Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

# Temporary change to the retiree enrollment deadline

Some information in this document has changed because of the Health Care Authority's response to the COVID-19 state of emergency. The Governor announced the state of emergency on February 29, 2020.

On April 2, 2020, the PEB Board passed a resolution to **extend the retiree enrollment deadline to 30 days past the date the Governor ends the state of emergency**.

- This means you may have extra time to enroll in PEBB retiree insurance coverage. For example, if your last day to enroll in PEBB retiree insurance coverage is April 30, and the state of emergency ends May 15, then your enrollment period will be extended to June 15.
- If your last day to enroll occurs more than 30 days after the last day of the state of emergency, your deadline **will not** be extended. For example, if your last day to enroll is July 31, and the state of emergency ends May 15, the extended enrollment date will be June 15. Your enrollment deadline will not be extended.
- The last day of the state of emergency is unknown at this time. We will communicate more information to you as it becomes available at **hca.wa.gov/coronavirus.**

Your first payment is due 45 days after the last day of your enrollment period, whether or not your enrollment period is extended.

Learn more about these and other resolutions at **hca.wa.gov/coronavirus**.

Washington State Health Care Authority

PUBLIC EMPLOYEES BENEFITS BOARD

## Your PEBB Benefits for 2020

# PEBB Retiree Enrollment Guide


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| *Monthly Premiums* | Pages 6-9 |
| *Eligibility Summary* | Pages 10-13 |
| *How PEBB Plans with Prescription Drug Coverage Compare to Medicare Part D* | Page 37 |
| *Benefits Comparisons* | Pages 43-50 |


HCA 51-205 (10/19)

# Contact Information

| Contact the health plans for help with: | Go to **hca.wa.gov/pebb-retirees** for help with: |
|---|---|
| • Specific benefit questions.<br>• Verifying if your doctor or other provider contracts with the plan.<br>• Verifying if your medications are listed in the plan's drug formulary.<br>• Claims.<br>• ID cards. | • Eligibility and enrollment questions or changes (Medicare, divorce, etc.).<br>• Changing your name, address, or phone number.<br>• Adding or removing dependents.<br>• Finding forms.<br>• Premium surcharge questions.<br>• Eligibility complaints or appeals.<br>You may also call the PEBB Program at 1-800-200-1004 for help. |

| Medical plans | Website addresses | Customer service phone numbers |
|---|---|---|
| **Kaiser Permanente NW Classic*, CDHP*, or Senior Advantage** | **my.kp.org/wapebb** | 503-813-2000 or<br>1-800-813-2000 (TRS: 711)<br>Medicare members:<br>1-877-221-8221 (TRS: 711) |
| **Kaiser Permanente WA Classic, CDHP, Medicare, SoundChoice, or Value** | **kp.org/wa/pebb** | 1-866-648-1928 (TRS: 711)<br>Medicare members: 1-206-630-4600<br>(TTY: 1-800-833-6388 or 711) |
| **Premera Blue Cross Medicare Supplement Plan F and Plan G**<br>***Note: Plan F is closed to new enrollees as of January 1, 2020.*** | **premera.com**<br>(general information, not specific to the PEBB Program) | 1-800-817-3049<br>(TTY: 1-800-842-5357) |
| **Uniform Medical Plan (UMP) Classic or UMP CDHP, administered by Regence BlueShield and Washington State Rx Services (WSRxS)** | Medical services: (Regence BlueShield)<br>**regence.com/ump/pebb**<br>Prescription drugs: (WSRxS)<br>**regence.com/ump/pebb/benefits/prescriptions** | Regence BlueShield: 1-888-849-3681<br>(TRS: 711)<br>WSRxS: 1-888-361-1611<br>(TRS: 711) |
| **UMP Plus–Puget Sound High Value Network, administered by Regence BlueShield** | **pugetsoundhighvaluenetwork.org** | 1-855-776-9503 (TRS: 711) |
| **UMP Plus–UW Medicine Accountable Care Network, administered by Regence BlueShield** | **pebb.uwmedicine.org** | 1-855-520-9500 (TRS: 711) |

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

*(continued)*

# Contact Information

| Dental plans | Website addresses | Customer service phone numbers |
|---|---|---|
| **DeltaCare, administered by Delta Dental of Washington** | **deltadentalwa.com/group/pebb** | 1-800-650-1583 (TTY: 1-800-833-6384) |
| **Uniform Dental Plan, administered by Delta Dental of Washington** | **deltadentalwa.com/group/pebb** | 1-800-537-3406 (TTY: 1-800-833-6384) |
| **Willamette Dental of Washington, Inc.** | **wapebb.willamettedental.com** | 1-855-433-6825 (TRS: 711) |

| Additional contacts | | | |
|---|---|---|---|
| **Auto and home insurance** | Liberty Mutual Insurance Company | **hca.wa.gov/public-employee-benefits/retirees/auto-and-home-insurance** | 1-800-706-5525 |
| **Health savings account (HSA) trustee** | HealthEquity, Inc. | **healthequity.com/pebb** | **UMP members:** 1-844-351-6853 (TRS: 711) **Kaiser Permanente members:** 1-877-873-8823 (TRS: 711) |
| **Life insurance** | Metropolitan Life Insurance Company (MetLife) | **metlife.com/wshca-retirees** | 1-866-548-7139 |
| **SmartHealth** | Limeade | **smarthealth.hca.wa.gov** | 1-855-750-8866 (TRS: 711) |
| **Health reimbursement arrangement (HRA)** | Voluntary Employees' Beneficiary Association (VEBA) | VEBA Plan or VEBA Medical Expense Plan (MEP): **veba.org** HRA VEBA Plan: **hraveba.org** | **VEBA Plan or VEBA MEP:** 1-888-828-4953 **HRA VEBA Plan:** 1-888-659-8828 |

## PEBB Program is saving the green

Help reduce our reliance on paper mailings—and their toll on the environment—by signing up to receive PEBB Program mailings by email. To sign up, go to PEBB My Account at **hca.wa.gov/my-account.**

# Introduction

## This booklet contains information you need to know about benefits, monthly premiums, Public Employees Benefits Board (PEBB) rules and timelines, and the plans available to you for 2020. Keep this booklet for future reference.

Important requirements and timelines to remember:

- **In general, you have 60 days** to enroll in or defer (postpone) enrollment in PEBB retiree insurance coverage. For details, see "Eligibility Summary" starting on page 10.
- If the PEBB Program doesn't receive your *2020 PEBB Retiree Coverage Election Form* (form A) within the required timeline, you could lose your right to enroll.
- **To enroll dependents, you must provide valid documents to prove their eligibility** within the PEBB Program's enrollment timelines, or they will not be enrolled. This applies to subscribers who are not entitled to Medicare Part A and Part B and any subscriber enrolling a state-registered domestic partner.
- **If you and/or your dependents are entitled to Medicare,** you each must enroll and stay enrolled in Medicare Part A and Part B to qualify for a PEBB retiree health plan.
- **We must receive your first premium payment and applicable premium surcharges before we will enroll you** (unless you choose to pay through Department of Retirement Systems [DRS] pension deduction). See "How do I pay for coverage?" on page 19 for more information.

