO)
	DeltaCare	Willamette Dental	Uniform Dental Plan
Subscriber only	$46.48	$59.84	$52.45
Subscriber & spouse	$92.96	$119.68	$104.90
Subscriber & children	$92.96	$119.68	$104.90
Subscriber, spouse, & children	$139.44	$179.52	$157.35

Vision plan premiums (for members not enrolled in Medicare)

You must enroll in medical coverage to enroll in vision. If you are enrolled in Medicare, vision coverage is included in your medical plan except, with Medicare Supplement Plans.

	Davis Vision by MetLife	EyeMed Vision Care	MetLife Vision
Subscriber only	$5.02	$6.57	$8.30
Subscriber & spouse	$10.04	$13.14	$16.60
Subscriber & children	$8.79	$11.50	$14.53
Subscriber, spouse, & children	$13.81	$18.07	$22.83

Retiree term life insurance plan premiums

The table below shows that the monthly cost increases as your age increases, but your coverage amount does not change. Life insurance plans are administered by Metropolitan Life Insurance Company.

	Your age										
	45–49	50–54	55–59	60–64	65–69	70–74	75–79	80–84	85–89	90–94	95+
Monthly cost for...											
$5,000 coverage	$0.87	$1.34	$2.50	$3.84	$7.38	$11.97	$19.41	$31.43	$50.90	$82.45	$133.57
$10,000 coverage	$1.74	$2.68	$5.00	$7.68	$14.76	$23.94	$38.82	$62.86	$101.80	$164.90	$267.14
$15,000 coverage	$2.61	$4.02	$7.50	$11.52	$22.14	$35.91	$58.23	$94.29	$152.70	$247.35	$400.71
$20,000 coverage	$3.48	$5.36	$10.00	$15.36	$29.52	$47.88	$77.64	$125.72	$203.60	$329.80	$534.28

Legacy retiree life insurance plan premium

The legacy retiree life insurance plan premium is $7.75. This plan is only available to retirees enrolled as of December 31, 2016, who didn't elect to increase their retiree term life insurance amount during MetLife's open enrollment (November 1–30, 2016)

Retiree eligibility

Who's eligible for PEBB retiree insurance?

This guide provides a general summary of retiree eligibility. The PEBB Program will determine your eligibility based on PEBB Program rules and when you make your election.

To be eligible to enroll in PEBB retiree insurance coverage, you must meet the procedural and eligibility requirements of Washington Administrative Code (WAC) 182-12-171, 182-12-180, 182-12-211, 182-12-250, or 182-12-265. Procedural requirements include submitting all required documents and paying your premiums and applicable premium surcharges on time. If you are eligible to enroll in PEBB retiree insurance coverage, you may be eligible to defer (postpone) your enrollment, see "Deferring your coverage" on page 18.

Employment requirements

You may be eligible for PEBB retiree insurance coverage if you are a retiring or separating employee of a:

- State agency
- State higher-education institution
- PEBB- or SEBB-participating employer group
- Washington school district, educational service district, or charter school

Requirements for elected or full-time appointed officials

You may be eligible if you are an elected or full-time appointed official of the legislative or executive branch of state government who leaves public office (see WAC 182-12-180).

Surviving dependent requirements

You may be eligible if you are a surviving dependent of:

- A retiree, public employee, or school employee (see WAC 182-12-265)
- An elected or full-time appointed official (see WAC 182-12-180)
- An emergency service worker killed in the line of duty (see WAC 182-12-250)

Disability requirements

You may be eligible if you are a public or school employee determined to be retroactively eligible for disability retirement (see WAC 182-12-211).

Retirement plan requirements

You must be a vested member of and meet the eligibility criteria to retire from a Washington State–sponsored retirement plan when your own employer-paid coverage, COBRA coverage, or continuation coverage ends. (Different rules apply to surviving dependents, elected or full-time appointed officials, and employees and school employees of an employer group that does not participate in a Washington State–sponsored retirement plan.)

Washington State-sponsored retirement plans include:

- Public Employees' Retirement System (PERS) 1, 2, or 3
- Public Safety Employees' Retirement System (PSERS) 2
- Teachers' Retirement System (TRS) 1, 2, or 3
- Washington Higher Education Retirement Plan (HERP) (for example, TIAA)
- School Employees' Retirement System (SERS) 2 or 3
- Law Enforcement Officers' and Fire Fighters' Retirement System (LEOFF) 1 or 2
- Washington State Patrol Retirement System (WSPRS) 1 or 2
- State Judges/Judicial Retirement System
- Civil Service Retirement System and Federal Employees' Retirement System (for Washington State University Extension employees covered under PEBB benefits at the time of retirement)

You must begin to receive a monthly retirement plan payment no later than the first month following your own employer-paid coverage, COBRA coverage, or continuation coverage ending unless one of the following **exceptions** apply:

- If you receive a lump sum payment, you are only eligible for PEBB retiree insurance coverage if the Department of Retirement Systems offered you the choice between a lump sum actuarially equivalent payment and an ongoing monthly payment.
- If you are retiring or separating under PERS Plan 2, TRS Plan 2, or SERS Plan 2, and you separated

from employment on or after January 1, 2024, and you are at least age 55 and have at least 20 years of service.

- If you are retiring or separating under PERS Plan 3, TRS Plan 3, or SERS Plan 3, and you are at least age 55 and have at least 10 years of service.
- If you are an employee retiring under a Washington Higher Education Retirement Plan (such as TIAA) and meet your plan's retirement eligibility criteria, or you are at least age 55 with 10 years of state service.
- If you are a retiring employee from a PEBB employer group who is eligible to retire under a retirement plan sponsored by an employer group or tribal government and your employer does not participate in a Washington State–sponsored retirement plan. However, you must meet the same age and years of service requirement as members of PERS Plan 1 (if your date of hire with your employer group was before October 1, 1977) or Plan 2 (if your date of hire was on or after October 1, 1977).
- If you are a retiring school employee from a SEBB employer group who is eligible to retire under a retirement plan sponsored by an employer group and your employer does not participate in a Washington State-sponsored retirement plan. However, you must meet the same age and years of service requirement as members of TRS Plan 1 (if your date of hire with your employer group was before October 1, 1977) or Plan 2 (if your date of hire was on or after October 1, 1977).
- If you are an elected or full-time appointed official of the legislative or executive branch of state government, or a surviving dependent of such an official, as described in WAC 182-12-180.
- If you are a survivor of an emergency services worker killed in the line of duty as described in WAC 182-12-250, or a surviving dependent who loses eligibility because of the death of a retiree as described in WAC 182-12-265.

Medicare requirement

If you or a dependent is eligible for Medicare, you (or they) must enroll and stay enrolled in Medicare Part A and Part B. PEBB retiree insurance coverage works in coordination with Medicare. In addition to the premiums you pay to the PEBB Program, you must also pay the Part B premium directly to Medicare.

Returning to work requirements

Once enrolled in PEBB retiree insurance coverage, if you or a dependent becomes eligible for the employer contribution toward PEBB or SEBB benefits by working for a PEBB employing agency, SEBB organization, or SEBB employer group, you or your dependent cannot waive coverage from the employer in order to remain in PEBB retiree health plan coverage. In this case, your PEBB retiree insurance coverage will be automatically deferred and you will be exempt from the deferral form requirement, or your dependent will be automatically disenrolled. Once PEBB Program or SEBB Program employee coverage ends, use Benefits 24/7 (or submit a *PEBB Retiree Election Form* [form A] or *PEBB Retiree Change Form* [form E]) to reenroll yourself or your eligible dependent in PEBB retiree insurance coverage.

Dependent eligibility

You may enroll the following dependents:

- Your legal spouse.
- Your state-registered domestic partner, as defined in RCW 26.60.020(1) and WAC 182-12-109. This includes substantially equivalent legal unions from other jurisdictions, as defined in RCW 26.60.090. Strict requirements apply to these partnerships, including that one partner is age 62 or older and you live in the same residence. Individuals in a state-registered domestic partnership are treated the same as a legal spouse except when in conflict with federal law.
- Children, through the last day of the month in which they turn age 26, regardless of marital status, student status, or eligibility for coverage under another plan. This also includes children age 26 or older with a disability, as described under "Children with disabilities."

How children are defined

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

- Your children or children of your spouse or state-registered domestic partner, based on the establishment of a parent-child relationship as described in RCW 26.26A.100, except when parental rights have been terminated.
- Children you are legally required to support ahead of adoption.
- Children named in a court order or divorce decree for whom you are legally required to provide support or health care coverage.
- Extended dependents who meet certain eligibility criteria.
- Children of any age with a developmental or physical disability.

Extended dependents

Children may include extended dependents (such as a grandchild, niece, nephew, or other children) for whom you, your spouse, or your state-registered domestic partner are legal custodians or legal guardians. The legal responsibility for them is shown by a valid court order and the child officially residing with the custodian or guardian.

An extended dependent does not include foster children unless you, your spouse, or your state-registered domestic partner are legally required to provide support ahead of adoption.

Children with disabilities

Eligible children include children of any age with a developmental or physical disability that leaves them incapable of self-sustaining employment and chiefly dependent upon the subscriber for support and ongoing care. Their condition must have occurred before they turned age 26. To enroll a child age 26 or older, or to continue the child's enrollment, you must provide proof of the disability and dependency by submitting the *PEBB Certification of a Child with a Disability*.

If you have already enrolled a child with a disability and are changing to a health plan administered by a different insurance carrier, you will need to submit a new *PEBB Certification of a Child with a Disability*, even if they were previously certified.

The PEBB Program, with input from your medical plan, will verify the disability and dependency of a child with a disability, starting at age 26. The first verification at age 26 lasts for at least two years. After that, we may periodically review their eligibility, but not more than once a year. These verifications may require renewed proof of the child's disability and dependence. If we do not receive your verification within the time allowed, the child will no longer be covered.

A child with a disability age 26 or older who becomes self-supporting is not eligible as of the last day of the month they become capable of self-support. If the child becomes capable of self-support and later becomes incapable, they do not regain eligibility.

Verifying dependent eligibility

All subscribers must verify (prove) their dependents are eligible before we will enroll them. Verifying dependent eligibility helps us make sure we cover only people who qualify for health plan coverage. You provide this proof by submitting official documents. We will not enroll a dependent if we cannot prove their eligibility by the required deadline. We reserve the right to review a dependent's eligibility at any time.

If you are enrolling a dependent, submit the documents when you apply, using Benefits 24/7 (or paper forms), within PEBB Program timelines. The documents we will accept to prove dependent eligibility are listed on the next page.

Submit the documents in English. Documents written in another language must include a translated copy prepared by a professional translator and notarized. These documents must be approved by the PEBB Program.

A few **exceptions** apply to the dependent verification process:

- Extended dependents are reviewed through a separate process (legal responsibility for them is shown by a valid court order and the child's official residence with the custodian or guardian).
- Previous dependent verification data verified by the School Employees Benefits Board (SEBB) Program may be used when a subscriber moves from SEBB Program coverage to PEBB Program coverage and is requesting to enroll an eligible dependent who has been previously verified under the SEBB Program, as long as there is no gap in that dependent's coverage.

Documents to enroll a spouse

Provide a copy of (choose one):

- The most recent year's federal tax return filed jointly that lists your spouse (black out financial information).
- The most recent year's federal tax return for you and your spouse if filed separately (black out financial information).
- A marriage certificate[1] and evidence that the marriage is still valid (do not need to live together). For example: a life insurance beneficiary document, a utility bill[2] or bank statement dated within the last six months showing both your and your spouse's names (black out financial information).
- A petition for dissolution, petition for legal separation, or petition to invalidate (annul) marriage. Must be filed within the last six months.
- Defense Enrollment Eligibility Reporting System (DEERS) registration.
- Valid J-1 or J-2 visa issued by the U.S. government.

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

Provide a copy of (choose one):

- A certificate/card[1] of state-registered domestic partnership or legal union and evidence that the partnership is still valid (do not need to live together). For example: a life insurance beneficiary document, a utility bill[2], or a bank statement dated within the last six months showing both your and your partner's names (black out financial information).
- A petition to invalidate (annul) a state-registered domestic partnership. Must be filed within the last six months.

If enrolling a partner of a legal union, proof of Washington State residency for both you and your partner is required, in addition to dependent verification documents. Additional dependent verification documents will be required within one year of your partner's enrollment for them to remain enrolled. More information can be found in PEBB Program Administrative Policy 33-1 on the HCA website at **hca.wa.gov/pebb-rules**.

Documents to enroll children

Provide a copy of (choose one):

- The most recent year's federal tax return that includes children (black out financial information). You can use one copy of your tax return to include more than one dependent that requires verification.
- Birth certificate, or hospital certificate with the child's footprints on it, showing the name of the parent who is the subscriber, the subscriber's spouse, or the subscriber's state-registered domestic partner. If the dependent is the subscriber's stepchild, the subscriber must also verify the spouse or state-registered domestic partner to enroll the child, even if they are not enrolling the spouse or partner in health plan coverage.
- Certificate or decree of adoption showing the name of the parent who is the subscriber, the subscriber's spouse, or the subscriber's state-registered domestic partner.
- Court-ordered parenting plan.

1 If within six months of marriage or partnership, only the certificate/card is required.
2 Or separate utility bills with the same address showing your or your spouse's/partner's names on it as evidence the marriage/partnership is still valid.

- National Medical Support Notice.
- Defense Enrollment Eligibility Reporting System (DEERS) registration.
- Valid J-2 visa issued by the U.S. government.

Additional required documents

If you are enrolling a dependent listed below, you must submit the associated forms when you apply.

- **State-registered domestic partner or their child, or other nonqualified tax dependent:** Submit a *PEBB Declaration of Tax Status*.
- **Child with a disability age 26 or older:** Submit a *PEBB Certification of a Child with a Disability.*
- **Extended dependent:** Submit a *PEBB Extended Dependent Certification* and the *PEBB Declaration of Tax Status*.

You must notify the PEBB Program in writing when your dependent is no longer eligible. See "What happens when a dependent loses eligibility?" on page 63 to learn more.

Learn more about dependent eligibility

For more information about proving dependent eligibility, go to HCA's website at **hca.wa.gov/pebb-retirees** and select *Dependents* or call the PEBB Program at 1-800-200-1004.

If I die, are my surviving dependents eligible?

Your dependents may be eligible to enroll in or defer PEBB retiree insurance coverage as survivors. To do so, they must meet the eligibility and procedural requirements outlined in WAC 182-12-180 or 182-12- 265. If required, the PEBB Program must receive your dependent's *PEBB Retiree Election Form* (form A) and any other required forms and documents within the following timelines:

- For an eligible survivor of an employee, **no later than 60 days** after the date of the employee's death, or the date the survivor's PEBB insurance coverage or School Employees Benefits Board (SEBB) insurance coverage ends, whichever is later.
- For an eligible survivor of a retiree, **no later than 60 days** after the retiree's death.

For details about how to continue coverage as a survivor, see "How does a survivor pay for coverage?" on page 56 and "What are my family's options if I die?" on page 64.

For more information about deferring coverage, see "What are required timelines for survivors to defer?" on page 19.

When are surviving dependents of emergency workers eligible?

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 or defer (postpone) PEBB retiree insurance coverage. To be eligible, you must meet both the procedural and eligibility requirements outlined in WAC 182-12-250. To learn more about this coverage, including deadlines to apply, call the PEBB Program at 1-800-200-1004.

The easiest way to enroll is with our online enrollment system, Benefits 24/7, at **benefits247.hca.wa.gov**. For details, see "How to use Benefits 24/7" on page 22. If you need a paper form, see "How to use forms to enroll" on page 70.

Your employer is responsible for terminating your employee coverage. In some cases, we cannot enroll you in retiree insurance coverage until this occurs.

You can enroll in the following benefits:

- Medical coverage (includes vision coverage if you are enrolled in a Medicare plan with the exception of Premera Plan F or Plan G)
- Vision coverage (separate from medical coverage) if you are enrolled in a non-Medicare medical plan
- Dental coverage
- Retiree term life insurance
- SmartHealth (for subscribers not enrolled in both Medicare Part A and Part B)
- Auto and home insurance

Steps to enroll

1. **Enroll yourself**
   Log in to our online enrollment system, Benefits 24/7, at **benefits247.hca.wa.gov**. See "How to use Benefits 24/7" for step-by-step instructions.

   If you would rather use paper forms, they are located at the back of this guide.

   The enrollment must be submitted online, or the forms and documents must be received by the PEBB Program, **no later than 60 days** after your own employer-paid coverage, COBRA, or continuation coverage ends. For elected or full-time appointed officials, the timeline is 60 days after you leave public office.