### If you have questions about PEBB Program coverage

Visit **hca.wa.gov/pebb-retirees** for forms, publications, and information updates.

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

**Fax documents to us** at 360-725-0771.

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

**Visit our office**
Health Care Authority
626 8th Avenue SE
Olympia, WA 98501
**Note:** The PEBB Program does not take appointments. We see visitors on a first-come, first-served basis. The last visitor will be accepted at 4:30 p.m.

**Send us a secure message at hca.wa.gov/fuze-questions.** You must set up a secure login to use this feature. This helps protect your privacy and sensitive health information.

### Paying your premiums

**Mail your first premium payment (and applicable premium surcharges) to:**
Health Care Authority
PO Box 42691
Olympia, WA 98504-2691

**For automatic bank account withdrawals through Electronic Debit Service (EDS):** Submit a *2020 PEBB Electronic Debit Service Agreement* form, provided in the back of this booklet.

**For Department of Retirement Systems (DRS) pension deduction:** 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 enrolled. The PEBB Program will send you an invoice if a first payment is needed.

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

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# 2020 PEBB Retiree Monthly Premiums

Effective January 1, 2020

**Special Requirements**

- 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 are reduced by the state-funded contribution, up to the lesser of $183 or 50 percent of the plan rate per retiree per month.

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

| Non-Medicare medical plan premiums | | | | |
|---|---|---|---|---|
| **For members not eligible for Medicare (or enrolled in Part A only)** | **Subscriber** | **Subscriber and spouse[2]** | **Subscriber and child(ren)** | **Subscriber, spouse[2], and child(ren)** |
| **Kaiser Permanente NW[1] Classic** | $715.66 | $1,426.25 | $1,248.60 | $1,959.20 |
| **Kaiser Permanente NW[1] CDHP** | $608.85 | $1,206.99 | $1,072.04 | $1,611.85 |
| **Kaiser Permanente WA Classic** | $752.15 | $1,499.24 | $1,312.47 | $2,059.55 |
| **Kaiser Permanente WA CDHP** | $610.16 | $1,210.10 | $1,074.70 | $1,616.32 |
| **Kaiser Permanente WA SoundChoice** | $618.49 | $1,231.92 | $1,078.57 | $1,692.00 |
| **Kaiser Permanente WA Value** | $675.71 | $1,346.36 | $1,178.70 | $1,849.35 |
| **UMP Classic** | $679.72 | $1,354.37 | $1,185.71 | $1,860.37 |
| **UMP CDHP** | $608.35 | $1,206.48 | $1,071.53 | $1,611.34 |
| **UMP Plus—PSHVN** | $644.97 | $1,284.88 | $1,124.91 | $1,764.82 |
| **UMP Plus—UW Medicine ACN** | $644.97 | $1,284.88 | $1,124.91 | $1,764.82 |

*[1]Kaiser Foundation Health Plan of the Northwest offers plans in Clark and Cowlitz counties in WA and select counties in OR.*
*[2]Or state-registered domestic partner*

## Medicare medical plan premiums

| For members enrolled in Medicare Parts A and B: | Subscriber | Subscriber and spouse[1] | | Subscriber and child(ren) | | Subscriber, spouse[1], and child(ren) | | |
|---|---|---|---|---|---|---|---|---|
| | *1 Medicare eligible* | *1 Medicare eligible* | *2 Medicare eligible* | *1 Medicare eligible* | *2 Medicare eligible* | *1 Medicare eligible* | *2 Medicare eligible* | *3 Medicare eligible* |
| **Kaiser Permanente NW Senior Advantage** | $173.91 | $884.51†† | $342.75 | $706.86†† | $342.75 | $1,417.45†† | $875.70†† | $511.60 |
| **Kaiser Permanente WA Classic** | N/A | $921.64 | N/A† | $734.87 | N/A† | $1,481.96 | $904.36 | N/A† |
| **Kaiser Permanente WA Medicare Plan** | $174.55 | N/A† | $344.04 | N/A† | $344.04 | N/A† | N/A† | $513.53 |
| **Kaiser Permanente WA SoundChoice** | N/A | $787.98 | N/A† | $634.62 | N/A† | $1,248.06 | $804.11 | N/A† |
| **Kaiser Permanente WA Value** | N/A | $845.20 | N/A† | $677.54 | N/A† | $1,348.19 | $847.03 | N/A† |
| **UMP Classic** | $320.54 | $995.20 | $636.02 | $826.53 | $636.02 | $1,501.19 | $1,142.01 | $951.50 |

*[1]Kaiser Foundation Health Plan of the Northwest offers plans in Clark and Cowlitz counties in WA and select counties in OR.*

*[2]Or state-registered domestic partner*

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

*††If a Kaiser Permanente NW member is enrolled in Medicare Part A and Part B and other enrolled members are not eligible for Medicare, the non-Medicare members will be enrolled in Kaiser Permanente NW[1] Classic. The subscriber will pay the combined Medicare and non-Medicare premium shown for Kaiser Permanente NW Senior Advantage.*

### Premium surcharges (for non-Medicare subscribers only)

Two premium surcharges may apply in addition to your monthly medical premium. They only apply if you, the subscriber, are **not** enrolled in Medicare Part A and Part B. You will be charged for them if the conditions described below apply, or if you do not attest to the surcharges.

- A monthly $25-per-account premium surcharge will apply if you or any dependent (age 13 and older) enrolled in PEBB medical uses tobacco products.
- A monthly $50 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 PEBB's Uniform Medical Plan (UMP) Classic.

For more guidance on whether these premium surcharges apply to you, see the *2020 PEBB Premium Surcharge Attestation Help Sheet*.