   If you are a dependent becoming eligible as a survivor, see "If I die, are my surviving dependents eligible?" on page 14.
2. **Enroll dependents**
   If you are enrolling dependents, you may need to prove their eligibility by submitting documents. Learn more about this process under "Dependent eligibility" on page 12.
3. **Make your first payment**
   You must make your first payment for PEBB retiree insurance coverage, including applicable premium surcharges, before we can enroll you. To learn more, see "Paying for coverage" on page 55.
4. **Enroll in Medicare if you're eligible**
   If you or your dependents are eligible for Medicare, you (or they) must be enrolled in and stay enrolled in Medicare Part A and Part B. You will need to submit proof of Medicare enrollment.

Have questions?

Contact PEBB Customer Service. Contact information is provided at the front of this guide.

Don't lose your right to enroll

You must enroll in or defer (postpone) PEBB retiree insurance coverage **no later than 60 days** after your own employer-paid coverage, COBRA coverage, or continuation coverage ends. Deferring retains your right to enroll in the future.

See important information about deferring on page 18.

If you do not meet the requirements, future enrollment rights may be affected.

Enrollment deadlines

All applicants

If you miss the 60-day election period, you lose all rights to enroll in or defer enrollment in PEBB retiree insurance coverage unless you regain eligibility in the future. You can regain it, for example, by returning to work in a position where you are eligible for PEBB or SEBB benefits and meeting procedural and eligibility requirements.

Retiring employees

You must enroll and submit all required documents, including dependent verification documents through Benefits 24/7 (or we must receive your enrollment form and any other required documents) **no later than 60 days** after your own employer-paid coverage, COBRA coverage, or continuation coverage ends.

If you select an MAPD plan or Uniform Medical Plan (UMP) Classic Medicare with Part D (PDP), the enrollment for each member cannot be retroactive. Coverage starts the first day of the month following the date the form is received. We encourage you to apply using Benefits 24/7 (or submit *Form A* so that we receive it) **no later than the last day of the month** in which your own employer-paid coverage, COBRA coverage, or continuation coverage ends.

Otherwise, we will enroll you and your eligible dependents in another medical plan during the months between when your other coverage ends and the selected Medicare plan begins.

Retiring elected and appointed officials

If you are an elected or full-time appointed official as described in WAC 182-12-180(1), you must apply using Benefits 24/7 (or we must receive your forms) **no later than 60 days** after you leave public office. If you select an MAPD plan or UMP Classic Medicare with Part D (PDP), enrollment may not be retroactive. Otherwise, you and your enrolled dependents will be enrolled in another medical plan during the months between when your other coverage ends and the selected Medicare plan begins.

Survivors

If you are a dependent becoming eligible as a survivor, see "If I die, are my surviving dependents eligible?" on page 14.

Medical, dental, and vision enrollment

You can enroll in medical only, or in medical and dental coverage. If you or your dependent are not enrolled in Medicare, you can elect vision coverage for any non-Medicare enrollees. You cannot enroll in dental or vision coverage only. Generally, you and your dependents must be enrolled in the same medical, dental, and vision plans. The exception is if there are both Medicare and non-Medicare enrollees on your account (see "Medicare and PEBB retirees" on page 24).

Can I enroll or defer retroactively due to a disability?

Under some circumstances, yes. If you feel this situation may apply to you, contact us to learn more by sending a secure message through HCA Support at **support.hca.wa.gov** or by calling 1-800-200-1004.

What if I am eligible as a retiree and a dependent?

You cannot enroll in medical, dental, or vision coverage under two PEBB accounts. You could choose to enroll only on your own retiree account or defer (postpone) PEBB retiree insurance coverage for yourself and enroll as a dependent on your spouse's or state-registered domestic partner's PEBB medical.

If you and your spouse or state-registered domestic partner are both independently eligible for PEBB insurance coverage, you need to decide which account you will use to cover any eligible children. A dependent may be enrolled in only one PEBB medical plan, one PEBB dental plan, and one PEBB vision plan.

Should I enroll in PEBB retiree insurance coverage and in SEBB insurance coverage as a dependent?

No. You should not enroll in both the PEBB Program as a retiree and in the School Employee Benefits Board (SEBB) Program as a dependent. There is little financial reason to do so. Both programs are administered by the Health Care Authority. Because coverage levels are similar in PEBB and SEBB medical plans, the second plan will likely offer little or no extra payment for most health care services. The payments will not exceed the allowed amounts. There is no added coverage if you enroll in both PEBB and SEBB dental and vision.

In general, SEBB employee medical premiums are lower than PEBB retiree medical premiums. You should defer your PEBB retiree insurance coverage and enroll in SEBB health plan coverage as a dependent. That way, you do not pay two monthly medical premiums.

If you enroll in both the PEBB Program as a retiree and in the SEBB Program as a dependent, in most cases, your SEBB coverage will be primary (pay first), and your PEBB retiree insurance coverage will be secondary.

To defer enrollment in PEBB retiree insurance coverage, see page 18. To avoid enrolling in both PEBB and SEBB Programs, use Benefits 24/7 (or submit forms) to defer on or before the date SEBB health plan coverage begins.

As you make this decision, we suggest that you compare SEBB and PEBB benefits and premiums to decide which option best suits your needs. Visit HCA's website at **hca.wa.gov/pebb-retirees** and **hca.wa.gov/sebb-employee** to get premiums and benefit information.

What can I expect after I enroll?

After you enroll and submit your documents, we will process them and send you a letter notifying you of the next steps. In most cases, you must make the first payment of your monthly premiums and applicable premium surcharges before we can enroll you. See "Paying for coverage" on page 55.

When does coverage begin?

If you are a newly eligible retiring employee, your PEBB retiree insurance coverage will start on the first day of the month after your own employer-paid coverage, COBRA coverage, or continuation coverage ends.

If you are an eligible elected or full-time appointed official, your coverage will start on the first day of the month after you leave public office.

If you are returning from deferral, see "How do I enroll after deferring?" on page 21 for when your coverage will start.

If you are a surviving dependent of a retiree, your coverage will start the first day of the month following the retiree's death.

If you are a surviving dependent of an employee, your coverage will start the first day of the month following the later of, the date of the employee's death or the date the survivor's PEBB or SEBB insurance coverage ends.

If you are an employee determined to be retroactively eligible for disability retirement, see WAC 182-12-211 for when your coverage may start.

Deferring your coverage

Deferring means postponing your enrollment in PEBB retiree insurance coverage so you keep your eligibility to enroll later. You may choose to defer when you first become eligible for PEBB retiree insurance coverage or after you enroll.

Why would I defer?

You may want to defer if you have other qualified medical coverage available. For example, if you are retiring but your spouse or state-registered domestic partner is still working, you may want to use their employer's health coverage. Later, when your spouse or partner retires or separates from employment, you can apply to enroll yourself and any eligible dependents in a PEBB retiree health plan.

Am I eligible to defer?

You must be eligible to enroll in PEBB retiree insurance coverage in order to defer your enrollment. You may defer:

- If you are enrolled in a PEBB-sponsored or SEBB-sponsored health plan as a dependent, including COBRA or continuation coverage.
- Beginning January 1, 2001, if you are enrolled in employer-based group medical as an employee or employee's dependent, including coverage continued under COBRA or continuation coverage. You cannot defer based on an employer's retiree coverage.
- Beginning January 1, 2001, if you are enrolled in medical coverage as a retiree or a dependent of a retiree in a TRICARE plan or the Federal Employees Health Benefits Program.
- Beginning January 1, 2006, if you are enrolled in Medicare Part A **and** Part B and a Medicaid program that provides creditable coverage. To count as creditable, your Medicaid coverage must include medical and hospital benefits. Any dependents who are not eligible for creditable coverage under Medicaid may stay enrolled in a PEBB retiree health plan.
- Beginning January 1, 2014, if you are not eligible for Medicare Part A and Part B and you are enrolled in qualified health plan coverage through a health benefit exchange established under the Affordable Care Act. This does not include Medicaid coverage (known as Apple Health in Washington State).
- Beginning July 17, 2018, if you are enrolled in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).
- Beginning January 1, 2025, if you are enrolled in Medicare and permanently live in a location outside of the United States.

Returning to retiree coverage after deferring

There are strict requirements for returning to a PEBB retiree health plan after deferring. Please read WAC 182-12-200 and 182-12-205 to learn more.

How do I defer?

To defer your enrollment, you must:

- Be eligible for PEBB retiree insurance coverage.
- Have a qualifying reason to defer as described above.
- Use Benefits 24/7 (or submit the *PEBB Retiree Election Form* [form A] to the PEBB Program) within the required timeline.

When you defer, you are postponing medical, dental, and vision coverage. **Retirees cannot enroll only in dental or vision.** Except as stated on page 27, when you defer, your dependents' coverage is also deferred.

If we do not receive your election to defer by the deadline, it may affect your ability to enroll in PEBB retiree insurance coverage in the future.

Proof of enrollment is required to enroll after deferring

If you defer enrollment while enrolled in qualifying coverage, you must provide proof of continuous enrollment in one or more qualifying medical coverages to return to a PEBB retiree health plan after deferral. The proof of continuous enrollment may include a health plan sponsored by a Washington State educational service district if enrollment was deferred because you were enrolled in a PEBB- or SEBB-sponsored health plan as a dependent, including COBRA or continuation coverage, prior to January 1, 2024.

A gap in coverage of 31 days or less is allowed between the date you defer PEBB retiree insurance coverage and the start date of a qualified coverage, and between each qualified coverage during the deferral period.

We encourage you to collect proof of coverage annually and keep a file to provide to the PEBB Program in the event you want to enroll in a PEBB retiree health plan in the future.

If you defer enrollment while enrolled in Medicare and permanently living outside of the United States, and you return to the United States permanently, you must provide proof of enrollment in Medicare Parts A and B to return to a PEBB retiree health plan after deferral. Evidence of continuous enrollment in a qualified coverage is waived while you live outside of the United States.

What are the required timelines for retirees to defer?

You can defer enrollment in PEBB retiree insurance coverage in the following timelines:

- If you are an eligible retiring employee (or in some cases, a separating employee), use Benefits 24/7 (or the PEBB Program must receive the *PEBB Retiree Election Form* [form A]) **no later than 60 days** after your own employer-paid coverage, COBRA coverage, or continuation coverage ends. The PEBB Program will defer your enrollment the first of the month after the date your own employer-paid coverage, COBRA coverage, or continuation coverage ends.
- If you are an employee who is eligible for disability retirement, contact us to learn more by sending a secure message through HCA Support at **support.hca.wa.gov** or by calling 1-800-200-1004.
- If you are an eligible elected or full-time appointed official leaving public office, use Benefits 24/7 (or we must receive the *PEBB Retiree Election Form* [form A]) **no later than 60 days** after you leave public office. We will defer your enrollment the first of the month after the date you leave public office.
- If you are already enrolled in PEBB retiree insurance coverage and want to defer, use Benefits 24/7 (or we must receive the *PEBB Retiree Change Form* [form E] and any other required forms) before we can defer your coverage. Enrollment will be deferred effective the first of the month after you defer in Benefits 24/7 (or we receive all the required forms). If that is the first day of the month, enrollment will be deferred that day. When a member is enrolled in a Medicare Advantage with Part D (MAPD) plan or Uniform Medical Plan (UMP) Classic Medicare with Part D (PDP), enrollment will be deferred effective the first of the month after the date we receive the *PEBB Medicare Plan Disenrollment Form* (form D).
- If you enrolled as a dependent in a PEBB- or SEBB-sponsored health plan, including COBRA or continuation coverage, and then lose coverage, you will have 60 days to enroll in a PEBB retiree health plan. To continue in a deferred status, the subscriber must defer enrollment as described in WAC 182-12-205.
- If you are enrolled in PEBB retiree insurance coverage and you return to work with a PEBB employing agency, SEBB organization, or SEBB employer group and your employer determines you are eligible for the employer contribution toward PEBB or SEBB benefits, PEBB retiree insurance coverage will be automatically deferred. You do not need to defer using Benefits 24/7 or submit a form. When you are no longer eligible for the employer contribution toward PEBB or SEBB benefits, you may enroll in PEBB retiree insurance coverage as described in WAC 182-12-171, 182-12-180, or 182-12-205 (6)(a)(ii), or continue in a deferred status if you meet the requirements as described in WAC 182-12-200 or 182-12-205.
- If you are not on Medicare and permanently live outside of the United States, become eligible for Medicare Parts A and B, and do not respond to HCA within the required timeframe, PEBB retiree insurance coverage will be automatically deferred. You do not need to defer using Benefits 24/7 or submit a form. You will have the opportunity to enroll in a PEBB health plan when you return to the United States as described in the "How do I enroll after deferring?" section.

What are the required timelines for survivors to defer?

To defer PEBB retiree insurance coverage, except as stated below, a survivor must submit a *PEBB Retiree Election Form* (form A) to the PEBB Program.

- In the event of an employee's death, we must receive the form **no later than 60 days** after the date of the employee's death, or the date the survivor's PEBB insurance coverage or SEBB insurance coverage ends, whichever is later. Enrollment will be deferred the first day of the month following the later of, the date of the employee's death, or the date the survivor's PEBB insurance coverage or SEBB insurance coverage ends.

- In the event of an elected or full-time appointed official's death, we must receive the form **no later than 60 days** after the date of the official's death, or the date the survivor's PEBB insurance coverage ends, whichever is later. Enrollment will be deferred the first day of the month following the later of the date of the official's death, or the date the survivor's PEBB insurance coverage ends.
- In the event of a retiree's death, we must receive the form **no later than 60 days** after the death. Enrollment will be deferred the first day of the month following the date of the retiree's death.
- If a survivor enrolls in PEBB retiree insurance coverage and later wants to defer, they must use Benefits 24/7 (or submit the *PEBB Retiree Change Form* [form E]) and any other required forms. Enrollment will be deferred effective the first of the month after you defer in Benefits 24/7 (or we receive all the required forms). If that is the first day of the month, enrollment will be deferred that day. When a member is enrolled in an MAPD plan or UMP Classic Medicare with Part D (PDP), enrollment will be deferred the first of the month after the date we receive the *PEBB Medicare Plan Disenrollment Form* (form D).
- In the event of the death of an emergency service worker killed in the line of duty, we must receive the form **no later than 180 days** after the later of:
  - The death of the emergency service worker.
  - The date on the eligibility letter from the Washington State Department of Retirement Systems or the board for volunteer firefighters and reserve officers.
  - The last day the survivor was covered under any health plan (including COBRA coverage) through the emergency service worker's employer.
- If you are enrolled in PEBB retiree insurance coverage and you become eligible for the employer contribution toward PEBB or SEBB benefits, PEBB retiree insurance coverage will be automatically deferred. You do not need to defer using Benefits 24/7 or submit a form. When you are no longer eligible for the employer contribution toward PEBB or SEBB benefits, you may enroll in PEBB retiree insurance coverage as described in WAC 182-12-171, 182-12-180, or 182-12-205 (6)(a)(ii), or continue in a deferred status if you meet the requirements as described in WAC 182-12-200 or 182-12-205.
- If you are not on Medicare and permanently live outside of the United States, become eligible for Medicare Parts A and B, and do not respond to HCA within the required timeframe, PEBB retiree insurance coverage will be automatically deferred. You do not need to defer using Benefits 24/7 or submit a form. You will have the opportunity to enroll in a PEBB health plan when you return to the United States as described in the "How do I enroll after deferring?" section.

What if I return to work?

If you are enrolled in PEBB retiree insurance coverage and you return to work for a PEBB employing agency, SEBB organization, or SEBB employer group and your employer determines you are eligible for the employer contribution toward PEBB or SEBB benefits, you cannot waive your enrollment in employee medical to stay enrolled in PEBB retiree insurance coverage, even if you are enrolled in Medicare. PEBB retiree insurance coverage is automatically deferred. You do not need to defer using Benefits 24/7 (or submit a form).

What if my dependent returns to work?

If your dependent is enrolled in PEBB retiree insurance coverage and they become eligible for the employer contribution toward PEBB or SEBB benefits from a PEBB employing agency, SEBB organization, or SEBB employer group, the dependent will be automatically disenrolled from PEBB retiree insurance coverage. In this case, you should defer your PEBB retiree insurance coverage and enroll in PEBB or SEBB employee health plan coverage as a dependent. To defer enrollment in PEBB retiree insurance coverage, see page 18.

How do I enroll after deferring?

If you deferred enrollment in PEBB retiree insurance coverage, you may enroll in a PEBB retiree health plan. In most cases, you must have been continuously enrolled in one or more qualifying medical coverages during your deferral.

- **During the PEBB Program annual open enrollment.** Use Benefits 24/7 (or the *PEBB Retiree Open Enrollment Election/Change form* [form A-OE]) and submit any other required forms **no later than the last day of open enrollment**. Your enrollment will begin January 1 of the next year. If you deferred enrollment while enrolled in qualifying coverage, you must also provide proof of continuous enrollment in one or more qualified medical coverages. If you deferred enrollment while enrolled in Medicare and permanently living outside of the United States, and you have permanently returned to the United States, you must also provide proof of enrollment in Medicare Parts A and B; evidence of continuous enrollment in a qualified coverage is waived while you lived outside of the United States.
- **When other qualifying medical coverage ends.** Use Benefits 24/7 (or the *PEBB Retiree Election Form* [form A]) and submit any other required forms and proof of continuous enrollment in one or more qualified medical coverages **no later than 60 days** after the date your other qualifying medical coverage ends. Enrollment will begin the first day of the month after the other coverage ends. Although you have 60 days to enroll, you must pay premiums and applicable premium surcharges back to when your other coverage ended. Proof of continuous enrollment in one or more qualifying medical coverages must list the dates the coverage began and ended.
- **When you permanently move back to the United States**. Use Benefits 24/7 (or the *PEBB Retiree Election Form* [form A]), and submit any other required forms and proof of enrollment in Medicare Parts A and B **no later than 60 days** after the date of the permanent move or the date you provide notification of such move, whichever is later. Enrollment will begin the first day of the month after the permanent move or the date you provide notification of such move, whichever is later.

Exception: If you select a Medicare Advantage with Part D (MAPD) plan or Uniform Medical Plan (UMP) Classic Medicare with Part D (PDP), enrollment may not be retroactive. We encourage you to use Benefits 24/7 (or submit the required forms so that we receive them) **no later than the last day of the month** before the date PEBB retiree insurance coverage is to begin. Otherwise, we will enroll you and your enrolled dependents in another medical plan during the gap months prior to when the selected Medicare plan begins.

If you deferred while enrolled in Medicare Part A and Part B and a Medicaid program that provides creditable coverage, you may enroll in a PEBB retiree health plan as described above, or no later than the end of the calendar year in which your Medicaid coverage ends. See WAC 182-12-205 (6)(c)(iii) to learn more.

You have a one-time opportunity to enroll in a PEBB retiree health plan if you deferred PEBB retiree insurance coverage for CHAMPVA, a TRICARE plan, the Federal Employees Health Benefits Program, or coverage through a health benefit exchange established under the Affordable Care Act.

If you deferred, you may later enroll in a PEBB retiree health plan if you receive formal notice that the Health Care Authority has determined it is more cost effective to enroll you or your eligible dependents in PEBB medical than a medical assistance program.

How to use Benefits 24/7

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

What's your browser?

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

What can I do in Benefits 24/7?

- Enroll in or defer PEBB retiree insurance coverage
- Choose your medical and dental plans, and a vision plan if you are a non-Medicare retiree
- Enroll or remove your eligible dependents in PEBB health plan coverage
- Upload documents to prove dependent eligibility
- Attest to premium surcharges (for subscribers not enrolled in Medicare)
- Access vendor website to enroll in term life insurance
- Request a change due to a special open enrollment event

How do I set up an account?

You will need to create a login for Benefits 24/7 using SecureAccess Washington (SAW), the state's secure online portal. A SAW account will keep your sensitive information secure.

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

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

When can I access Benefits 24/7?

You can use Benefits 24/7 to apply for PEBB retiree insurance coverage and you can enroll in benefits up to the last day of your 60-day eligibility period. Then, come back anytime to check your coverage or request special open enrollment changes.

How do I enroll using Benefits 24/7?

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

1. **Create a retiree enrollment request.** From your dashboard, click on the Retiree and continuation coverage tile. In the PEBB retiree insurance coverage box click on Create request.
2. **Select your payment method.** Or indicate that you are deferring your enrollment. If you have selected invoicing or electronic debit service, you must submit payment to HCA before your coverage can begin. Click on *Proceed to enrollment/deferral form*.
3. **Enter your personal information.** Your personal information will auto-populate. Please ensure that this information is correct and current. You may make changes to this information such as updating your phone number if necessary.
   a. Select the appropriate options for your request such as enrolling, deferring or enrolling after deferring.
   b. Indicate your requested coverage effective date, your Washington State retirement plan and your retirement date if you have one.

c. Enter your Medicare enrollment status and information

d. Select the coverage you are requesting to enroll in. You may enroll in medical; medical and dental; medical, dental, and vision (if you are not enrolled in Medicare); and/or retiree term life insurance.

e. If you have chosen to defer your enrollment in PEBB retiree insurance coverage, select a reason for your deferral.

f. Complete your tobacco surcharge attestation. Surcharges do not apply to anyone on your account if you are eligible for Medicare.

g. *Click on Proceed to dependent form.*

4. **Enroll your dependents.** If you are not enrolling dependents, you may click continue at the bottom of the dependent section to skip this step. You may add new dependents who were not previously enrolled. Your existing or former dependents will auto-populate in the *Current dependents* section. To enroll an existing dependent, click on their name.

   a. Enter information for your dependents.

   b. Select the medical and dental benefits you want to enroll your dependents in. If your dependents are not enrolled in Medicare, also select vision benefits for them.

   c. Retirees who are not enrolled in Medicare must attest to premium surcharges.

   d. *Click Save changes and then click Continue when you have finished enrolling your dependents.*

5. **Select your medical plan.** Click the box for the medical plan you would like to enroll in. If you or a dependent are enrolling in a Kaiser Medicare plan and not all members on your account are eligible for Medicare, you must select a second non-Medicare Kaiser plan for those members. Click *Continue*.
6. **Select your dental plan.** Click the box for the dental plan you would like to enroll in. If you are unsure about your current or former dental plan, please contact PEBB Customer Service to confirm. Click *Continue*.
7. **Select your vision plan.** Click the box for the vision plan you would like to enroll yourself (if you are not enrolled in Medicare) or any dependents who are not enrolled in Medicare in. Click *Continue*.
8. **Upload additional documentation.** You may upload additional documentation such as dependent verification documents, proof of Medicare enrollment, or additional enrollment forms. Click *Continue*.
9. **Submit your enrollment request.** You may download a copy of your enrollment request from this page. Click the *Submit* button to finalize your enrollment request.

Help with Benefits 24/7

If you need help accessing Benefits 24/7, send a secure message through HCA Support at **support.hca.wa.gov**, a secure website that allows you to log in to your own account to communicate with us, or call us at 1-866-335-0043 (TRS: 711).

Medicare and PEBB retirees

You or a covered dependent eligible for Medicare must enroll and stay enrolled in Medicare Part A and Part B. In addition to the premiums that you pay to the PEBB Program, you must also pay the Part B premium directly to Medicare.

What is Medicare?

Medicare is the federal health insurance program. It is administered by the Centers for Medicare and Medicaid Services (CMS). It provides health insurance for people age 65 and older and for people under age 65 with certain disabilities. Medicare has four main parts:

- **Part A (Hospital insurance):** Inpatient hospital care, skilled nursing facility care, and hospice services. Medicare Part A does not usually have a premium if you or your spouse paid Medicare taxes for a certain amount of time while working. Check with the Social Security Administration (SSA) to see if you will pay a premium.
- **Part B (Medical insurance):** Outpatient services, provider office visits, preventive services, and durable medical equipment. Medicare Part B has a monthly premium you must pay directly to Medicare; this is in addition to your monthly premium for PEBB retiree insurance coverage. **Note**: Part A and Part B are also known as Original Medicare.
- **Part C (Medicare Advantage):** Private insurance plans approved by Medicare that offer coverage in addition to what is covered by Parts A and B. The PEBB Program offers several Medicare Advantage plans.
- **Part D (Prescription drug coverage):** The PEBB Program offers Medicare plans that include Part D coverage.

If I have Medicare coverage, why would I also enroll in PEBB retiree insurance coverage?

The Centers for Medicare and Medicaid Services estimates that Medicare covers about half of enrollees' medical expenses. Medicare enrollees without other coverage may face substantial health care costs. Enrolling in PEBB retiree insurance coverage will help cover some of the remaining costs that Medicare does not cover.

What kind of Medicare medical benefits are available?

The PEBB Program offers several types of plans to support your Medicare coverage. They interact with Medicare in different ways. In general, these plans offer more benefits and help lower your costs for covered services.

Coordination of benefits

The Uniform Medical Plan (UMP) Classic Medicare with Part D (PDP) plan is a "coordination of benefits" (COB) plan, which means that it coordinates with Medicare to provide your full set of medical benefits. This plan pays medical benefits after Original Medicare covers their portion. Generally, your provider bills Medicare for covered medical services, and then bills the plan for the rest. In some cases, the provider may bill you for the rest, in which case you would request reimbursement from the plan.

The pharmacy and prescription drug benefits are covered by a Medicare Part D plan. The cost of the Part D coverage is included in the premium for UMP Classic Medicare with Part D (PDP).

While this plan may have higher deductibles and out-of-pocket limits, enrollees in UMP Classic Medicare with Part D (PDP) have the unique benefit of a COB bank which allows for reimbursement of some out-of-pocket costs for Medicare-covered services

Medicare Advantage with Part D plans

Medicare Advantage plans cover the same services as Original Medicare Part A and Part B. They also offer additional benefits and services that Original Medicare does not cover and may include Part D coverage for prescription drugs. Plans that include Part D are called Medicare Advantage Prescription Drug (MAPD) plans. The PEBB Program offers several MAPD plans: UnitedHealthcare PEBB Balance and PEBB Complete; Kaiser Permanente NW Senior Advantage with Part D; and Kaiser Permanente WA Medicare Advantage with Part D.

These plans limit your out-of-pocket costs, which include most of the deductible, coinsurance, and copays. The providers bill the plans, which coordinate with Medicare, so you don't need to submit claims. Because these plans are subsidized by the federal government, their costs may be lower than Original Medicare.

If you enroll in a PEBB Program MAPD plan, you do not need to enroll in Part D separately. You cannot

enroll in an MAPD plan and in another Medicare Advantage or standalone Part D plan at the same time.

Some MAPD plans have specific provider networks you must use. These plans might be health maintenance organizations (HMOs) or preferred provider organization (PPO) plans. Check with the plan before you enroll to see if your providers are in network, if there is a difference in cost share for in-network and out-of-network providers, and if they offer coverage where you intend to travel or live part of the year.

Medicare supplement plans

Premera Blue Cross Medicare Supplement Plan G is designed to cover the cost share of medical costs that are not covered by Original Medicare. However, coverage is limited to only those medical services covered by Medicare Part A and Part B.

Medicare supplement plans do not include prescription drug coverage. If you don't have creditable drug coverage (for example, through your spouse's insurance), you will need to enroll in a standalone Medicare Part D plan to get your prescriptions and to avoid a Medicare Part D late enrollment penalty, unless you have other creditable prescription drug coverage. The PEBB Program does not offer a standalone Part D plan, but they are available through private insurance companies.

Medicare supplement plans have the lowest monthly premiums of the Medicare plans offered by the PEBB Program. Members must also pay the annual Part B deductible in Plan G.

What should I do when I become Medicare eligible?

Apply for Medicare early

If you or a dependent are enrolled in PEBB retiree insurance coverage and become eligible for Medicare, that creates a special open enrollment event that requires you to change your medical plan. You may be able to enroll in a less expensive Medicare plan.

Medicare has different timelines than the PEBB Program. We encourage you to apply for Medicare three months before turning age 65. Doing so will make sure that you can enroll (or meet the requirements to stay enrolled) in PEBB retiree insurance coverage within our timelines.

Members must have a permanent residence within the United States or U.S. territories. Those who are eligible for Medicare and living permanently outside of the United States may be automatically deferred from PEBB retiree insurance coverage.

To enroll in Medicare, visit the Social Security Administration's Plan for Medicare webpage at **ssa.gov/medicare** or call 1-800-772-1213 (TTY: 1-800-325-0778).

Send us proof of Medicare

Once you or your dependent have applied for Medicare Part A and Part B, you must send us proof of the Medicare enrollment or denial.

If you are enrolling in PEBB retiree insurance coverage for the first time, submit one of the Medicare documents listed below.

If you or your dependent are already enrolled in PEBB retiree insurance coverage, send us one of the documents listed below **30 days before turning age 65**, so we can properly adjust your premium (if applicable). If your Medicare coverage is delayed, send us the document **no later than 60 days** after turning age 65.

If you do not meet these requirements, you will not be enrolled in PEBB retiree insurance coverage, or your eligibility will end and we will send you a termination notice.

Send us either of these:

- A copy of the Medicare card or Medicare benefit verification letter showing the effective date of Medicare Part A and Part B along with the required form to change your medical plan; or
- A copy of the Medicare denial letter from the Social Security Administration

Write your (the subscriber's) full name and the last four digits of your Social Security number on the copy so we can identify your account. You can choose a new plan and upload your document in Benefits 24/7 at **benefits247.hca.wa.gov** or submit a *PEBB Retiree Change Form (*form E), any other required forms, and your document by mail, fax, or secure message. Contact information is at the front of this guide.

When do I start paying PEBB Medicare premiums?

If you are already enrolled as a non-Medicare retiree, you must enroll in a different plan to receive Medicare rates. When you send us the information noted above, we will change your plan or reduce your medical premium to the lower Medicare rate, if applicable, and notify your medical plan of the Medicare enrollment.

If you are paying premium surcharges, the surcharges will end automatically when you (the subscriber) enroll in Medicare Part A and Part B.

If you are enrolling in PEBB retiree insurance coverage for the first time, see "Paying for coverage" on page 55.

Learn more about Medicare

To find out more about Medicare benefits and how to pay the Medicare premiums, visit the Medicare website at **medicare.gov** or call 1-800-633-4227.

For information regarding Medicare Part A and Part B premium costs as well as costs that may be associated with your Income-Related Monthly Adjustment Amount (IRMAA) please visit **medicare.gov/basics/get-started-with-medicare/medicare-basics/what-does-medicare-cost**.

Can I enroll in an HSA and in Medicare?

No. The IRS does not allow individuals who are enrolled in Medicare to make contributions to a health savings account (HSA). If you are enrolled in Medicare and in a CDHP with an HSA, you will be responsible for any tax penalties that result from contributions to your HSA after you are no longer eligible.

If you are not eligible for Medicare and are enrolled in a CDHP, and you have a dependent enrolled in Medicare, you may choose to remove the dependent from your coverage in order to stay in a CDHP plan. The dependent would not be eligible for PEBB Continuation Coverage.

Can I enroll in a CDHP or UMP Select plan and Medicare Part A and Part B?

No. If you are enrolled in a consumer-directed health plan (CDHP) with a health savings account (HSA) or UMP Select, you must change medical plans when you or someone on your account enrolls in Medicare Part A or Part B. This qualifies as a special open enrollment event.

Changing plans when you enroll in Medicare

To change medical plans, use Benefits 24/7 (or we must receive your *PEBB Retiree Change Form* [form E]) **no later than 60 days** after the Medicare enrollment date. If you choose an MAPD plan or UMP Classic Medicare with Part D (PDP), the deadline is no later than two months after the date your previously selected health plan becomes unavailable.

Since you must change plans if you are enrolled in a CDHP or UMP Select plan, and enrolling in Medicare Part A and Part B may lower your premium, we encourage you to change your plan as soon as possible, especially before your Medicare enrollment date. Doing so will help you avoid paying a higher non-Medicare plan premium. It will also end applicable premium surcharges.

The effective date of the plan change will be the first of the month after the date the medical plan becomes unavailable, the date you make the change in Benefits 24/7, or the date we receive your form, whichever is later. If that day is the first of the month, the change in the medical plan begins on that day, unless you are enrolling in an MAPD plan or UMP Classic Medicare with Part D (PDP), in which case your coverage will start the first day of the month following the date you make the change in Benefits 24/7, or the date we receive your form.

Here are your options for changing plans, depending on which member is enrolled in Medicare Part A and Part B:

- **If you (the subscriber)** are eligible for Medicare: You must choose a different type of medical plan for yourself and your dependents. Your annual deductible and annual out-of-pocket maximum may restart with your new plan.
- **If your covered dependent** is eligible for Medicare: You must choose a different type of medical plan for your family if you want to keep your dependent enrolled in PEBB health plan coverage. Your annual deductible and annual out-of-pocket maximum may restart with your new medical plan. To keep your CDHP or UMP Select plan, you may choose to remove your dependent from your PEBB health plan coverage before they enroll in Medicare Part A or Part B. They will not qualify for PEBB Continuation Coverage.