*(continued)*

# 2020 PEBB Retiree Monthly Premiums

| Premera Blue Cross Medicare Supplement Plan F and Plan G premiums | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | **Subscriber** | **Subscriber and spouse[1]** | | | **Subscriber and child(ren)** | **Subscriber, spouse[1], and child(ren)** | | |
| | *1 Medicare eligible* | *1 Medicare eligible[2]* | *2 Medicare eligible: 1 retired, 1 disabled* | *2 Medicare eligible* | *1 Medicare eligible[2]* | *1 Medicare eligible[2]* | *2 Medicare eligible: 1 retired, 1 disabled[2]* | *2 Medicare eligible[2]* |
| **Plan F** Age 65 or older, eligible by age | $112.84 | $787.50 | $296.25 | $220.61 | $618.83 | $1,293.49 | $802.99 | $726.60 |
| **Plan F** Under age 65, eligible by disability | $188.47 | $863.13 | $296.25 | $371.88 | $694.46 | $1,369.12 | $802.99 | $877.87 |
| **Plan G** Age 65 or older, eligible by age | $97.56 | $772.22 | $254.81 | $190.06 | $603.55 | $1,278.21 | $761.55 | $696.05 |
| **Plan G** Under age 65, eligible by disability | $162.31 | $836.97 | $254.81 | $319.56 | $668.30 | $1,342.96 | $761.55 | $825.55 |

## Dental plan premiums

*You must enroll in medical coverage to enroll in dental. You cannot enroll in ONLY dental coverage. Once enrolled, you must keep dental coverage for at least two years.*

| | **Subscriber** | **Subscriber and spouse[1]** | **Subscriber and child(ren)** | **Subscriber, spouse[1], and child(ren)** |
|---|---|---|---|---|
| **DeltaCare, administered by Delta Dental of Washington** | $39.53 | $79.06 | $79.06 | $118.59 |
| **Uniform Dental Plan, administered by Delta Dental of Washington** | $47.01 | $94.02 | $94.02 | $141.03 |
| **Willamette Dental of Washington, Inc.** | $44.45 | $88.90 | $88.90 | $133.35 |

[1]*or state-registered domestic partner*

[2]*If a Medicare supplement plan is selected, non-Medicare enrollees are enrolled in UMP Classic. The rates shown reflect the total due, including premiums for both plans.*

## Legacy Retiree Life Insurance Plan Premiums (administered by MetLife)

The Legacy Retiree Life Insurance 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).

| Age at death | Amount of insurance | Monthly cost |
|---|---|---|
| **Under 65** | $3,000 | $7.75 |
| **65 through 69** | $2,100 | $7.75 |
| **70 and over** | $1,800 | $7.75 |

## Retiree Term Life Insurance Premiums (administered by Metlife)

The table below shows that monthly costs increase as your age increases, but your benefit coverage amount does not change.

| Your age | Monthly cost for $5,000 coverage | Monthly cost for $10,000 coverage | Monthly cost for $15,000 coverage | Monthly cost for $20,000 coverage |
|---|---|---|---|---|
| **45–49** | $0.87 | $1.74 | $2.61 | $3.48 |
| **50–54** | $1.34 | $2.67 | $4.01 | $5.34 |
| **55–59** | $2.50 | $5.00 | $7.50 | $10.00 |
| **60-64** | $3.84 | $7.67 | $11.51 | $15.34 |
| **65–69** | $7.38 | $14.76 | $22.14 | $29.52 |
| **70–74** | $11.97 | $23.94 | $35.91 | $47.88 |
| **75–79** | $19.41 | $38.81 | $58.22 | $77.62 |
| **80–84** | $31.43 | $62.86 | $94.29 | $125.72 |
| **85–89** | $50.90 | $101.79 | $152.69 | $203.58 |
| **90–94** | $82.45 | $164.89 | $247.34 | $329.78 |
| **95+** | $133.57 | $267.14 | $400.71 | $534.28 |

# Eligibility Summary

## Who is eligible for PEBB retiree insurance coverage?

This guide provides a general summary of retiree eligibility. The PEBB Program will determine your eligibility based on PEBB Program rules and when your election form is received. If you disagree with the determination, see "PEBB Appeals" on page 15.

You may be eligible to enroll in PEBB retiree insurance coverage if one of the following applies.

You are a retiring employee of a:

- PEBB-participating employer group.
- State agency.
- State higher-education institution.

You are a retiring school employee of a:

- Washington State school district, educational service district, or charter school that participates in the School Employees Benefits Board (SEBB) Program.
- A non-represented employee of an educational service district.

You may also be eligible to enroll in PEBB retiree insurance coverage if you are an eligible surviving dependent, or an elected or full-time appointed official of the legislative or executive branch of state government who leaves public office.

To be eligible to enroll in PEBB retiree insurance coverage, you must meet both the procedural requirements and all the eligibility requirements of WAC 182-12-171, 182-12-180, 182-12-211, 182-12-250, or 182-12-265.

### Procedural requirements include:

- If you are a retiring employee or retiring school employee, you must submit a *2020 PEBB Retiree Coverage Election Form* (form A) to enroll or defer enrollment in PEBB retiree insurance coverage. Form A describes other forms and documents that may be required. The PEBB Program must receive your forms and any other required documents **no later than 60 days** after your employer-paid coverage, COBRA coverage, or continuation coverage ends. For elected or full-time appointed officials described in WAC 182-12-180(1), the PEBB Program must receive the form **no later than 60 days** after the official leaves public office. Your first premium payment and applicable premium surcharges are due to the Health Care Authority **no later than 45 days** after your 60-day election period ends. If you are a dependent becoming eligible as a survivor, please see "When are dependents of emergency service employees eligible?" on page 13 for enrollment timelines.
- If you or a dependent is entitled to Medicare and your retirement date is after July 1, 1991, you must enroll and stay enrolled in Medicare Part A and Part B to become and remain eligible for a PEBB retiree health plan.
- If you do not enroll in PEBB retiree insurance coverage at retirement, when eligible and separating from service, or when leaving public office as an eligible official, you are only eligible to enroll at a later date if you defer (postpone) enrollment and maintain continuous enrollment in other qualifying medical coverage as described in WAC 182-12-200 and 182-12-205. **See important information about deferring PEBB retiree health plan coverage on page 27.**

### In general, the eligibility requirements state:

You must be a vested member and meet the eligibility criteria to retire from a Washington State-sponsored retirement plan when your employer-paid coverage, COBRA coverage, or continuation coverage ends, unless you are an elected or full-time appointed official as described under WAC 182-12-180.

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 (for example, TIAA-CREF)
- School Employees' Retirement System (SERS) 2 and 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 are considered a Washington State-sponsored retirement system for Washington State University Extension for an employee covered under PEBB insurance coverage at the time of retirement.