Health savings account (HSA)

After you leave a CDHP, you will still have access to your existing HSA funds, but you can no longer contribute to the HSA. The IRS does not allow individuals who are enrolled in Medicare to make contributions to an HSA. If you are enrolled in a CDHP and do not select a new medical plan, you will be liable for any tax penalties resulting from contributions made to your HSA after you are no longer eligible.

Your medical plan options are based on eligibility and where you live. If you cover dependents, everyone must enroll in the same medical plan, with some exceptions based on eligibility for Medicare Part A and Part B. See "Medicare and PEBB retirees" on page 24.

Eligibility

You and your enrolled dependents must be enrolled in Medicare Part A and Part B to enroll in a PEBB Medicare plan. Also, not everyone qualifies to enroll in a consumer-directed health plan (CDHP) with a health savings account (HSA) or UMP Select plan. See "Can I enroll in a CDHP or UMP Select plan and Medicare Part A and Part B?" on page 26.

Where you live

In most cases, you must live in the plan's service area to join the plan. See "Medical plans available by county" starting on page 34. Be sure to call the plans you're interested in (not the provider) to ask about provider availability in your county. If you travel or choose to live outside of the United States, you should confirm that your PEBB health plan provides coverage in that location.

If you move out of your medical plan's service area, you must change your medical plan. You must report your new address and the request to change your medical plan to the PEBB Program **no later than 60 days** after your move. If you do not change your medical plan, we will enroll you in a PEBB medical plan designated by the HCA director or designee. If you enroll in a Medicare Advantage Prescription Drug (MAPD) plan or Uniform Medical Plan (UMP) Classic Medicare with Part D (PDP), you must permanently live in the United States. If you enroll in one of these plans and later move to permanently live in a location outside of the United States, your medical plan enrollment will terminate on the last day of the month as required by federal law. You may request to defer your enrollment in PEBB retiree insurance coverage as described in "Deferring your coverage" on page 18.

Types of medical plans

The PEBB Program offers three types of medical plans:

Consumer-directed health plans (CDHP)

A CDHP lets you use a health savings account (HSA) to help pay for out-of-pocket medical expenses tax-free. These plans have a lower monthly premium, a higher deductible, and a higher out-of-pocket limit than most other plans. You cannot enroll in a CDHP if you or an enrolled dependent are enrolled in Medicare.

Managed-care plans

These plans may require you to choose a network primary care provider to meet or coordinate your health care needs. You can change network providers at any time. The plan may not pay benefits if you see an out-of-network provider.

Preferred provider organization (PPO) plans

PPOs allow you to self-refer to any approved provider type in most cases and usually provide a higher level of coverage if the provider is in network.

What are the differences between the plans?

All medical plans cover the same basic health care services, except for Premera Blue Cross Medicare Supplement Plan G. The plans vary in other ways, such as provider networks, premiums, out-of-pocket costs, and drugs they cover. When choosing a plan to best meet your needs, here are some things to consider.

Premiums

A premium is the monthly amount the subscriber pays to cover the cost of insurance. It does not cover copays, coinsurance, or deductibles. Premiums vary by plan. When considering plans, remember that the premium is not the only factor that determines what you'll pay for your health care; pay attention to deductibles, cost sharing, and maximum out of pocket amounts, too. A higher premium doesn't necessarily mean higher quality of care or better benefits. Generally, plans with higher premiums may have lower annual deductibles, copays, or coinsurance costs. Plans with lower premiums may have higher deductibles, coinsurance, copays, and more limited networks. Premiums are listed starting on page 6. If you or a dependent are enrolled in Medicare, the Medicare plan you select includes the premium for Medicare Part D, except for Premera Medicare Supplement Plans F and G, which do not include prescription drug coverage. The premiums for Medicare Part B are not included and you must pay those directly to Medicare.

Deductibles

A deductible is a fixed dollar amount you must pay each calendar year for covered health care expenses before the plan starts paying for covered services. Medicare plans may also have a separate annual deductible for prescription drugs. You do not have to meet the deductible before receiving covered preventive care services when you see a network provider.

Copays and coinsurance

When you receive care, some plans require you to pay a fixed amount, called a copay. Other plans require you to pay a percentage of the cost, called coinsurance. These amounts vary by plan and are based on the type of care received. Copays and coinsurance are also called "cost sharing".

Out-of-pocket limit

The annual out-of-pocket limit is the most you will pay in a calendar year for covered benefits. Once you have reached the out-of-pocket limit, the plan pays 100 percent of the allowed amount for most in-network covered services for the rest of the calendar year. Certain charges (such as your annual deductible, copays, and coinsurance) may count toward your out-of-pocket limit. Others, such as your monthly premiums, do not. Read each plan's benefits booklet for details.

Your providers

When you enroll in a medical plan, you may choose your primary care provider. If you want to see a particular provider, check with the plan (not the provider) to see if the provider is in the plan's network before you join. After you join a plan, you may change your provider, although the rules vary by plan.

Network adequacy

All health carriers in Washington are required to maintain provider networks that offer members reasonable access to covered services. Check the plans' provider directories to see how many providers in your area are accepting new patients and what the average wait time is for an appointment.

Referral procedures

Some plans allow you to self-refer to network providers for specialty care. Others require you to have a referral from your primary care provider. Although some medical plans may not require a referral from your primary care provider to see a specialist, the specialist may require you to have one prior to seeing them for services.

Paperwork

In general, PEBB plans don't require you to file claims. However, Uniform Medical Plan (UMP) members may need to file a claim if they receive services from an out-of-network provider. If you have a Kaiser Permanente plan, you may need to file a claim if you receive services out of the plan's service area, including outside the country. You may also be required to submit claims for urgent or emergency care. CDHP members should keep paperwork they receive from providers and for qualified health care expenses to verify eligible payments from their health savings account.

Coordination with your other benefits

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

If you are also covered by another health plan, call the plan to ask how they coordinate benefits. This is especially important for those coordinating benefits between the PEBB and SEBB Programs, and those enrolled in Medicaid.

One exception to coordination of benefits: PEBB medical plans that cover prescription drugs will not coordinate prescription drug coverage with a standalone Medicare Part D plan. All PEBB Medicare medical plans, except Premera Blue Cross Medicare Supplement Plan G, provide Medicare Part D coverage. PEBB non-Medicare plans provide creditable prescription drug coverage, which means the prescription drug coverage offered by these plans is as good as or better than Medicare Part D coverage.

If you enroll in a standalone Medicare Part D plan, you must enroll in Premera Blue Cross Medicare Supplement Plan G or terminate your PEBB retiree health plan coverage.

How can I compare the plans?

Benefits comparisons

You'll find benefits comparisons for health plans starting on page 36. These will help you compare the costs and availability of the most widely used features of plans.

Benefits booklets

The health plans provide benefits booklets, also called certificates of coverage (COCs) or evidence of coverage (EOC), to provide detailed information about plan benefits and what is and is not covered. You can find the benefits booklets for all PEBB medical plans on the *Medical benefits* webpage at **hca.wa.gov/pebb-retirees**.

Summary of Benefits and Coverage

The federal Affordable Care Act requires most health plans to provide Summaries of Benefits and Coverage (SBCs) to help members understand plan benefits and medical terms. (SBCs are not required for Medicare Part D plans.) SBCs help you compare things like:

- Whether there are services a plan doesn't cover.
- What isn't included in a plan's out-of-pocket limit.
- Whether you need a referral to see a specialist.

Most PEBB Program medical plans provide SBCs, or explain how to get them, at different times throughout the year (like when you apply for coverage or renew your plan). SBCs are available upon request in your preferred language.

Find SBCs on the *Medical benefits* webpage at **hca.wa.gov/pebb-retirees** or from the medical plans' websites. You can also call the plan's customer service or the PEBB Program at 1-800-200-1004 (TRS: 711) to request a copy at no charge. Medical plan websites and customer service phone numbers are listed at the front of this guide. SBCs do not replace medical benefits comparisons or the plans' benefits booklets.

Virtual benefits fair

The virtual benefits fair is a way to learn about your benefit options online. It includes information about your plan options to help you choose the right plans for you and your dependents. Visit the virtual benefits fair on HCA's website at **hca.wa.gov/vbf-pebb**.

What plans does PEBB retiree insurance coverage offer?

Medicare options

These medical plans are for members enrolled in Medicare Part A and Part B. You must pay your Medicare Part B premium directly to Medicare in addition to the PEBB premiums you pay to the Health Care Authority.

- Kaiser Permanente NW Senior Advantage with Part D
- Kaiser Permanente WA Medicare Advantage with Part D
- Premera Blue Cross Medicare Supplement Plan G
- UMP Classic Medicare with Part D (PDP), administered by Regence BlueShield and ArrayRx
- UnitedHealthcare PEBB Balance
- UnitedHealthcare PEBB Complete

Non-Medicare options

These medical plan options are for members not eligible for Medicare or enrolled in Part A only.

Consumer-directed health plans (CDHPs)
These are not available if any member is enrolled in Medicare.

- Kaiser Permanente NW CDHP
- Kaiser Permanente WA CDHP
- UMP CDHP, administered by Regence BlueShield and ArrayRx

Managed-care plans
At least one member on your account must not be enrolled in Medicare.

- Kaiser Permanente NW Classic
- Kaiser Permanente WA Classic
- Kaiser Permanente WA SoundChoice
- Kaiser Permanente WA Value

Preferred-provider organization (PPO) plans

- UMP Classic, administered by Regence BlueShield and ArrayRx
- UMP Select, administered by Regence BlueShield and ArrayRx (not available if any member is enrolled in Medicare)

Consumer-directed health plans (CDHPs)

A consumer-directed health plan (CDHP) is a high-deductible health plan combined with a health savings account (HSA). They generally have lower premiums and higher out-of-pocket costs than other types of medical plans. If you cover dependents, you must pay the whole family deductible before the CDHP starts paying benefits.

When you enroll in a CDHP, you are automatically enrolled in a tax-free HSA that you can use to pay for IRS-qualified, out-of-pocket medical expenses (such as deductibles, copays, and coinsurance), including some that your health plans may not cover. See *IRS Publication 969, Health Savings Accounts and Other Tax-Favored Health Plans* on the IRS website at **irs.gov** for details. Your HSA balance can grow over the years, earn interest, and build savings that you can use to pay for health care as needed or pay for Medicare Part B premiums. You may be able to deduct your HSA contributions from your federal income taxes.

All of the HSAs combined with PEBB CDHPs are administered by HealthEquity, Inc.

Am I eligible for a CDHP?

Not everyone is eligible. You cannot enroll in a CDHP with an HSA if:

- You or a covered dependent is enrolled in Medicare Part A or Part B.
- You or a covered dependent is enrolled in Medicaid (called Apple Health in Washington).
- You are enrolled in another health plan that is not a high-deductible health plan (HDHP), unless the health plan coverage is limited-purpose coverage, for example, limited to dental, vision, or disability coverage.
- You or your spouse or state-registered domestic partner is enrolled in a fully claims-eligible health reimbursement arrangement (HRA), such as a Voluntary Employees' Beneficiary Association (VEBA) plan. However, you may enroll in a CDHP if you convert your HRA to "limited HRA" coverage by submitting a *Limited HRA Coverage Election* form to your VEBA plan.
- You have a TRICARE plan.
- You are enrolled in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).
- Your spouse is enrolled in a flexible spending arrangement (FSA), even if you are not covering your spouse.
- You are claimed as a dependent on someone else's tax return.

Other exclusions apply. To check whether you qualify, see the *HealthEquity Complete HSA Guidebook* at **healthequity.com/doclib/hsa/guidebook.pdf**, see *IRS Publication 969, Health Savings Accounts and Other Tax-Favored Health Plans* on the IRS website at **irs.gov**, contact your tax advisor, or call HealthEquity toll-free at 1-877-873-8823 for Kaiser Permanente CDHP members or 1-844-351-6853 (TRS: 711) for UMP CDHP members.

What does the PEBB Program contribute to my HSA?

The PEBB Program will contribute the following amounts to your HSA for 2026:

- $58.34 each month for an individual subscriber, up to $700.08.
- $116.67 each month for a subscriber with one or more enrolled dependents, up to $1,400.04.
- $125 if you qualify for the SmartHealth wellness incentive in 2026.

The entire amount is not deposited to your HSA in January. Contributions from the PEBB Program are deposited into your HSA in monthly installments on the last day of each month. If you qualify for the SmartHealth wellness incentive, $125 will be deposited in your HSA at the end of January the following year.

How do I contribute to my HSA?

You can choose to contribute to your HSA through monthly direct deposits to HealthEquity. The IRS has an annual limit for HSA contributions from all sources. In 2026, the limits are $4,400 (for subscriber-only accounts) and $8,750 (for you and one or more dependents). If you are age 55 or older, you may contribute up to $1,000 more per year.

To make sure you do not go beyond the limit, consider the PEBB Program's contributions, your contributions, and the SmartHealth wellness incentive in January (if you qualify for it).

Should I choose a CDHP if I am enrolled in Medicare?

No. IRS rules do not allow you to contribute to an HSA when you or your dependent is enrolled in Medicare. If you choose a CDHP and you or a covered dependent enroll in Medicare Part A or Part B during the year, you must change to a different type of medical plan. If your covered dependent enrolls in Medicare, you may choose to remove the Medicare-enrolled dependent from PEBB coverage to keep your CDHP.

What happens to my HSA if I leave the CDHP?

You can keep any unspent funds in your HSA. You can spend them on qualified medical expenses in the future. However, you, the PEBB Program, and other individuals can no longer contribute to your HSA.

If you leave employment or retire, HealthEquity may charge you a monthly fee if you have less than $2,500 in your HSA after December 31. You can avoid this charge by either ensuring you have at least $2,500 in your HSA or by spending all of your HSA funds by December 31. Other fees may apply. For details, call HealthEquity toll-free at 1-877-873-8823 (TRS: 711) for Kaiser Permanente CDHP members or 1-844-351-6853 (TRS: 711) for UMP CDHP members.

If you set up direct deposits to your HSA, contact HealthEquity to stop them.

Behavioral health coverage

What is behavioral health?

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

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

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

Ensuring timely access to care

All health carriers in Washington State must maintain provider networks that provide enrollees reasonable access to covered services. To find a provider for mental health, physical health, or substance use, you can start by checking your plan's online provider directory. Carriers are required by law to include a notation on the online provider directory when a mental health or substance use provider is closed to new patients. If you need more information, check the plan's website or call the plan's customer service number.

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

Crisis information

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

For immediate help

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

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

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

+ For additional support

Find county-based crisis support assistance options on the HCA website at **hca.wa.gov/mental-health-crisis-lines**.

Washington Recovery Help Line

Call 1-866-789-1511 any time, day or night. This anonymous and confidential help line provides crisis intervention and referral services for individuals in Washington State experiencing substance use disorder, problem gambling, or a mental health challenge. Professionally trained volunteers and staff are available to provide emotional support 24 hours a day, seven days a week. In addition, they can suggest local treatment resources for substance use, problem gambling, and mental health, as well as other community services.

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

If you are having trouble receiving services

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

Compare coverage by plan

When you need information about what mental health or substance use disorders are covered, you can read the PEBB medical plans' benefits booklets, which are on the *Medical benefits* webpage at **hca.wa.gov/pebb-retirees**. Also see the *Behavioral health services by plan* webpage at **hca.wa.gov/bh-pebb**.

Key words to look for in these documents include inpatient and outpatient coverage, mental health, chemical dependency, residential treatment facility, and substance use disorder. The "Medical benefits comparison" on page 36 and the "Medicare benefits comparison" on page 43 include high-level summaries of coverage by plan.

Support beyond the crisis

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

- Resources such as Crisis Connections, **crisisconnections.org**. The *Get Help* section includes many resources, including the Washington Warm Line, which supports people living with emotional and mental health challenges, **crisisconnections.org/wa-warm-line**.
- Resources available through your medical plans, such as counseling, apps to support mental health, and other programs. See the *Behavioral health services by plan* webpage at **hca.wa.gov/bh-pebb**.