You must immediately begin to receive a monthly retirement plan payment, with the following exceptions:

- 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 (as allowed by the plan).
- If you are an employee or school employee retiring or separating under PERS Plan 3, TRS Plan 3, or SERS Plan 3, and you meet the retirement plan's eligibility criteria, you do not have to receive a retirement plan payment to enroll in PEBB retiree insurance coverage.
- If you are an employee retiring under a Washington State 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, you do not have to receive a monthly retirement plan payment.
- If you are an employee retiring from a PEBB employer group and your employer does not participate in a Washington State-sponsored retirement plan, you do not have to receive a monthly retirement plan payment. However, you do have to meet the same age and years of service requirement as if you had been employed as a member of PERS Plan 1 or Plan 2.
- If you are one of the following elected or full-time appointed officials, you do not have to meet the age and years of service requirement or receive a monthly retirement plan payment from a Washington state-sponsored retirement plan:
  - A member of the state Legislature
  - A statewide elected official of the executive branch
  - An executive official appointed directly by the governor as the single head of an executive branch agency
  - An official appointed directly by a state legislative committee as the single head of a legislative branch agency
  - An official appointed to secretary of the Senate or chief clerk of the House of Representatives

## Can I cover my dependents?

You may enroll the following dependents (as described in WAC 182-12-260):

- Your legal spouse
- Your state-registered domestic partner, as defined in WAC 182-12-109 and RCW 26.60.020(1). This includes substantially equivalent legal unions from other jurisdictions (RCW 26.60.020[1]) and substantially equivalent legal unions from other jurisdictions (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
- Your children through the last day of the month in which they turn age 26, except for children with a disability (who may be covered past the age of 26 if they qualify)

### How are children defined?

Children are defined based on the establishment of a parent-child relationship as described in RCW 26.26A.100, except when parental rights have been terminated. The definition includes:

- Your children
- Children of your spouse
- Children whose total or partial support is your legal obligation in anticipation of adoption

*(continued)*

- Children of your state-registered domestic partner
- Children specified in a court order or divorce decree for whom you have a legal obligation to provide total or partial support for health care coverage

### Eligible extended dependents

Children may also include extended dependents in your, your spouse's, or your state-registered domestic partner's legal custody or legal guardianship. An extended dependent may be your grandchild, niece, nephew, or other child for whom you, your spouse, or state-registered domestic partner have legal responsibility as shown by a valid court order and the child's official residence with the custodian or guardian.

This does not include foster children unless you, your spouse, or your state-registered domestic partner has a legal obligation for their total or partial support in anticipation of adoption.

### Eligible children with disabilities

Eligible children also include children of any age with a developmental or physical disability that leaves the child incapable of self-sustaining employment and chiefly dependent upon the subscriber for support and ongoing care, provided the condition occurred before age 26. You must provide proof of the disability and dependency within 60 days of the child turning age 26.

The PEBB Program, with input from your medical plan (if the child is enrolled in medical), will verify the disability and dependency of a child with a disability at age 26, but no more frequently than annually after the two-year period after the child turns age 26. These verifications may require renewed proof from you.

A child with a developmental or physical disability who becomes self-supporting is not eligible as a child 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, the child does not regain eligibility as a child with a disability.

### Verifying dependent eligibility

The PEBB Program verifies the eligibility of all dependents of subscribers not entitled to Medicare Part A and Part B, and any subscriber enrolling a state-registered domestic partner, before they are enrolled under your coverage. You must submit proof of a dependent's eligibility within the PEBB Program's enrollment timelines.

You can find a list of documents you must provide to verify your dependent's eligibility on page 15. Submit the documents with your election or change form(s).

The PEBB Program will not enroll a dependent if they cannot verify the dependent's eligibility. The PEBB Program reserves the right to review a dependent's eligibility at any time (except for children with a disability, who are reviewed separately).

If you are enrolling a dependent described in the table below, you must complete the listed form(s) in addition to your election or change form(s). The PEBB Program must receive the forms and any required documents within the required timelines.

| If enrolling a: | Complete this form: |
|---|---|
| State-registered domestic partner or their child, or other non-qualified tax dependent | *2020 PEBB Declaration of Tax Status* |
| Dependent child with a disability age 26 or older | *2020 PEBB Certification of a Child With a Disability* |
| Extended dependent child | *2020 PEBB Extended Dependent Certification*<br>*2020 PEBB Declaration of Tax Status* |

To find forms and to get more information, go to **hca.wa.gov/employee-retiree-benefits/retirees/dependent-verification,** or call the PEBB Program at 1-800-200-1004 and select option 5.

You must notify the PEBB Program in writing when your dependent is no longer eligible. The PEBB Program must receive notice **within 60 days** of the last day of the month your dependent loses eligibility for health plan coverage. If you do not notify us within this time, you may face consequences as listed in WAC 182-12-262.

## If I die, are my surviving dependents eligible?

As an eligible employee, school employee, or retiree, your surviving dependent may be eligible to enroll or defer enrollment in PEBB retiree insurance coverage as a survivor. To do so, they must meet both eligibility and procedural requirements outlined in WAC 182-12-180, 182-12-205, or 182-12-265.

The PEBB Program must receive all required forms to enroll or defer enrollment in PEBB retiree insurance coverage within the following timelines:

- For an eligible survivor of an employee (including school employees and elected or full-time appointed officials), **no later than 60 days** after the date of the employee's death, or the date the survivor's PEBB, educational service district, or School Employees Benefits Board (SEBB) insurance coverage ends, whichever is later.
- For an eligible survivor of a retiree, n**o later than 60 days** after the retiree's death.

For more information about how to continue coverage as a surviving dependent, see "How does a surviving dependent pay for coverage?" on page 19 and "What are my options when coverage ends?" on page 25. For more information about deferring coverage, see "Deferral rights for survivors of employees or retirees" on page 27.

## When are dependents of emergency service employees eligible?

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

The PEBB Program must receive all required forms for enrolling or deferring PEBB retiree insurance coverage **no later than 180 days** after the later of:

- The death of the emergency service worker
- The date on the letter from the Department of Retirement Systems or the board for volunteer firefighters and reserve officers that informs the survivor that they are determined to be eligible
- The last day the surviving spouse, state-registered domestic partner, or child was covered under any health plan through the emergency service worker's employer
- The last day the surviving spouse, state-registered domestic partner, or child was covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage from the emergency service worker's employer

For more information, contact the PEBB Program at 1-800-200-1004 and select menu option 6. To learn about deferring coverage, see "Deferral rights for survivors of emergency service personnel"on page 30.

# Valid Dependent Verification Documents

Dependent verification helps make sure the PEBB Program covers only people who qualify. If you want to enroll dependents, you must provide documents to prove their eligibility if you (the subscriber) are not enrolled in Medicare Part A and Part B, or if enrolling a state-registered domestic partner (regardless of your Medicare enrollment status). You must show they are eligible before they can be enrolled under your account.

You must submit all documents in English. Documents written in a foreign language must include a translated copy prepared by a professional translator and notarized.

Use the lists below to determine which documents to submit. Submit the documents with your enrollment forms within PEBB Program enrollment timelines.

## To enroll a spouse

**Provide a copy of** (choose one):

- Last year's federal tax return filed jointly that lists the spouse (black out financial information)
- The most recent year's federal tax return for the subscriber and the spouse if filed separately (black out financial information)
- Marriage certificate and evidence that the marriage is still valid (example: a utility bill or bank statement within the last 2 months showing both your and your spouse's name – black out financial information)
- Petition for dissolution or invalidity of marriage
- Legal separation notice
- Defense Enrollment Eligibility Reporting System (DEERS) registration
- Valid J-1 or J-2 visa issued by the U.S. government

## To enroll a state-registered domestic partner or legal union partner

Include the *2020 PEBB Declaration of Tax Status* form to indicate whether they qualify as a dependent for tax purposes under IRC Section 152, as modified by IRC Section 105(b).