Access to Naloxone

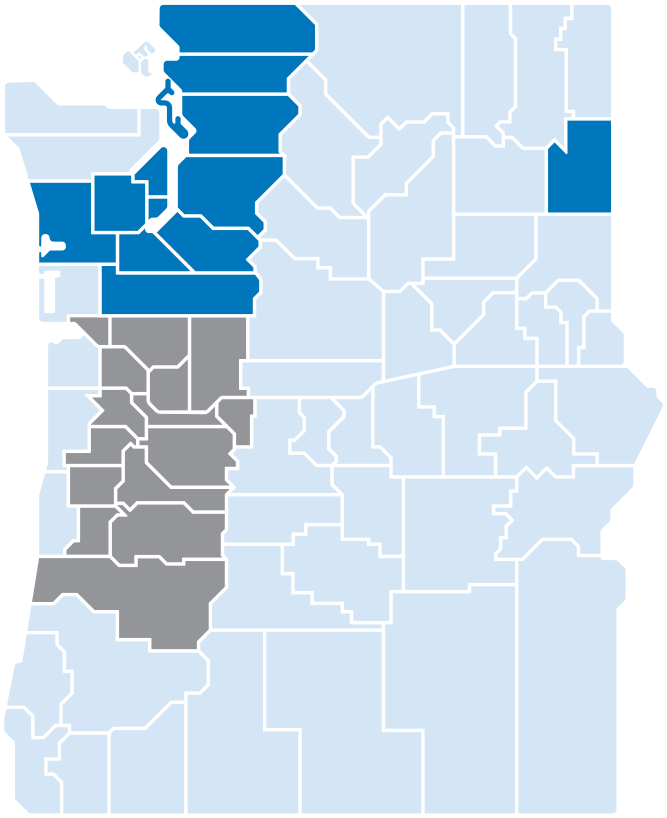
Naloxone, also known by the brand name, Narcan, is a fast-acting medication that can reverse the effects of opioids and stop an overdose. You can get naloxone for free. Visit **StopOverdose.org** to find a location near you, or request naloxone to be mailed to you by the People's Harm Reduction Alliance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

2026 PEBB retiree medical plans available by county

If you move out of your medical plan's service area, you may need to change your plan. You must report your new address and any request to change your medical plan to the PEBB Program no later than 60 days after you move.

Medicare plans

Kaiser Permanente NW (KPNW), Kaiser Permanente WA (KPWA), Premera Blue Cross, Uniform Medical Plan (UMP), UnitedHealthcare



UMP Classic Medicare with Part D (PDP), UnitedHealthcare PEBB Balance and PEBB Complete, and Premera Blue Cross Medicare Supplement Plan G

Available in all Washington counties and nationwide.

KPWA Medicare Advantage with Part D

- Grays Harbor (ZIP codes: 98541, 98557, 98559, and 98568)
- Island
- King
- Kitsap
- Lewis
- Mason (ZIP codes: 98524, 98528, 98546, 98548, 98555, 98584, 98588, and 98592)
- Pierce
- Skagit
- Snohomish
- Spokane
- Thurston
- Whatcom

KPNW Senior Advantage with Part D

–**Washington**

- Clark
- Cowlitz
- Skamania
- Wahkiakum (ZIP codes: 98612 and 98647)

–**Oregon**

- Benton County (ZIP codes: 97321, 97330, 97331, 97333, 97339, 97370)
- Clackamas
- Columbia
- Hood River
- Lane
- Linn County (ZIP codes: 97321, 97322, 97335, 97355, 97358, 97360, 97374, 97383, 97389)
- Marion
- Multnomah
- Polk
- Washington
- Yamhill

Non-Medicare plans

Uniform Medical Plan (UMP)

UMP Classic, UMP Select, and UMP CDHP

Available in all Washington counties and nationwide.

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

KPWA Classic, KPWA CDHP, and KPWA Value

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

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

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

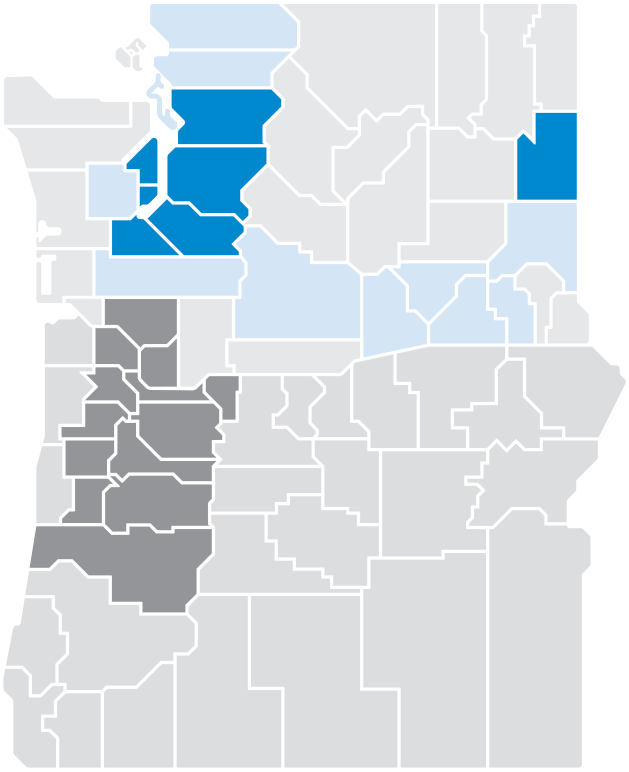
KPNW Classic and KPNW CDHP

–Washington

- Clark
- Cowlitz

–Oregon

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



2026 PEBB Medical Benefits Comparison

Use the following charts to view the deductibles, out-of-pocket limits, out-of-pocket costs per visit, and prescription drug costs for PEBB medical plans.

You must pay your annual deductible before most coinsurance (%) or co-pays ($) apply, unless noted that the deductible is waived.

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

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

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

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

Physical, occupational, speech, and neurodevelopmental therapies have a combined visit limit unless otherwise noted.

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

Continued on next page →

What you pay ↘	Managed Care and Health Maintenance Organization (HMO) Plans					
	Kaiser Permanente NW		Kaiser Permanente WA			
	Classic	CDHP	Classic	SoundChoice	Value	CDHP
Annual costs (individual/family)						
Medical deductible	$300 / $900	$1,700 / $3,400	$175 / $525	$125 / $375	$250 / $750	$1,700 / $3,400
Medical out-of-pocket limit	$2,500 / $5,000	$5,100 / $10,200	$2,000 / $4,000		$3,000 / $6,000	$5,100 / $10,200
Prescription drug deductible	None	Combined with medical deductible	$100 / $300 (does not apply to Value or Tier 1 drugs)			Combined with medical deductible
Prescription drug out- of-pocket limit	Combined with medical limit		$2,000 / $8,000			Combined with medical limit
Emergency services						
Ambulance	15%		20%*			10%
Emergency room			$250	$75 + 15%	$300	
Hearing services						
Hearing aids (per ear)	$0 every 36 months*	$0 every 36 months	$0 every 36 months*			$0 every 36 months
Routine annual hearing exam	$35	$30	$15 ($30#)	$20* (15%#)	$30 ($50#)	10%

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

- * Deductible is waived
- # Specialist copay/coinsurance
- ‡ Total combined visits
- ⁂ $0 for ages 17 and under
- ▲ Out-of-pocket limit not to exceed $7,000 per member

What you pay ↘	Preferred Provider Organization (PPO) Plans		
	Uniform Medical Plan		
	Classic	Select	CDHP
Annual costs (individual/family)			
Medical deductible	$250 / $750	$750 / $2,250	$1,700 / $3,400
Medical out-of-pocket limit	$2,000 / $4,000	$3,500 / $7,000	$4,200 / $8,400▲
Prescription drug deductible	$100 / $300 (Tier 2 only)	$250 / $750(Tier 2 only)	Combined with medical deductible
Prescription drug out of pocket limit	$2,000 / $4,000		Combined with medical out-of-pocket limit
Emergency services			
Ambulance	20%		
Emergency room	$75 + 15%	$75 + 20%	15%
Hearing services			
Hearing aids (per ear)	$0 up to the allowed amount every 36 months‡*		$0 up to the allowed amount every 36 months‡
Routine annual hearing exam	$0		15%

Uniform Medical Plan is administered by Regence BlueShield and ArrayRx.

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

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

Behavioral health benefits

Use the charts below to find out what you pay for behavioral health services such as substance use disorder treatment and mental health counseling.

What you pay ↘	Managed Care and Health Maintenance Organization (HMO) Plans					
	Kaiser Permanente NW		Kaiser Permanente WA			
	Classic	CDHP	Classic	SoundChoice	Value	CDHP
Inpatient treatment						
Hospital facility – mental health & substance use **Withdrawal management/ detoxification** **Residential treatment facility**	15%		$150 per day up to $750 admission	$500 per admission	$250 per day up to $1,250 per admission	10%
Outpatient treatment						
Hospital facility (mental health & substance use) **Partial hospitalization (or day treatment program)** **Intensive outpatient** **Withdrawal management/ detoxification**	$25* per visit or per day⁂	$20* per visit or per day⁂	$150	15%	$200	10%
Office visits for accessing outpatient mental health and substance use services						
Mental health & substance use	$25*	$20	$15	$20*	$30	10%
Specialist	$35*	$30				
Telemedicine / virtual care	$0*	$0	$10 ($0 virtual care)*			$10 ($0 virtual care)
Urgent care (mental health & substance use crisis services)	$45*	$40	$15 ($30#)	$20* (15%#)	$30 ($50#)	10%
Therapies						
Occupational and neurodevelopmental therapy (NDT) †	$35/60	$30/60	$30/60 (no limit NDT)	15%/60 (no limit NDT)	$50/60 (no limit NDT)	10%/60 (no limit NDT)

What you pay ↘	Preferred Provider Organization (PPO) Plans		
	Uniform Medical Plan		
	Classic	Select	CDHP
Inpatient treatment			
Hospital facility (mental health & substance use) **Withdrawal management / detoxification** **Residential treatment facility**	$200 per day up to $600‡		15%
Outpatient treatment			
Hospital (mental health & substance use) **Partial hospitalization (or day treatment program)** **Intensive outpatient** **Withdrawal management / detoxification**	15%	20%	15%
Office visits for accessing outpatient mental health and substance use services			
Mental health & substance use **Specialist** **Telemedicine / virtual care** **Urgent care (mental health & substance use crisis services)**	15%	20%	15%
Therapies			
Occupational and neurodevelopmental therapy	15%	20%	15%

Prescription drug benefits

Amounts below show what you pay for prescription drugs. If your plan has a prescription drug deductible, you must pay the deductible before most copays or coinsurance apply, unless noted that the deductible is waived. **Note:** Immunizations (vaccines) recommended by the Centers for Disease Control (CDC) are not subject to a deductible. You pay $0 for immunizations covered under the preventive care benefit when received from a preferred or participating provider, network vaccination pharmacy, or public health department. All plans cover legally required preventive prescription drugs at 100 percent of the allowed amount with no deductible. **Deductible is waived for covered insulins and you pay no more than $35 per 30-day supply.**

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

Drug tiers	Kaiser Permanente WA							
	Retail (up to 30-day supply)				Mail-order (up to 90-day supply)			
	Classic	SoundChoice	Value	CDHP	Classic	SoundChoice	Value	CDHP
Value	$5*			N / A	$10*			N / A
Preferred generic	$20*	$15*	$25*	$20	$40*	$30*	$50*	$40
Preferred brand name	$40	$60	$50	$40	$80	$120	$100	$80
Non-preferred generic and brand name	50% up to $250	50%		50% up to $250	50% up to $750	50%		50% up to $750
Preferred specialty	Not covered	$150		Not covered	Not covered	$150 (30-day supply)		Not covered
Non-preferred specialty		50% up to $400				50% up to $400 (30-day supply)		

Drug tiers	Uniform Medical Plan					
	Retail and mail order (up to 30-day supply)			Retail and mail order (up to 90-day supply)		
	Classic	Select	CDHP	Classic	Select	CDHP
Value	5% up to $10*		15%; 5% up to $10 ‡	5% up to $30		15%; 5% up to $30 ‡
Tier 1 (Primarily low-cost generic)	10% up to $25*		15%; 10% up to $25 ‡	10% up to $75		15%; 10% up to $75 ‡
Tier 2 (Preferred brand name, high-cost generic, and specialty drugs)	30% up to $75; 30% up to $35 ‡		15%; 30% up to $35 ‡	30% up to $225; 30% up to $105 ‡		15%; 30% up to $105 ‡

2026 PEBB Medicare Benefits Comparison

Use the following charts to view the per- visit costs for some network benefits and prescription drug costs for PEBB Medicare plans. If your plan has a deductible, you must pay the deductible before most copays ($) or coinsurance (%) apply, unless noted that the deductible is waived.

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

Call the plans directly for more information on specific benefits, including preauthorization requirements and exclusions. If anything in these tables conflicts with the plan's benefits booklet (also called evidence of coverage or certificate of coverage), the benefits booklet takes precedence and prevails.

- Uniform Medical Plan (UMP) with Part D (PDP) is administered by Regence BlueShield and ArrayRx.
- Kaiser Permanente NW and Kaiser Permanente WA offer Medicare Advantage plans with Part D, but not in all areas.
- Premera Blue Cross offers Medicare Supplement Plan F and Medicare Supplement Plan G. Plan F is closed to new enrollees.

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

***** Deductible is waived

‡ See additional terms and conditions in the plan's benefits booklet

▲Visit cms.gov for updates

Specialist copay

What you pay ↘	Original Medicare	Medicare Supplement	Medicare Advantage with Part D			
	Uniform Medical Plan	Premera Blue Cross	Kaiser Permanente WA	Kaiser Permanente NW	UnitedHealthcare	
	UMP Classic Medicare with Part D (PDP)	Medicare Supplement Plan G	Medicare Advantage with Part D	Senior Advantage with Part D	PEBB Balance	PEBB Complete
Annual costs (individual/family)						
Medical deductible	$250 / $750	Part B deductible ▲	$0	$0	$0	
Medical out-of- pocket limit	$2,500 / $5,000		$2,500	$1,500	$2,000	$500
Prescription drug deductible	$100 (Tiers 3, 4, and 5)	N/A	$0	$0	$100 (Tiers 2, 3, and 4)	
Prescription drug out-of-pocket limit	$2,100		$2,100	$2,100	$2,100‡	
Emergency services						
Ambulance	20%	$0	$150	$50	$100	$0
Emergency room	$75 + 15%		$65		$65	

What you pay ↘	Original Medicare	Medicare Supplement	Medicare Advantage with Part D			
	Uniform Medical Plan	Premera Blue Cross	Kaiser Permanente WA	Kaiser Permanente NW	UnitedHealthcare	
	UMP Classic Medicare with Part D (PDP)	Medicare Supplement Plan G	Medicare Advantage with Part D	Senior Advantage with Part D	PEBB Balance	PEBB Complete
Hospital care						
Inpatient	$200 per day up to $600 per admission	$0	$200 per day up to $1,000 per admission‡	$500 per admission	$500 per admission	$0
Outpatient	15%		$200	$50	$250	
Office visits						
Primary care	15%	$0	$15	$25	$15	$0
Specialist			$30	$35	$30	
Urgent care			$15 ($30#)		$15	$15
Preventive care	$0		$0	$0	$0	$0
Telemedicine/ virtual care	Varies‡		$0	$0	Varies‡	
Hearing services						
Hearing aids (per ear)	$0 up to the allowed amount every 36 months‡	Not covered	$0 up to $3,000 every 36 months	$0 up to $3,000 every 36 months	$0 up to $3,000 every 3 years (limited to UnitedHealthcare Hearing Network)	
Routine annual hearing exam	$0*		$15 ($30#)	$35	$0	
Vision care						
Glasses and contact lenses	Any amount over $200 every 2 years‡	Not covered	Any amount over $300 every 24 months	Any amount over $200 every 24 months	Any amount over $300 every 24 months	
Routine annual eye exam	$0‡		$15‡	$25	$0	

Behavioral health benefits

Use the charts below to find out what you pay for behavioral health services such as substance use disorder treatment and mental health counseling. If your plan has a deductible, you must pay the deductible before most copays or coinsurance apply, unless noted that the deductible is waived.