**Provide a copy of** (choose one):

- A certificate/card of state-registered domestic partnership or legal union and evidence that the partnership is still valid (for example: a utility bill or bank statement within the last two months showing both your and your partner's name – black out financial information)
- Petition for invalidity (annulment) of state-registered domestic partnership or legal union
- Petition for dissolution or invalidity of a state-registered domestic partnership or legal union
- Legal separation notice of a state-registered domestic partnership or legal union
- Valid J-1 or J-2 visa issued by the U.S. government

## To enroll children

**Provide a copy of** (choose one):

- Last year's federal tax return that includes dependent child(ren) – black out financial information
  **Note:** You can submit one copy of your tax return if it includes all dependents that require 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*
- Certificate or decree of adoption showing the name of the subscriber or their spouse/state-registered domestic partner
- Court-ordered parenting plan
- National Medical Support Notice
- Defense Enrollment Eligibility Reporting System (DEERS) registration
- Valid J-2 visa issued by the U.S. government*

*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 not enrolling the spouse/partner in PEBB insurance coverage.

If you are enrolling the child of a state-registered domestic partner, an extended dependent, or other non-qualified tax dependent, also submit the *2020 PEBB Declaration of Tax Status* form to indicate whether the child qualifies as a dependent for tax purposes under IRC Section 152, as modified by IRC Section 105(b).

If you are enrolling an extended dependent, also submit the *2020 PEBB Extended Dependent Certification* form.

# PEBB Appeals

If you or your dependent disagrees with a decision or denial notice from the PEBB Program, you or your dependent may file an appeal. Submit your appeal in one of the following ways:

**Mail:** PEBB Appeals Unit
PO Box 45504
Olympia, WA 98504-5504

**Fax:** 360-586-9080

Use the table below to find instructions for filing your appeal. You will find guidance on filing an appeal in chapter 182-16 WAC and at **hca.wa.gov/pebb-appeals.**

## How can I make sure my personal 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 at **hca.wa.gov/pebb-appeals** or by calling the PEBB Program at 1-800-200-1004.

| If you are: | And your appeal concerns: | Follow these instructions: |
|---|---|---|
| • An applicant for PEBB insurance coverage<br>• A retiree<br>• A survivor of a deceased employee or retiree as described in WAC 182-12-265 or 182-12-180<br>• A survivor of emergency service personnel killed in the line of duty as described in WAC 182-12-250<br>• A continuation coverage enrollee<br>• The dependent of one of the above | • A decision from the PEBB Program about:<br>  • Eligibility for benefits<br>  • Enrollment<br>  • Premium payments<br>  • Premium surcharges<br>• Eligibility to participate in SmartHealth or receive a wellness incentive | Complete the *PEBB Retiree/ Continuation Coverage Notice of Appeal* form and submit it to the PEBB Appeals Unit as instructed above.<br>The PEBB Appeals Unit must receive the form **no later than 60 calendar days** after the date of the denial notice regarding the decision you are appealing. |
| Seeking a review of a decision by a **PEBB health plan, insurance carrier,** or **benefit administrator** | • The administration of the health plan or benefit<br>• A benefit or claim<br>• Completion of the SmartHealth requirements or a reasonable alternative request | Contact the health plan, insurance carrier, or benefit administrator to request information on how to appeal the decision.<br>Do not use the *PEBB Retiree/ Continuation Coverage Notice of Appeal* form. |

# New Enrollment

If you are a retiring public or school employee, the PEBB Program must receive your *2020 PEBB Retiree Coverage Election Form* (form A), and any other required documents **no later than 60 days** after your employer-paid coverage, COBRA coverage, or continuation coverage ends.

If you are an elected or full-time appointed official as described in WAC 182-12-180(1), the PEBB Program must receive your forms **no later than 60 days** after you leave public office.

If you are a dependent becoming eligible as a survivor, please see page 13 for enrollment timelines.

> You must submit Form A even if you decide to defer (postpone) your enrollment. See "Deferring Your Coverage" on page 27 for more information.

If you miss that 60-day election period, you lose all rights to enroll in or defer PEBB retiree insurance coverage unless you regain eligibility in the future, for example, by returning to work in a PEBB or SEBB benefits-eligible position and, at the time of termination, meet procedural and eligibility requirements.

> If we receive your Form A within the required 60 days and it is incomplete, we will send you a letter asking you for the missing information and giving you a deadline to respond. It is better to submit an incomplete form than to miss your 60-day election period to enroll or defer.

Include any eligible dependents you wish to enroll on Form A. If you are a retiree or survivor who is not enrolled in Medicare Part A and Part B, or if you are enrolling a state-registered domestic partner, you must provide proof of your dependents' eligibility before the PEBB Program will enroll them. See page 14 for a list of acceptable documents to verify dependents.

**You must enroll in medical to enroll in dental.** If you select dental coverage for yourself, you and your dependent(s) must be enrolled in the same dental plan. You must keep dental coverage for at least two years unless you defer or terminate enrollment as allowed under PEBB Program rules. You may change dental plans within those two years. If you terminate your dependent(s) from your dental coverage, they will also be terminated from medical coverage.

## When do I send payment?

Your first premium payment and applicable premium surcharges are due to the Health Care Authority **no later than 45 days** after your 60-day election period ends, unless you choose to have them deducted from your monthly pension from the Department of Retirement Systems (DRS). 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 enrolled. The PEBB Program will send you an invoice if a first payment is needed. 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.

See "Paying for Benefits" starting on page 18 for details.

## Can I enroll retroactively due to a disability?

An employee or school employee who is determined to be retroactively eligible for a disability retirement can enroll or defer enrollment in PEBB retiree insurance coverage if they meet the following requirements:

- The PEBB Program receives the required form, and a copy of the formal determination letter sent by the Department of Retirement Systems or the appropriate higher education authority, **no later than 60 days** after the date on the determination letter, and
- The employee or school employee immediately begins to receive a monthly pension benefit or monthly supplemental retirement plan benefit under their higher education retirement plan. Some exceptions to the monthly benefit apply, as described in WAC 182-12-211.

The effective date of the enrollment or deferral may be retroactive to the date of eligibility for retirement, or prospective from the date on the determination letter.

## Can I enroll on two PEBB accounts?

No. If you and your spouse or state-registered domestic partner are both independently eligible for PEBB insurance coverage, you need to decide which of you will cover yourselves and any eligible children on your PEBB medical or dental plans. A dependent may be enrolled in only one PEBB medical or dental plan. For example, you could defer (postpone) PEBB retiree insurance coverage for yourself (see "Deferring Your Coverage" on page 27) and enroll as a dependent on your spouse's or state-registered domestic partner's PEBB medical.