What you pay ↘	Original Medicare	Medicare Supplement	Medicare Advantage with Part D			
	Uniform Medical Plan	Premera Blue Cross	Kaiser Permanente WA	Kaiser Permanente NW	UnitedHealthcare	
	UMP Classic with Part D (PDP)	Medicare Supplement Plan G	Medicare Advantage with Part D	Senior Advantage with Part D	PEBB Balance	PEBB Complete
Inpatient treatment						
Hospital facility (mental health & substance use)	$200 per day up to $600 per admission‡	$0	$200 per day up to 5 days per admission and up to 190 days per lifetime in a Medicare-certified psychiatric hospital	$500 per admission up to 190 days per lifetime in a Medicare-certified psychiatric hospital	$500 per admission	$0
Residential treatment facility			Not covered	$250 per admission		
Outpatient treatment						
Hospital (mental health)	15%	$0	$15 per individual or group therapy visit	$25 per individual therapy visit $12 per group therapy visit	$55 per day‡	$0
Hospital (substance use)			$30 per visit (opioid treatment) $0 per individual or group therapy visit‡			
Partial hospitalization (or day treatment program)	15%	$0	$0 per day‡	$25 per day	$55 per day‡	$0
Intensive outpatient (mental health)			$15 per individual or group therapy visit‡			
Intensive outpatient (substance use)			$30 per visit (opioid treatment) $0 per individual or group therapy visit‡			

What you pay ↘	Original Medicare	Medicare Supplement	Medicare Advantage with Part D			
	Uniform Medical Plan	Premera Blue Cross	Kaiser Permanente WA	Kaiser Permanente NW	UnitedHealthcare	
	UMP Classic with Part D (PDP)	Medicare Supplement Plan G	Medicare Advantage with Part D	Senior Advantage with Part D	PEBB Balance	PEBB Complete
Office visits for accessing outpatient mental health and substance use services						
Mental health	15%	$0	$15*	$25*	$15‡	$0
Substance use			$30 per visit (opioid treatment) $0 per individual or group therapy visit‡			
Specialist			$30*	$35*	$30	
Urgent care (mental health & substance use crisis services)			$15* ($30#)		$15	$15
Telemedicine/ virtual care			$0*	$0*	$30	$0
Therapies (cost/visits per year)						
Occupational and neurodevelopmental therapy (NDT)	15%	$0	$30‡	$35	$15/30‡	$0

Therapeutic service benefits

The therapies listed in the tables below are limited by the number of visits per year. Please refer to the plan's benefits booklet for specific details of the therapy you are seeking. Neurodevelopmental therapy is abbreviated as NDT. Physical, occupational, speech, and neurodevelopmental therapies have a combined visit limit unless otherwise noted.

What you pay ↘	Original Medicare	Medicare Supplement	Medicare Advantage with Part D			
	Uniform Medical Plan	Premera Blue Cross	Kaiser Permanente WA	Kaiser Permanente NW	UnitedHealthcare	
	UMP Classic with Part D (PDP)	Medicare Supplement Plan G	Medicare Advantage with Part D	Senior Advantage with Part D	PEBB Balance	PEBB Complete
Therapies (cost/visits per year)						
Acupuncture	$15/24	Medicare-covered services only‡	$15/24‡	$35/12‡	$15/24‡	$0/24‡
Chiropractic (spinal manipulations)	$15/24		$15‡	$35/12‡	$15/24‡	$0/24‡
Massage	$15/24	Not covered	$30/24‡	$25/12‡	$15/30	$0/30
Physical, speech, occupational, NDT	15%/60	$0‡	$30‡	$35‡	$15‡	$0‡

Prescription drug benefits

Amounts in the following tables show what you pay for prescription drugs. If your plan has a prescription drug deductible, you must pay the deductible before most copays or coinsurance apply, unless noted that the deductible is waived.

For all plans, immunizations (vaccines) recommended by the Centers for Disease Control (CDC) are not subject to a deductible. You pay $0 for immunizations covered under the preventive care benefit when received from a preferred or participating provider, network vaccination pharmacy, or public health department. All plans cover legally-required preventive prescription drugs at 100 percent of allowed amount with no deductible. See the plan's benefits booklet for details. You pay no more than $35 per 30-day supply for covered insulins. Prices shown for UnitedHealthcare 90-day supply are only for the preferred mail-order pharmacy, Optum Rx.

Note: Premera Blue Cross Medicare Supplement Plan G does not cover prescription drugs

Drug tiers	UMP Classic Medicare with Part D (PDP)	
	Retail/Mail order (up to 30-day supply)	**Retail/Mail order** (up to 90-day supply)
Tier 1: Preferred generic*	$0	$0
Tier 2: Generic*	$10	$20
Tier 3: Preferred brand name	$40	$80
Tier 4: Non-preferred brand name	$75	$150
Tier 5: Specialty	$90	Not offered

Drug tiers	Kaiser Permanente WA Medicare Advantage with Part D	
	Retail/Mail order (up to 30-day supply)	**Retail/Mail order** (up to 90-day supply)
Tier 1: Preferred generic	$20	$40
Tier 2: Generic	$20	$40
Tier 3: Preferred brand name	$40	$80
Tier 4: Non-preferred brand name	$100	$200
Tier 5: Specialty	$250	$250 (limited to 30-day supply)

Drug tiers	Kaiser Permanente NW Senior Advantage with Part D	
	Retail/Mail order (up to 30-day supply)	**Retail/Mail order** (up to 90-day supply)
Tier 1: Preferred generic	$20	$40
Tier 2: Generic	$20	$40
Tier 3: Preferred brand name	$40	$80
Tier 4: Non-preferred brand name	$100	$200
Tier 5: Specialty	$200	$200 (limited to 30-day supply)

Drug tiers	UnitedHealthcare			
	Retail/Mail order (up to 30-day supply)		**Retail/Mail order** (up to 90-day supply)	
	PEBB Balance	**PEBB Complete**	**PEBB Balance**	**PEBB Complete**
Tier 1: Preferred generic*	$5		$10	
Tier 2: Preferred brand	$45		$90	
Tier 3: Non-preferred drug	$100		$200	
Tier 4: Specialty	$100		$100 (limited to 30-day supply)	

To enroll in dental, you must also enroll in medical. You and any dependents must enroll in the same PEBB dental plan. If you terminate dental coverage for yourself, dental coverage for your dependents will also be terminated.

Before you enroll, check with the plan (not your provider) to make sure your provider is in the plan's network and group. The table below lists the dental plans' network and group numbers.

To find a provider, visit the dental plans' online directories or contact them using phone numbers listed in the front of this guide.

How does Uniform Dental Plan (UDP) work?

UDP is a preferred provider organization (PPO) plan. You can change providers at any time and do not need a referral to see a specialist. More than three out of four dentists in Washington State are in network with this PPO. UDP offers a tiered network of providers. When you see a provider in the Delta Dental PPO network, you maximize your coverage for services, as you have a lower coinsurance with these providers. A second tier of providers, the Delta Dental Premier network, is also available and considered in network.

Under UDP, you pay a percentage of the plan's allowed amount (coinsurance) for dental services after you have met the annual deductible. UDP pays up to an annual maximum of $1,750 for covered benefits for each member, including preventive visits.

How do the DeltaCare and Willamette Dental plans work?

DeltaCare and Willamette Dental are managed-care plans. You must choose and receive care from a primary care dentist (PCD) in that plan's network. Your PCD must give you a referral to see a specialist. You may change network providers at any time. If you seek services from a provider not in the plan's network, these plans will not pay your claims.

Neither plan has an annual deductible. You don't need to track how much you have paid out-of-pocket before the plan begins covering benefits. When you receive dental services, you pay a set amount, called a copay. Neither plan has an annual maximum for covered benefits, with some exceptions.

Dental plan options

Make sure you contact the dental plan before you enroll to confirm that your provider is part of the specific plan network and plan group.

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

ID cards

Willamette Dental does not use ID cards. Uniform Dental Plan (UDP) and DeltaCare do not mail ID cards, but you can download one from **deltadentalwa.com/pebb**. If you have questions about your dental ID card, contact your plan. Contact information is provided at the front of this guide.

2026 PEBB Dental Benefits Comparison

Use the chart below to see what you pay for dental services. Before you select a dental plan or provider, compare the plans to find out what is covered, which providers are in-network, and your costs for care. For benefit details, refer to the plan's benefits booklet (also called a certificate of coverage) or contact the plan. If anything in this chart conflicts with the plan's benefits booklet, the benefits booklet takes precedence and prevails.

Uniform Dental Plan (UDP) is a preferred-provider organization (PPO) plan available throughout the U.S. You can choose any dental provider and change providers at any time. UDP offers a tiered network of providers, which means there are two cost-sharing levels. Providers in the Delta Dental Premier network charge more for covered services than providers in the Delta Dental PPO network. The UDP amounts shown below are for the Delta Dental PPO network only.

*The UDP deductible does not apply to orthodontia, preventive care, and services for children under age 15. You must meet the deductible before the plan pays for all other covered services.

DeltaCare and Willamette Dental (underwritten by Willamette Dental of Washington, Inc.) are managed-care plans.

You must select and receive care from a primary care dental provider in that plan's network. DeltaCare's service area is limited to Washington State. Willamette Dental has office locations in Washington, Oregon, and Idaho.

What you pay ↘	Managed Care Plans		Preferred Provider Organization (PPO)	
	DeltaCare (Group 3100) DeltaCare network	**Willamette Dental** (Group WA82)	**Uniform Dental Plan (Group 3000 Delta Dental PPO)** PPO and out-of-state	Non-PPO
Annual Costs				
Deductible	None		$50/person*; $150/family*	
Annual maximum	None		Any amount over $1,750/person	
Services				
Crowns	$100 to $175		50%	60%
Dentures	$140 for complete upper or lower		50%	60%
Fillings	$10 to $50		20%	30%
Nonsurgical temporomandibular joint (TMJ) treatment	30% then any amount over $1,000 per year; any amount over $5,000 in member's lifetime	Any amount over $1,000 per year; any amount over $5,000 in member's lifetime	30% then any amount over $1,000 per year; any amount over $5,000 in member's lifetime	
Oral surgery	$0 to $50 per tooth removed	$10 to $50 per tooth removed	20%	30%
Orthodontia	$1,500 per case		50% up to $1,750, then any amount over $1,750 in member's lifetime	
Orthognathic surgery (jaw surgery)	30% up to $5,000, then any amount over $5,000 in member's lifetime		30% up to $5,000, then any amount over $5,000 in member's lifetime	
Periodontic services (treatment of gum disease)	$15 to $100		20%	30%
Preventive services	$0		$0 (10% out-of-state)	20%
Root canals (endodontics)	$100 to $150		20%	30%

The vision plan options described below only apply to retirees or their dependents who are not enrolled in a Medicare plan. If you select a Medicare plan, you may choose a vision plan for any non-Medicare enrollees. **Vision coverage for Medicare retirees or their dependents who are enrolled in Medicare is included in their PEBB retiree Medicare plan except for members enrolled in Premera Blue Cross Medicare Supplement Plan F or G.**

You must enroll in medical to enroll in vision. You may choose a vision plan for you and your dependents who are not enrolled in Medicare. You and any dependents must enroll in the same PEBB vision plan. Vision coverage will have a monthly premium. For more details, see Vision benefits comparison on the next page.

Vision plan options

There are three PEBB Program vision plans to choose from.

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

Each plan will have a network of providers that offers services like routine eye exams, eyeglass frames and lenses, contact lenses, and discounts on treatments like LASIK. All plans offer private practice optometrists and ophthalmologists in Washington State and nationwide, but each plan's network will include different providers.

Make sure you contact the vision plan before you enroll to confirm that your provider is part of the specific plan network and plan group.

2026 PEBB Vision Benefits Comparison

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

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

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

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

Benefits for adults 19+

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

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

	Davis Vision by MetLife	EyeMed	MetLife Vision
Contact lenses (instead of glasses)			
Conventional	$0 up to $200, then 85% of balance; $0 for 4 boxes of Collection lenses ($105)	$0 up to $200, then 85% of balance ($200)*	$0 up to $200, then 100% of balance ($105)
Disposable	$0 up to $200, then 85% of balance; or 8 boxes from Collection lenses without copay ($105)	$0 up to $200, then 100% of balance ($200)*	
Medically necessary	$0 ($225)	$0 ($300)*	$0 ($210)
Fitting fee	$0 for Collection lenses or 85% of retail price ($0)	Standard fit and follow-up: Up to $55 ($0) Premium: 90% of retail prince ($0)	$60 ($0)
Additional member savings			
Additional prescription glasses	You pay 70% on complete pairs: some limitations apply ($0)	You pay 60% on complete pairs ($0)	You pay 80% on complete pairs: some limitations apply ($0)
LASIK surgery	You pay 65% to 80% of national average price of traditional LASIK ($0)	You pay 85% of retail price or 95% of a promotional offer ($0)	You pay 85% of retail price or 95% of a promotional offer ($0)

Benefits for children under 19

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

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

	Davis Vision by MetLife	EyeMed	MetLife Vision
UV treatment	$0 ($0)	$15 ($0)	$0 ($0)
Contact lenses (instead of glasses)			
Conventional	$0 up to $300 then 85% of balance or $0 for 4 boxes of Collection lenses ($105)	Any amount over $300 (50% of charge up to $300)*	Any amount over $300 ($105)
Disposable	$0 up to $300 then 85% of balance or 8 boxes of Collection lenses ($105)		
Medically necessary	$0 ($225)		$0 ($210)
Fitting fee	Conventional: $0 Specialty: $0 up to $60 then 85% of balance ($0)	Standard: $0 Premium: up to $65, then 90% of the balance ($65)	Covered in full ($0)
Additional member savings			
Additional prescription glasses	You pay 70% on complete pairs: some limitations apply ($0)	You pay 60% on complete pairs ($0)	You pay 80% on complete pairs: some limitations apply ($0)
LASIK surgery	You pay 65% to 80% of national average price of traditional LASIK ($0)	You pay 85% of retail price or 95% of a promotional offer ($0)	You pay 85% of retail price or 95% of a promotional offer ($0)

The Health Care Authority collects premiums and applicable premium surcharges for the full month and will not prorate them for any reason, including when a member's coverage is terminated. When a retiree dies, HCA waives the premium payment for medical, dental, vision, and any applicable premium surcharges for the retiree for the month in which the death occurred. If surviving dependents are enrolled, see "How does a survivor pay for coverage?" on page 56.

In most cases, you cannot have a gap in coverage between your previous coverage and your retiree coverage. Premiums are due starting with the first month after your own employer-paid coverage, COBRA coverage, or continuation coverage ends. When you enroll, you must pay premiums and applicable premium surcharges starting with the date your other coverage ended. For example, if your other coverage ends in December, but you don't apply for enrollment until February, you must pay premiums and applicable premium surcharges for January and February.

How much will my monthly premiums be?

The cost for your health plan coverage depends on which medical, dental, or vision plan you choose and whether you and any dependents are eligible for Medicare. The list of monthly premiums starts on page 6. You may also be subject to premium surcharges, along with your monthly premium. See "Premium surcharges" on page 58.

How do I pay for coverage?

In most cases, you must make your first payment, including applicable premium surcharges, by check or money order before we can enroll you. Send your first payment to HCA **no later than 45 days** after your 60-day election period ends. If we do not receive your first payment by the deadline, you will not be enrolled and you may lose your right to enroll in PEBB retiree insurance coverage.

Make checks payable to Health Care Authority and send to:

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

You have three options for paying for PEBB retiree insurance coverage:

Pension deduction

Your payments will be taken from your end-of-the-month pension through the Department of Retirement Systems (DRS). For example, if your coverage takes effect January 1, your January 31 pension will show your deductions for January. If you select this option, you are not required to make your first premium payment and applicable premium surcharges to begin enrollment; however, due to timing issues with DRS, you may receive an invoice for any premiums and applicable premium surcharges not deducted from your pension when you first enroll. We will send you an invoice if a first payment is needed. If you receive an invoice, your payment is due by the deadline listed on the invoice.

Electronic debit service (EDS)

You can pay through automatic bank account withdrawals. To choose this option, submit the *PEBB Electronic Debit Service Agreement*, available in the back of this guide. If you select this option, you must make your first premium payment to begin enrollment as EDS approval takes six to eight weeks. After your first payment is received and you are enrolled, please make payments as invoiced until you receive a letter from us with your EDS start date.

Monthly invoice

After your first payment is received and you are enrolled, we will send you a monthly invoice. Payments are due on the 15th of each month for that month of coverage. Send your payment to the address listed on the invoice.

Can I use a VEBA account?

If you have a Voluntary Employees' Beneficiary Association (VEBA) account, you can set up automatic reimbursement of your qualified insurance premiums. **Your VEBA account reimburses you; it does not pay your monthly premiums directly to the PEBB Program**. It is important that you notify your VEBA plan when your premium changes.

Qualified insurance premiums that can be reimbursed include medical, dental, vision, Medicare supplement, Medicare Part B, Medicare Part D, and qualified long-term care (LTC) insurance. LTC insurance reimbursements are subject to annual IRS limits. Retiree term life insurance premiums are not eligible for reimbursement from your VEBA account.

Your VEBA account is a health reimbursement arrangement (HRA). Certain limits apply.