## What can I expect after I submit my election form?

Your employer's payroll office is responsible for terminating your coverage. In some cases, **we cannot enroll you in retiree insurance coverage until this occurs.** If you chose to defer your coverage, see "Deferring Your Coverage" on page 27.

Here is what will happen after you submit your *PEBB Retiree Coverage Election Form*:

1. When the PEBB Program processes your form, we will send you a letter confirming that we received it and notifying you of next steps.
2. The health plan(s) that covered you as an employee or school employee will send you a termination letter after your employer's payroll office terminates your coverage.
3. Federal rules require us to send you a *Continuation Coverage Election Notice* booklet. Keep it for future reference.
4. If your election form is incomplete, we will send you a letter requesting more information.
5. If you choose to pay your premiums by invoice or electronic debit service (EDS), we must receive your first premium payment and applicable premium surcharges **no later than 45 days** after your 60-day election period ends. If we do not receive your payment by the required deadline, you will not be enrolled and you may lose your right to PEBB insurance coverage.
6. If you select pension deduction, you will be invoiced for any premiums owed prior to the pension deduction being set up. You will be responsible for remitting payment for this amount owed; it will not be deducted from your pension.
7. We will enroll you in PEBB retiree insurance coverage once all of the following occur:
   - Your employer's payroll office terminates your coverage.
   - We determine you are eligible.
   - We receive your election form, any other required documents, and your first payment.
8. After your enrollment begins, your health plan(s) will send you a welcome packet.

If we find you are not eligible, you will receive a denial letter that includes your rights to appeal and a refund of any premiums and applicable premium surcharges received.

## When does coverage begin?

If you meet PEBB eligibility and procedural requirements, your PEBB retiree insurance coverage will begin according to the following timelines:

- **If you are a retiring employee of a state agency, employer group, or higher-education institution:** On the first day of the month after your employer-paid coverage, COBRA coverage, or continuation coverage ends.
- **If you are an elected or full-time appointed official leaving public office:** On the first day of the month after you leave public office.
- **If you are a retiring school employee of a Washington State school district, educational service district, or charter school:** On the first day of the month after your employer-paid coverage, COBRA coverage, or continuation coverage ends.

## How much will my monthly premiums be?

The cost for your health benefits depends on which medical or dental plan you select. The list of monthly premiums starts on page 6. In addition to your monthly premium and applicable premium surcharges, you must pay for any deductibles, coinsurance, or copayments under the plan you choose. These costs are outlined in the certificate of coverage or summary of benefits and coverage available from each plan.

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 dies or terminates coverage before the end of the month.

You cannot have a gap in coverage. Premiums are due back to the first month after your employer-paid coverage, COBRA coverage, or continuation coverage ends.

## What are the premium surcharges?

The premium surcharges described below **do not apply** if the subscriber is enrolled in Medicare Part A and Part B. However, if a dependent is enrolled in Medicare and the subscriber is not, you must attest to the surcharges. See the *2020 PEBB Premium Surcharge Attestation Help Sheet* in the back of this book for more information.

**Non-Medicare** subscribers must attest to the premium surcharges:

- A monthly **$25-per-account tobacco use premium surcharge** will apply if you or one of your enrolled dependents (age 13 or older) uses tobacco products. You must attest to this surcharge for each dependent you want to enroll. If you do not attest within the PEBB Program's timelines, or if your attestation results in you incurring the surcharge, you will be charged the premium surcharge in addition to your monthly medical premium. If your or your dependent's tobacco use status changes, or enrolled in or accessed one of the tobacco cessation resources described in the *2020 PEBB Premium Surcharge Attestation Help Sheet*, you must reattest to the premium surcharge. If a provider finds that ending tobacco use or participating in your medical plan's tobacco cessation program will negatively affect your or your dependent's health, see more information in PEBB Program Administrative Policy 91-1 at **hca.wa.gov/pebb-rules**.
- A monthly **$50 spouse or state-registered domestic partner coverage premium surcharge** will apply if you enroll your spouse or state-registered domestic partner and they have chosen not to enroll in another employer-based group medical insurance that is comparable to PEBB's Uniform Medical Plan (UMP) Classic. If you enroll a spouse or partner and do not attest within the PEBB Program's timelines, or if your attestation results in you incurring the premium surcharge, you will be charged the surcharge in addition to your monthly medical premium.

**To report a change (non-Medicare subscribers only)** If your or your enrolled dependent's tobacco use status changes, or:

- You or your dependent who is **18 years and older and uses tobacco products** enrolls in your PEBB medical plan's free tobacco cessation program.
- Your dependent who is **13–17 years old and uses tobacco products** accesses one of the tobacco cessation resources for teens mentioned in the *2020 PEBB Premium Surcharge Attestation Help Sheet.*

You may report the change one of two ways:

- Go to PEBB My Account at **hca.wa.gov/my-account**.
- Submit a *2020 PEBB Premium Surcharge Attestation Change Form* (found at **hca.wa.gov/pebb-retirees**).

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 day is the first of the month, then the change begins on that day.

If you submit a change that results in the removal of the premium surcharge, the change is effective the first day of the month after the PEBB Program receives your attestation. If that day is the first of the month, then the change begins on that day.

## How do I pay for coverage?

You must send your first premium payment and applicable premium surcharges to the Health Care Authority (HCA) **no later than 45 days** after your 60-day election period ends (unless you elect to pay by pension deduction through the Department of Retirement Systems [DRS]; see "DRS pension deduction" below for details). If we do not receive your first payment within the deadline, you will not be enrolled, and you may lose your right to enroll in PEBB retiree insurance coverage.

Please make checks payable to **Health Care Authority** and send to:

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

You can help ensure that future payments are made on time and avoid disruptions in your coverage by using pension deduction through DRS or electronic debit service (EDS) automatic bank account withdrawals.

Here are your payment options:

- **DRS pension deduction**. Your premium and applicable premium surcharges are taken from your end-of-the-month pension. For example, if your coverage takes effect January 1, your January 31 pension will show your deductions for January. 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 enrolled. The PEBB Program will send you an invoice if a first payment is needed.
- **EDS automatic bank account withdrawals**. You must submit the *2020 PEBB Electronic Debit Service Agreement* form to the HCA. You can find the form in the back of this booklet. **You cannot make your first premium payment through EDS**. Approval takes six to eight weeks. You must pay your monthly premiums and applicable premium surcharges as invoiced until you receive a letter from HCA with your EDS start date.
- **A personal check or money order.** You will receive a monthly invoice from HCA for your monthly premiums and applicable premium surcharges. Payments are due on the 15th of each month for that month of coverage. Send payment to the address listed on the invoice.

When you enroll, you must pay premiums and applicable premium surcharges back to the date when your other coverage ended. You cannot have a gap in coverage. For example, if your other coverage ends in December, but you don't submit your enrollment form until February, you must pay premiums and applicable surcharges for January and February to enroll in PEBB retiree insurance coverage.

## How does a surviving dependent pay for coverage?

HCA collects premiums and applicable premium surcharges for the full month and does not prorate them for any reason, including when a member passes away before the end of the month. When you become eligible as a surviving dependent, you will move from being a dependent to having your own subscriber account. You cannot have a gap in coverage between these accounts. As a result, you may receive two invoices and must pay both:

- The invoice for the month the subscriber passed away (when you were a dependent on their account).
- The invoice for your first month under your own PEBB account.

If these premiums were deducted from the subscriber's pension through 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 health plan premiums and applicable premium surcharges remain unpaid for the month in which the subscriber passed away, your PEBB retiree health plan coverage will be terminated back to the last day of the month in which the premium and applicable premium surcharges were paid. This may cause a gap in coverage, which means that any claims paid from the month the subscriber passed to the current month would be your financial responsibility. If you are terminated, you may not be able to enroll again unless you regain eligibility in the future.

*(continued)*

## 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:

- No premium or applicable premium surcharges are paid and remain unpaid for 30 days.
- A premium payment or applicable premium surcharges are underpaid by an amount greater than an insignificant shortfall (described in WAC 182-08-015) and remains underpaid for 30 days past the due date.

If either of the events listed above occur and the payment remains 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 your PEBB retiree health plan coverage is terminated, coverage for your dependents is also terminated. You cannot enroll again unless you regain eligibility, for example, by returning to employment in a PEBB or School Employees Benefits Board (SEBB) benefits-eligible position.

## Can I use a VEBA account?

If you have a Voluntary Employees' Beneficiary Association Medical Expense Plan (VEBA MEP) account, you can set up automatic reimbursement of your qualified insurance premiums. The VEBA MEP does not pay your monthly premiums directly to the PEBB Program. It is important that you notify the VEBA MEP when your premium changes.

Your VEBA MEP account is a health reimbursement arrangement (HRA). Qualified insurance premiums include medical, dental, vision, Medicare supplement, Medicare Part B, Medicare Part D, and tax-qualified long-term care insurance (subject to annual IRS limits). Retiree term life insurance premiums are not eligible for reimbursement from your VEBA MEP account.

**Retiree Rehire Limitation:** You must notify the VEBA MEP if you become rehired by the employer that contributed to your account. Only certain limited or "excepted" qualified medical care expenses and premiums you incur while re-employed are eligible for reimbursement. Excepted benefits include expenses and premiums for dental, vision, and tax-qualified long-term care insurance (subject to annual IRS limits). You can still be reimbursed for all types of qualified medical care expenses incurred prior to and after re-employment.

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

Only the following types of expenses and premiums can be reimbursed from your VEBA MEP account while coverage is limited:

- CDHP/HDHP premiums
- Dental expenses and premiums
- Vision expenses and premiums
- Orthodontia expenses
- Transportation expenses (if related to a permitted expense)

Keep in mind that limiting your VEBA MEP coverage is not the only HSA contribution eligibility requirement.

More information and forms, including the *Automatic Premium Reimbursement* form and *Limited HRA Coverage Election* form, are available after logging in at **veba.org** or by calling the VEBA MEP customer care center at 1-888-828-4953.

# Medicare Enrollment

When you or a covered dependent becomes entitled to Medicare, you or your dependent must enroll and stay enrolled in Medicare Part A and Part B to remain eligible for PEBB retiree health plan coverage.

Because the Social Security Administration and the PEBB Program have different timelines for Medicare enrollment, we encourage you to apply for Medicare three months before turning age 65. Doing so will make sure that you enroll in PEBB retiree insurance coverage within our timelines. To enroll in Medicare, contact the Social Security Administration at 1-800-772-1213 (TTY: 1-800-325-0778) or go to **socialsecurity.gov.** To learn more about Medicare benefits, call Medicare at 1-800-633-4227 or go to **medicare.gov**.

Once you or your Medicare-entitled dependent enrolls in Medicare Part A and Part B, you must send us proof of the enrollment. Send us one of the following documents **30 days before turning age 65**, so we can properly adjust your premium (or, if delayed, no later than 60 days after turning age 65):

- A copy of the Medicare card showing the effective date of Medicare Part A and Part B
- A copy of the Medicare entitlement letter showing the effective date of Medicare Part A and Part B

If you or your dependent are not entitled to Medicare, you must send us 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. Mail or fax to:

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

**Fax:** 360-725-0771

We will 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 in addition to your monthly medical premium, the premium surcharges will end automatically when you (the subscriber) enroll in Medicare Part A and Part B.

Entitlement to Medicare also qualifies as a special open enrollment event, allowing you to change your medical plan. See "What is a special open enrollment?" on page 23.

## Can I enroll in a CDHP or UMP Plus 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 a UMP Plus plan when you or your covered dependent(s) become entitled to Medicare Part A or Part B, you must change medical plans. See the table below for details. The PEBB Program should receive your change form 30 days before the Medicare enrollment date, but must receive it **no later than 60 days** after the Medicare enrollment date.

After you leave a CDHP, you will still have access to your existing HSA funds, but you can no longer contribute to it. You will be liable for any tax penalties resulting from contributions made to your HSA when you are no longer eligible.

The effective date of the change in the medical plan will be the first of the month after the date the medical plan becomes unavailable, or the date the form is received, whichever is later. If that day is the first of the month, the change in the medical plan begins on that day. Since a medical plan change is required and enrollment in Medicare Part A and Part B may lower your premium, we encourage you to submit your change form promptly to avoid any delays.

| If the member entitled to Medicare Part A and Part B is: | You must: |
|---|---|
| You (the subscriber) | Choose a new medical plan that is not a consumer-directed health plan (CDHP) or UMP Plus plan. Your annual deductible and annual out-of-pocket maximum will restart with your new medical plan. |
| Your covered dependent | • Choose a new medical plan that is not a CDHP or UMP Plus plan and keep your Medicare dependent enrolled in PEBB medical coverage. Your annual deductible and annual out-of-pocket maximum will restart with your new medical plan.<br>• To keep your CDHP or UMP Plus plan, remove your dependent from your PEBB health plan coverage before they enroll in Medicare Part A or Part B. The dependent will not qualify for continuation coverage through the PEBB Program. |

# Making Changes in Coverage

To make changes, such as enrolling a dependent or switching to a different health plan, you must submit the required form(s) during the PEBB Program's annual open enrollment or when a special open enrollment event occurs. You must make all changes within the PEBB Program's timelines. Some changes are allowed at any time throughout the year.