Retiree rehire limitation

Post-separation HRA: If you have a "post-separation" VEBA, including VEBA MEP, you must notify your VEBA plan if you are rehired by the employer (agency) that set up your account. Only certain "excepted" medical expenses you incur while reemployed are eligible for reimbursement.

Standard HRA: If you have a "standard" VEBA account, no retiree-rehire limitations apply. You may be rehired by the employer that set up your account, and your VEBA account will remain fully claims-eligible.

What type of VEBA account do I have?

To find out what type of VEBA account you have, read the HRA dashboard in your VEBA welcome packet, log in from your VEBA plan's website at **veba.org** or **hraveba.org**, or call your VEBA plan's customer care center at 1-888-828-4953 (VEBA plan, VEBA MEP) or 1-888-659-8828 (HRA VEBA plan).

HSA contribution eligibility limitation

If you enroll in a consumer-directed health plan (CDHP) or other high-deductible health plan (HDHP) and want to become eligible for health savings account (HSA) contributions, you must limit your VEBA coverage by submitting a *Limited HRA Coverage Election* form to your VEBA plan.

More information and forms, including the *Automatic Premium Reimbursement* form and *Limited HRA Coverage Election* form, are available after logging in to your VEBA plan's website at **veba.org** or **hraveba.org** or by calling your VEBA plan's customer care center at 1-888-828-4953 (VEBA plan, VEBA MEP) or 1-888-659-8828 (HRA VEBA plan).

Can I pay for PEBB retiree insurance coverage through Social Security?

No. Your payments for PEBB retiree insurance coverage cannot be made through the Social Security Administration or deducted from your Social Security benefits.

How does a survivor pay for coverage?

If you were already enrolled as a dependent of a retiree

We will enroll you as a survivor, which means you will move from being a dependent to having your own account. You cannot have a gap in coverage between these accounts. As a result, **you may receive two invoices and must pay both**.

As a survivor, you will be responsible for paying monthly premiums and any applicable premium surcharges. We will send you a letter notifying you of your new enrollment and information on paying your retiree health plan premiums. You must pay premiums and any applicable premium surcharges as they become due. If your coverage is terminated, you may not be able to enroll again in PEBB insurance coverage unless you regain eligibility in the future. If premiums and applicable premium surcharges were deducted from the subscriber's pension through the Department of Retirement Systems (DRS), this will stop. You may be eligible for a survivor's pension from DRS. To find out, call DRS at 1-800-547-6657.

If you are a dependent of an employee or a dependent of a retiree who was not previously enrolled

If you are a dependent of an employee or a dependent of a retiree who was not enrolled in PEBB retiree insurance coverage when the retiree passed away, we must receive your enrollment form and first payment of monthly premiums and applicable premium surcharges before we will enroll you in coverage. You must make your first payment **no later than 45 days** after your 60-day election period ends, as described in "If I die, are my surviving dependents eligible?" on page 14. If we do not receive your first payment by the deadline, you will not be enrolled, and you may lose your right to enroll in PEBB retiree insurance coverage.

What happens if I miss a payment?

You must pay the monthly premium and applicable premium surcharges for your PEBB retiree health plan coverage when due. They will be considered unpaid if one of the following occurs:

- You make no payment for 30 days past the due date.
- You make a payment, but it is less than the total due by an amount greater than an insignificant shortfall (described in WAC 182-08-015). The remaining balance is considered underpaid for 30 days past the due date.

If either of these events occur and the payment stays unpaid for 60 days from the original due date, the PEBB Program will terminate your PEBB retiree health plan coverage back to the last day of the month for which the monthly premium and applicable premium surcharges were paid. If you are enrolled in a Medicare Advantage with Prescription Drug plan or Uniform Medical Plan (UMP) Classic Medicare with Part D (PDP), it will terminate at the end of the month after your termination notice is sent. We will also terminate coverage for any enrolled dependents.

You will not be allowed to enroll again unless you regain eligibility. You can regain eligibility, for example, by returning to work with a PEBB employing agency or a School Employees Benefits Board (SEBB) organization in which you are eligible for benefits.

Premium surcharges

Medicare subscribers

Subscribers who are enrolled in Medicare Part A and Part B do not have to attest to the premium surcharges. However, if your dependent is enrolled in Medicare and you (the subscriber) are not, you must attest to the surcharges.

Subscribers not enrolled in Medicare

Subscribers who are not enrolled in Medicare must attest (indicate whether they apply) to two premium surcharges:

- The tobacco use premium surcharge
- The spouse or state-registered domestic partner coverage premium surcharge (if you enroll a spouse or partner)

If you do not attest to these surcharges within the PEBB Program timelines or if your attestation shows the surcharge applies to you, the surcharge will be added to your monthly medical premium.

Find out more on HCA's website at **hca.wa.gov/pebb-retirees** under *Surcharges*.

Tobacco use premium surcharge

This $25-per-account premium surcharge will apply, in addition to your monthly medical premium, if you or one of your enrolled dependents (age 13 or older) has used tobacco products in the past two months. You must attest to this surcharge for yourself and each dependent age 13 or older you want to enroll.

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

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

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

Changing your tobacco attestation

You can report a change in tobacco use anytime if:

- You or any enrolled dependent age 13 and older starts using tobacco products.
- You or your enrolled dependent have not used tobacco products within the past two months.
- You or your enrolled dependent who is age 18 or older and uses tobacco products enrolls in the free tobacco-cessation program through your PEBB Program medical plan.
- Your enrolled dependent who is age 13 to 17 and uses tobacco products accesses the tobacco cessation resources on the Smokefree Teen website at **teen.smokefree.gov**.

You can report a change at any time in one of two ways:

- Go to Benefits 24/7 at **benefits247.hca.wa.gov**.
- Submit a *PEBB Premium Surcharge Attestation Change Form.*

If the change in tobacco use means the surcharge no longer applies to you, the surcharge will be removed from your account effective the first day of the month after we receive your new attestation. If that day is the first of the month, then the change to your account begins on that day.

If the change in tobacco use you report means the surcharge applies to you, the surcharge is effective the first day of the month after the status change. If that day is the first of the month, then the surcharge begins on that day.

Help quitting tobacco

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

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

Spouse or state-registered domestic partner coverage premium surcharge

If you do not enroll a spouse or state-registered domestic partner on your PEBB medical coverage, this premium surcharge does not apply to you and you do not need to attest.

You will be charged a $50 premium surcharge in addition to your monthly medical premium if you enroll a spouse or state-registered domestic partner on your PEBB medical coverage and one of the following applies:

- That person chose not to enroll in another employer-based group medical insurance that is comparable to Uniform Medical Plan (UMP) Classic.
- You do not attest by the required deadline.
- Your attestation response results in incurring the premium surcharge.

How to attest to this surcharge

If you enroll a spouse or state-registered domestic partner on your PEBB medical coverage, use Benefits 24/7 (or *Form A*) to find out if this premium surcharge applies to you. Then, attest in Benefits 24/7 (or submit *Form A* to the PEBB Program) to respond to this surcharge.

To report a change to this surcharge

Outside of annual open enrollment, you can only report a change to this surcharge **within 60 days** of a change in your spouse's or state-registered domestic partner's employer-based group medical insurance.

To change your attestation, submit the *PEBB Premium Surcharge Attestation Change Form* to the PEBB Program. The form is found under *Forms & publications* on the HCA website at **hca.wa.gov/pebb-retirees**. You must also provide proof of the qualifying event.

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

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

Making changes to your account

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

Many changes can be made in Benefits 24/7, our online enrollment system, at **benefits247.hca.wa.gov**.

You also have the option of submitting a *PEBB Retiree Change Form* (form E).

Changes you can make anytime

Change your name or address

Send the PEBB Program a written request with your new name or address. Contact information is at the beginning of this guide. Include your full name and the last four digits of your Social Security number so we can identify your account.

Terminate or defer (postpone) your coverage

See "How do I terminate coverage?" on page 63 or "Deferring your coverage," on page 18.

Change your retiree term life insurance beneficiary information

Visit MetLife's website at **mybenefits.metlife.com/wapebb** or call 1-866-548- 7139. See "Retiree term life insurance" on page 65.

Apply for, terminate, or change auto or home insurance coverage

See "Auto and home insurance" on page 68.

Remove a dependent

See "What happens when a dependent loses eligibility?" on page 63.

Make changes to your tobacco use premium surcharge attestation

See "Premium surcharges" on page 58.

Start, stop, or change your contributions to your health savings account (HSA)

Contact HealthEquity. UMP members, call 1-844-351-6853 (TRS: 711). Kaiser Permanente members, call 1-877-873-8823 (TRS: 711).

Change your HSA beneficiary information

Use the *HealthEquity Beneficiary Designation Form,* available at **learn.healthequity.com/pebb/hsa/documents**.

Submit special open enrollment requests

See "What is a special open enrollment?"

Changes you can make during annual open enrollment

These changes can be completed in Benefits 24/7 at **benefits247.hca.wa.gov** or by submitting a *PEBB Retiree Open Enrollment Election/Change Form* (form A-OE). Changes must be completed by the last day of annual open enrollment and are effective January 1 of the following year, except when you terminate enrollment or remove a dependent, then the change will be effective December 31.

- Change your medical, dental, or vision (if applicable) plan.
- Add dental coverage.
- Add vision coverage (if applicable).
- Enroll or remove dependents.
- Upload documents.
- Terminate or defer (postpone) your coverage.
- Enroll in a PEBB retiree health plan if you deferred coverage in the past.
- Change your spouse or state-registered domestic partner coverage premium surcharge attestation.

What is a special open enrollment?

A special open enrollment is a period after specific life events (such as marriage or moving outside your medical plan's service area) when subscribers may make changes outside of the PEBB Program's annual open enrollment. You must provide proof of the event that created the special open enrollment. An example of this proof includes a marriage certificate.

How do I make a change with a special open enrollment?

Generally, the change must be made in Benefits 24/7 (or the PEBB Program must receive the *PEBB Retiree Change Form* [form E] and any other required forms or documents) **no later than 60 days** after the event that created the special open enrollment.

If you are changing your medical plan to Premera Blue Cross Medicare Supplement Plan G, the PEBB Program must receive *Form E* and the *Group Medicare Supplement Enrollment Application* [form B]) **no later than six months** after you or your dependent enroll in Medicare Part B. You can upload *Form B* in Benefits 24/7 or send it to the PEBB Program.

If you are changing your medical plan to a Medicare Advantage with Part D (MAPD) plan or Uniform Medical Plan (UMP) Classic Medicare with Part D (PDP), you have seven months to enroll. The seven-month period begins three months before the enrollment in both Medicare Part A and Part B by either you or your dependent, and ends three months after the month of Medicare eligibility, or before the last day of the Medicare Part B initial enrollment period. You must make the change no later than the last day of the month before the month you or your dependent enroll in the MAPD plan or UMP Classic Medicare with Part D (PDP).

If you are changing your medical plan to a MAPD plan, Premera Blue Cross Medicare Supplement Plan G, or UMP Classic Medicare with Part D (PDP) due to you or your dependent gaining, losing, or having a change in low-income subsidy (LIS) eligibility as described in C.F.R. Sec 423.38 (c)(9), you must make the change no later than three months after you or your dependent gain, lose, or have a change in LIS eligibility, or notification of such a change, whichever is later.

To disenroll from an MAPD plan or UMP Classic Medicare with Part D (PDP), the change must be allowable under federal regulations 42 C.F.R. Secs. 422.62(b) and 423.38(c). If you are changing from an MAPD plan or UMP Classic Medicare with Part D (PDP) and using a paper form, also submit a *PEBB Medicare Plan Disenrollment Form* (form D).

When do special open enrollment changes take effect?

In most cases, the change will occur the first of the month after the event date or the date you make the change in Benefits 24/7 (or we receive your forms), whichever is later. If that day is the first of the month, the change in enrollment begins on that day.

One exception is MAPD plans or UMP Classic Medicare with Part D (PDP), which start the first of the month after you make the change using Benefits 24/7 (or the PEBB Program receives your forms), per federal rules.

Another exception is the addition of a child (such as a newborn, adopted child, or a child you are legally required to support ahead of adoption), in which case PEBB health plan coverage will start or end as follows:

- For a newborn child, PEBB health plan coverage will start on the date of birth.
- For a newly adopted child, PEBB health plan coverage will start on the date of placement or the date you assume legal responsibility for their support ahead of adoption, whichever is earlier.
- For a spouse or state-registered domestic partner being enrolled because of a birth or adoption, PEBB health plan coverage will start the first day of the month in which the event occurs.
- If removing the spouse or partner, their coverage will end as of the last day of the month in which the event occurred.
- For a child becoming eligible as an extended dependent or a dependent child age 26 or older with a disability, PEBB health plan coverage will start the first day of the month following either the event date or the date we confirm their eligibility, whichever is later.

Learn more

For more information about the changes you can make during these events, read PEBB Program Administrative Policy Addendum 45-2A at **hca.wa.gov/pebb-rules**.

Events that create special open enrollments

Note: A subscriber may not change medical, dental or, if applicable, vision plan during a special open enrollment if their state-registered domestic partner or their state-registered domestic partner's child is not a tax dependent.

Events that allow you to enroll dependents and change health plans

- Marriage or registering a state-registered domestic partnership (as defined by WAC 182-12-109).
- Birth or adoption, including assuming a legal responsibility for support ahead of adoption.
- Child becoming eligible as an extended dependent through legal custody or legal guardianship.
- Subscriber or dependent losing other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
- Subscriber having a change in employment status that affects the subscriber's eligibility for the employer contribution toward their employer-based group health plan.
- The subscriber's dependent has a change in their employment status that affects their eligibility or their dependent's eligibility for the employer contribution under their employer-based group health plan. ("Employer contribution" means contributions made by the dependent's current or former employer toward health coverage, as described in Treasury Regulation 26 C.F.R. 54.9801- 6.)
- A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber.
- Subscriber or a subscriber's dependent enrolls in coverage under Medicaid or a state Children's Health Insurance Program (CHIP) or loses eligibility for coverage under Medicaid or CHIP.
- Subscriber or a dependent becoming eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.

Events that allow you to enroll dependents

- Subscriber or dependent having a change in enrollment under another employer-based group health insurance plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment.
- Subscriber's dependent moving from another country to live within the United States, or from the United States to another country, and that change in residence resulted in the dependent losing their health insurance.
- Subscriber's dependent loses eligibility for Medicare.
- Subscriber or dependent enrolled in a Medicare Advantage with Part D, Medicare Supplement Plan, or the Uniform Medical Plan Classic Medicare with Part D (PDP) who gains, loses, or has a change to their low-income subsidy (LIS) eligibility as described in 42 C.F.R. Sec 423.38 (c)(9).

Events that allow you to change medical and/or dental plans

- Subscriber or dependent having a change in residence that affects health plan availability.
    - If the subscriber has a change in residence and the subscriber's current medical plan is no longer available, the subscriber must select a new medical plan as described in WAC 182-08-196(3). If the subscriber does not elect a new medical plan as required, they will be enrolled in a PEBB medical plan designated by the director or designee.
    - If the subscriber or dependent has a change in residence and the subscriber's current dental plan does not have available providers within 50 miles of the subscriber or their dependent's new residence, the subscriber may select a new dental plan.
- Subscriber's or their dependent's current medical plan becoming unavailable because the subscriber or their enrolled dependent is no longer eligible for a health savings account (HSA).
- Subscriber or dependent experiencing a disruption of care for active and ongoing treatment that could function as a reduction in benefits for the subscriber or their dependent (requires approval by the PEBB Program).

Event that allows you to change your medical plan

- Subscriber or dependent enrolls in Medicare or loses eligibility under Medicare; or enrolls (or terminates enrollment) in a Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP).
- Subscriber or dependent gains, loses, or has a change in low-income subsidy (LIS) as described in 42 C.F.R. Sec 423.38 (c)(9).

What happens when a dependent loses eligibility?

You must notify the PEBB Program using Benefits 24/7 (or a written letter) when your dependent no longer meets the eligibility criteria described in WAC 182-12-260. Some examples of reasons a dependent may lose eligibility include turning age 26, divorce, annulment, dissolution, or death.

We must receive your notice **within 60 days** of the last day of the month your dependent loses eligibility. For example, if your dependent child age 26 or older with a disability becomes self-supporting on March 15, their last day of eligibility is March 31. You must notify the PEBB Program that they are no longer eligible by May 30 (60 days after March 31).

If eligibility is lost due to divorce, you must submit a copy of the divorce decree. If eligibility is lost due to dissolution of a state-registered domestic partnership, you must submit a copy of the dissolution document.

We will remove the dependent on the last day of the month in which the dependent meets the eligibility criteria.

WAC 182-12-262 (2)(a) explains the consequences for not submitting written notice within 60 days. They may include, but are not limited to:

- The dependent may lose eligibility to continue PEBB medical, dental, or vision under one of the continuation coverage options described in WAC 182-12-270.
- You may be billed for claims your health plan paid for services that happened after the dependent lost eligibility.
- You may not be able to recover premiums you paid for dependents who lost eligibility.

How do I terminate coverage?

To terminate all or part of your PEBB health plan coverage, use Benefits 24/7 or submit your request in writing. If sending a written request, write your full name and the last four digits of your Social Security number on your request so we can identify your account. You cannot terminate over the phone. If you use HCA Support, attach your written request to the secure message. We cannot terminate your coverage in response to a secure message alone.

Your health plan coverage will terminate on the last day of the month in which we receive your written request (or a future date if you ask for one).

If we receive your request on the first day of the month, coverage will terminate on the last day of the previous month, unless you or a dependent is enrolled in a PEBB MAPD plan or UMP Classic Medicare with Part D (PDP). If so, submit a written request and a *PEBB Medicare Plan Disenrollment Form* (form D). You can upload the form in Benefits 24/7 or send it to the PEBB Program. Coverage will terminate on the last day of the month in which we receive *Form D*.

If you terminate all your PEBB retiree health plan coverage, your enrolled dependents will also be terminated.

Terminating your PEBB medical coverage also terminates PEBB dental coverage, and if applicable, vision coverage.

You cannot enroll again later unless you regain eligibility, for example, by returning to work with a PEBB employing agency, school district, charter school, educational service district, or an employee organization representing school employees or a tribal school in which you are eligible for PEBB or SEBB benefits.

When coverage ends

PEBB retiree insurance coverage is for an entire month and must end as follows:

- Coverage for you or a dependent ends on the last day of the month in which eligibility ends.
- Coverage for you and your enrolled dependents ends on the last day of the month for which the monthly premium and applicable premium surcharges were paid. If you or a dependent are enrolled in a Medicare Advantage with Part D (MAPD) plan or UMP Classic Medicare with Part D (PDP), termination will occur at the end of the month after your termination notice was sent.
- Coverage for you or an enrolled dependent ends if you fail to respond to a request from the PEBB Program for information about Medicare Part A and Part B enrollment or an action required due to enrolling in Medicare Part D.
- Coverage for you and your enrolled dependents ends the last day of the month as required by federal law when you or your dependent must be disenrolled by an MAPD or Medicare Part D plan due to permanently living in a location outside of the United States.

If you or a dependent loses eligibility for PEBB retiree insurance coverage, you and your dependents may be eligible to continue PEBB health plan coverage under PEBB Continuation Coverage (COBRA). If you enroll, you must pay the full premiums and any applicable premium surcharges. We will mail you a *PEBB Continuation Coverage Election Notice* when your coverage ends with more information about this option. This notice explains eligibility and deadlines, and it contains the form you need to enroll. You can also use Benefits 24/7 to enroll. To learn more about this option, visit the HCA website at **hca.wa.gov/pebb-continuation**.

Employer groups only

If you are a retiree or a survivor from an employer group that ended participation in PEBB insurance coverage or SEBB insurance coverage, you and your enrolled dependents will lose eligibility for PEBB retiree insurance coverage at the end of the month in which the contract with HCA ends.

You and your dependents may be eligible to continue PEBB health plan coverage under PEBB Continuation Coverage (Employer Group Ended Participation). If you enroll, you must pay the full premiums and any applicable premium surcharges. If your employer group ends participation, we will mail you a letter with more information. This letter explains eligibility and deadlines and includes the form you need to enroll. You can also use Benefits 24/7 to enroll. To learn more about this option, visit the HCA website at **hca.wa.gov/pebb-continuation** under *Am I eligible?*

What are my family's options if I die?

Your dependents lose eligibility when you (the retiree) die. However, they may be eligible for PEBB retiree insurance coverage as survivors, even if they were not covered at the time of your death.

If your dependents were covered at the time of your death, they will be moved to their own account. If they want to make changes to their health plan enrollment, we must receive their *PEBB Retiree Election Form* (form A) and any other required documents **no later than 60 days** after the date of your death.

If your dependents were not covered at the time of your death, to apply for coverage, we must receive their *PEBB Retiree Election Form* (form A) and any other required documents **no later than 60 days** after the date of your death.

Your eligible surviving spouse or state-registered domestic partner may continue PEBB retiree insurance coverage indefinitely as long as they pay for coverage on time. Your other eligible dependents may continue coverage until they are no longer eligible under PEBB Program rules. The survivor must pay monthly premiums and applicable premium surcharges as they become due.

Retiree term life insurance

Can I buy life insurance when I retire?

You may be eligible to purchase retiree term life insurance through Metropolitan Life Insurance Company (MetLife) on a self-pay basis. Retiree term life insurance is available to subscribers who meet the eligibility and procedural requirements described in WAC 182-12-209. Retiree term life insurance is only available to those who:

- Meet the PEBB Program's retiree eligibility requirements.
- Had life insurance through the PEBB or SEBB Program as an employee.
- Are not on a waiver of premium due to disability.

Your dependents are not eligible. **You cannot have a break in life insurance coverage.**

How do I enroll?

Submit the *PEBB Retiree Election Form* (form A) and the *MetLife Enrollment/Change Form for Retiree Plan* to apply for PEBB retiree term life insurance. These forms are available on HCA's website at **hca.wa.gov/pebb-retirees** under *Forms & publications*. You can upload the forms in Benefits 24/7 or send them to the PEBB Program.

We must receive them **no later than 60 days** after your PEBB or SEBB employee basic life insurance ends.

For elected or full-time appointed officials described in WAC 182-12-180(1), we must receive the required forms **no later than 60 days** after you leave public office.

Choose your payment method for retiree term life insurance. Premium payments will go directly to MetLife for your coverage. If you wish to change your payment method in the future, call MetLife. If you enroll when you become eligible and pay premiums on time, your coverage is effective the first day of the month after the date your PEBB or SEBB employee basic life insurance coverage ends.

Learn more

Visit the MetLife website at **metlife.com/wshca-retirees** or call 1-866-548-7139.

How much can I buy?

Retirees can buy $5,000, $10,000, $15,000, or $20,000 of PEBB retiree term life insurance coverage.

How do I continue my employee life insurance coverage?

If your PEBB or SEBB employee life insurance ends due to retirement, you may have an opportunity to continue all or part of your coverage through "portability" or "conversion." When porting or converting, your coverage will become an individual policy that is not tied to the PEBB or SEBB Program. If you are eligible for these options, MetLife will send you information and an application. For more information, contact MetLife. PEBB employees should call 1-866-548-7139, and SEBB employees should call 1-833-854-9624.

Whom can I name as my beneficiary?

You may name any beneficiary you wish. If you die with no named living beneficiary, payment will be made as described in the certificate of coverage.

How do my survivors file a claim?

If you die, your beneficiary should call MetLife. They should also notify the PEBB Program of your death. We may share this information with the Department of Retirement Systems to better serve your survivors.

Where can I get the retiree term life insurance certificate?

The information in this guide is only a summary of PEBB retiree term life insurance. For more information, or to get a copy of the insurance certificate, call MetLife or visit the MetLife website.

Do I have an option to continue PEBB retiree term life insurance if this benefit ends?

Yes. You have the option to convert your retiree term life insurance if coverage ends because this group policy ends (as long as you've been enrolled for at least five straight years) or is reduced because of a policy change. You may also convert if this group policy changes to end life insurance for a class of people of which you are a member. If you decide not to convert your retiree term life insurance as described above, you will not have the option to do so later.

What happens to my retiree term life insurance if I start working again?

If you are enrolled in retiree term life insurance and return to work, becoming eligible for the employer contribution toward PEBB or SEBB employee basic life insurance, you can choose whether to keep or terminate your retiree term life insurance.

If you terminate retiree term life insurance when you return to work, you may be eligible to elect it again when your PEBB or SEBB employee basic life insurance ends. If you wish to enroll in retiree term life insurance at that point, we must receive the required forms within the timelines described in WAC 182-12-209.

If you become eligible for employee life insurance, enroll on the MetLife website at **metlife.com/wshca-retirees**, and call them with any questions. You should also notify the PEBB Program so we can update your records.

For retirees who are not enrolled in Medicare Part A and Part B, SmartHealth is included in your benefits. SmartHealth is a voluntary wellness program that supports you on your journey toward living well. Participate in activities to help support your whole-person well-being, such as managing stress, building resiliency, and adapting to change. As you progress on your wellness journey, you can qualify for the SmartHealth wellness incentive each year.

Who is eligible?

Generally, a retiree and their spouse or state-registered domestic partner enrolled in PEBB medical coverage can use SmartHealth. However, only the retiree can qualify for the wellness incentive. **Exception:** If you defer PEBB retiree insurance coverage, you will not have access to SmartHealth. Retirees enrolled in Medicare Part A and Part B are not eligible to participate in SmartHealth.

What is the wellness incentive?

Each year, eligible subscribers can qualify for a $125 wellness incentive. How you receive the $125 depends on the type of medical plan you enroll in.

- **For a consumer-directed health plan (CDHP):** a one-time deposit of $125 goes into your health savings account (HSA).
- **For all other medical plans:** You get a $125 reduction to your medical plan deductible.

How do I qualify for the wellness incentive each year?

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

1. Sign in to SmartHealth at **smarthealth.hca.wa.gov** or on the Wellness At Your Side app. For help logging, in visit **hca.wa.gov/accessing-smarthealth**.
2. Complete the SmartHealth well-being assessment. It takes about 15 minutes and is worth 800 points.
3. Join and track activities to earn at least 2,000 total points by your deadline.

When is my deadline?

Your deadline to qualify for the $125 wellness incentive depends on the date your PEBB medical coverage becomes effective:

- If you are already enrolled in a PEBB medical plan, your deadline is November 30, 2026.
- If you are a new subscriber with a PEBB medical plan effective date in January through September 2026, your deadline is November 30, 2026.
- If you are a new subscriber with a PEBB medical plan effective date in October through December 2026, your deadline is December 31, 2026.

What if I can't complete the activities?

Any subscriber for whom it is medically inadvisable or, due to a medical condition, unreasonably difficult to attempt to satisfy the requirement for a PEBB Wellness Incentive Program can request an alternative requirement that will allow them to qualify for the PEBB wellness incentive or request to waive the requirement.

To request an alternative requirement, call SmartHealth Customer Service. To learn more, including how to appeal if your request is denied, see the *SmartHealth Reasonable Alternative Standard FAQs* on HCA's website at **hca.wa.gov/pebb-smarthealth**.

When do I get the wellness incentive?

If you (the retiree) qualify for the $125 wellness incentive in 2026, you will receive the SmartHealth incentive at the end of January 2027 if you are still eligible to participate in the PEBB wellness incentive program and you are enrolled in PEBB medical as your primary coverage on January 1, 2027.

If you are enrolled in Medicare Part A and Part B as your primary coverage on January 1, 2027, you will not receive the incentive, even if you qualified for it in 2026.

What if I don't have internet access?

Call SmartHealth Customer Service to learn more.

Who can I contact for more help?

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

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

Auto and home insurance

As a PEBB member, you may receive a discount of up to 12 percent off Liberty Mutual's auto and up to 5 percent off home insurance rates. In addition to the discount, Liberty Mutual also offers:

- Discounts based on your driving record, age, auto safety features, and more.
- Convenient payment options, including automatic pension deduction (for retirees), electronic funds transfer, or direct billing at home.
- Dedicated 24-hour claims assistance

When can I enroll?

You can choose to enroll in auto and home insurance coverage any time.

How do I enroll?

To request a free, no-obligation quote for auto or home insurance, contact Liberty Mutual one of these ways (have your current policy handy):

- Call Liberty Mutual at 1-800-706-5525. Be sure to mention that you are a State of Washington PEBB Program member (client #8250).
- Visit Liberty Mutual's website at **libertymutual.com/pebbretirees**.
- Look for auto/home insurance under *Life, auto & home benefits* on the HCA website at **hca.wa.gov/pebb-retirees**.

If you are already a Liberty Mutual policyholder and would like to take advantage of this group discount, call 1-800-706-5525 or email **libertymutual.service@libertymutual.com** to find out how they can convert your policy at your next renewal (have your current policy handy).

Liberty Mutual does not guarantee the lowest rate to all PEBB members. Rates are based on underwriting for each individual, and not all participants may qualify. Discounts and savings are available where state laws and regulations allow and may vary by state.

Use the following guidance to find instructions for filing your appeal. You will find more information on filing an appeal in chapter 182-16 WAC and on the HCA website at **hca.wa.gov/pebb-appeals**. If you have questions, call the PEBB Appeals Unit at 1-800-351-6827.

How can I make sure my representative has access to my health information?

You must provide us with an *Authorization for Release of Information* form naming your representative, or a copy of a valid power of attorney (and a doctor's note, if the power of attorney requires it) authorizing them to access your PEBB account and exercise your rights under the federal HIPAA privacy rule. HIPAA stands for the Health Insurance Portability and Accountability Act of 1996. The form is available on the HCA website at **hca.wa.gov/pebb-appeals** or by calling the PEBB Program at 1-800-200-1004.

Instructions and submission deadlines

If you are appealing a decision from the PEBB Program about:

- Eligibility for benefits
- Enrollment
- Premium payments
- Premium surcharges
- Eligibility to participate in SmartHealth or receive a wellness incentive

Instructions

Complete the *PEBB Retiree/Continuation Coverage Notice of Appeal* form and submit it to the PEBB Appeals Unit as instructed on the form, or use HCA Support at **support.hca.wa.gov**. The PEBB Appeals Unit must receive the form or a written letter stating why you disagree with the decision and requesting an appeal **no later than 60 calendar** days after the date of the decision you are appealing.

If you are appealing a decision from a medical, dental, or vison plan; insurance carrier; or benefits administrator about:

The administration of the medical, dental, vision, or benefit plan about a benefit or claim.

Instructions

Contact the medical, dental, or vision plan; insurance carrier; or benefit administrator to request information on how to appeal the decision. Do not use the *PEBB Retiree/Continuation Coverage Notice of Appeal* form.

How to use forms to enroll

Enrollment forms are included at the back of this guide. You can download other forms on HCA's website at **hca.wa.gov/pebb-retirees** under *Forms & publications*.

Enrolling when first eligible or after deferring (postponing) coverage

Use the *PEBB Retiree Election Form* (form A).

1. Check "PEBB medical plans available by county" on page 34 to find the plans available to you based on your home address.
2. Complete *Form A*. Include all eligible dependents you wish to enroll. **Note:** To enroll in Premera Blue Cross Medicare Supplement Plan G, also include the *Group Medicare Supplement Enrollment Application* (form B).
3. Submit the forms to the PEBB Program. We must receive your forms and any other requested documents, such as proof of dependent eligibility, by the deadline.

Deferring (postponing) enrollment when you're first eligible

Use the *PEBB Retiree Election Form* (form A). Submit the form to the PEBB Program. We must receive it by the deadline.

Making changes to your existing account

Use the *PEBB Retiree Change Form* (form E).

1. If you are changing medical plans, check "PEBB medical plans available by county" on page 34 to make sure the new plan is available based on your home address.
2. Complete *Form E*. Include all dependents you wish to enroll or continue covering.
   a. If you or a dependent is in a Medicare Advantage with Part D (MAPD) plan or UMP Classic Medicare with Part D (PDP) and is moving to another type of medical plan, then you must also submit a *PEBB Medicare Plan Disenrollment Form* (form D).
   b. To make changes or switch to Premera Blue Cross Medicare Supplement Plan G, also include the *Group Medicare Supplement Enrollment Application* (form B).
3. Submit the forms and any other requested documents to the PEBB Program by the deadline.

Deferring or terminating coverage after you have already enrolled

1. Use the *PEBB Retiree Change Form* (form E). Check "Defer" or "Terminate" on page 3. Complete sections 1, and 10. **Note:** If you or a dependent is enrolled in a Medicare Advantage with Part D (MAPD) plan or UMP Classic Medicare with Part D (PDP), also complete the *PEBB Medicare Plan Disenrollment Form* (form D).
2. Submit the forms to the PEBB Program.

Enrollment Forms

These forms referenced in this book are available online:

Retiree Election Form (form A)

Premera Form B

Electronic Debit Service (EDS) Agreement

Medicare Advantage Plan Disenrollment Form (form D)

MetLife Enrollment/Change Form for Retirees

Health Care Authority
Public Employees Benefits Board

PO Box 42684
Olympia, WA 98504-2684