## What changes can I make any time?

Below are the changes you can make any time during the year. You can use the *2020 PEBB Retiree Coverage Change Form* (form E) to report the change unless otherwise noted below.

- Change your or your enrolled dependent's tobacco use premium surcharge attestation. Use the *2020 PEBB Premium Surcharge Attestation Change Form* or log in to PEBB My Account at **hca.wa.gov/my-account.**
- Change your name or address. To do so, mail the PEBB Program a written request with your new name or address, send a fax to 360-725-0771, or call 1-800-200-1004 and select menu option 5.
- Terminate or defer (postpone) your PEBB retiree health plan coverage. (See "How do I terminate coverage?" on page 25 or "Deferring Your Coverage" beginning on page 27.)
- Remove a dependent from your PEBB retiree health plan coverage.
  - The PEBB Program will remove the dependent on the last day of the month in which we receive the written notice or on the last day of the month specified in the written notice, whichever is later. If we receive it on the first day of the month, coverage will end on the last day of the previous month.
  - If the dependent is enrolled in a PEBB Medicare Advantage Plan, coverage will end on the last day of the month we receive the *2020 PEBB Medicare Advantage Plan Disenrollment Form* (form D).
- Change your life insurance beneficiary information. Use the *MetLife Group Term Life Insurance Beneficiary Designation* form, or contact MetLife at 1-866-548-7139. (See "Life Insurance" on page 62.)
- Apply for, terminate, or change auto or home insurance coverage. (See "Auto and Home Insurance" on page 66.)
- Non-Medicare retirees only: Start, stop, or change your contributions to your health savings account (HSA). To do this, 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 **healthequity.com/pebb.**

## What changes can I make during the PEBB Program's annual open enrollment?

The PEBB Program's annual open enrollment is November 1 through 30. To make any of the changes below, the PEBB Program must receive the required form(s) no later than November 30. The change will become effective January 1 of the following year.

During the annual open enrollment, you can:

- Change your medical and/or dental plan.
- Add dental coverage. (If you enroll in a dental plan, you must stay enrolled for two years.)
- Enroll an eligible dependent. If you (the subscriber) are not enrolled in Medicare Part A and Part B or you are enrolling a state-registered domestic partner, you must also provide proof of your dependent's eligibility, or they will not be enrolled. (See "Valid Dependent Verification Documents" on page 14.)
- Terminate or defer (postpone) your PEBB retiree health plan coverage.
- Remove a covered dependent from your PEBB retiree health plan coverage.
- Enroll in a health plan if you previously deferred (postponed) PEBB retiree health plan coverage for other qualifying medical coverage. You will need to provide proof of continuous enrollment in other qualifying coverage.

  **Note:** You cannot enroll if there has been a gap in coverage. (See "Deferring Your Coverage" on page 27.)

## What happens when a dependent loses eligibility?

You must notify the PEBB Program in writing 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 the subscriber's divorce, annulment, dissolution, or the dependent turning age 26. The PEBB Program must receive your notice within **60 days** of the last day of the month your dependent loses eligibility. For example, if your dependent turns 26 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 (which is 60 days after March 31). If eligibility is lost due to divorce or dissolution of a state-registered domestic partnership, you must submit a copy of the divorce decree or dissolution document.

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

- The dependent may lose eligibility to continue health plan coverage under one of the continuation coverage options described in WAC 182-12-270.
- You may be billed for claims paid by the health plan for services that were rendered after the dependent lost eligibility.
- You may not be able to recover paid insurance premiums for dependents who lost eligibility.

## What is a special open enrollment?

A special open enrollment means a time period after specific life events (such as a birth or marriage) when subscribers may make changes outside of the PEBB Program's annual open enrollment. The change must be consistent with and correspond to the event that affects eligibility for coverage (see table on page 24). You must provide proof of the event that created the special open enrollment (for example, a marriage certificate or birth certificate).

To make a change, you must submit the *2020 PEBB Retiree Coverage Change Form* (form E) and any other required form(s) or documents. The PEBB Program must receive your completed forms and other required 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. If you are changing from a Medicare Advantage Plan, also include a *2020 PEBB Medicare Advantage Plan Disenrollment Form* (form D).

In most cases, the change will occur the first of the month following the event date or the date the required forms are received, whichever is later. If that day is the first of the month, the change in enrollment begins on that day. One exception is PEBB Medicare Advantage plans, which start the first of the month after the PEBB Program receives your form E and *2020 PEBB Medicare Advantage Plan Election Form* (form C), per federal regulations. Another exception is a special open enrollment due to the birth or adoption of a child (newborn, adopted child, or child whose total or partial support is your legal obligation in anticipation of adoption), in which case PEBB benefits will begin or end as follows:

- For a newly born child, PEBB benefits will begin the date of birth.
- For a newly adopted child, PEBB benefits will begin on the date of placement or the date you assume a legal obligation in anticipation of adoption, whichever is earlier.
- For a spouse or state-registered domestic partner of a subscriber due to birth or adoption, PEBB benefits will begin the first day of the month in which the event occurs. The spouse or state-registered domestic partner will be removed from health plan coverage the last day of the month in which the event occurred.
- If the special open enrollment is due to a child becoming eligible as an extended dependent or a dependent child with a disability, PEBB benefits will begin the first day of the month following eligibility certification.

See the table on the next page for a list of events that create a special open enrollment and the changes you can make.

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# Making Changes in Coverage

| If this event happens: | These changes may be allowed: | | |
|---|---|---|---|
| | Add dependent | Change medical plan | Change dental plan |
| Marriage or registering a domestic partnership (as defined by WAC 182-12-109) | Yes | Yes | Yes |
| Birth or adoption, including assuming a legal obligation for total or partial support in anticipation of adoption | Yes | Yes | Yes |
| Child becoming eligible as an extended dependent through legal custody or legal guardianship | Yes | Yes | Yes |
| Subscriber or dependent losing eligibility for other coverage under a group health plan or through health insurance, as defined by the Health Insurance Portability and Accountability Act (HIPAA) | Yes | Yes | Yes |
| Subscriber having a change in employment status that affects the subscriber's eligibility for the employer contribution toward their employer-based group health plan | Yes | Yes | Yes |
| The subscriber's dependent has a change in their employment status that affects their 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 54.9801-6.) | Yes | Yes | Yes |
| 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 | Yes | No | No |
| Subscriber's dependent moving from outside the United States to live within the United States, or from within the United States to outside of the United States, and that change in residence resulted in the dependent losing their health insurance | Yes | No | No |
| Subscriber or dependent having a change in residence that affects health plan availability | No | Yes | Yes |
| A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent | Yes | Yes | Yes |
| Subscriber or a subscriber's dependent becoming entitled to coverage under Medicaid or a Children's Health Insurance Program (CHIP), or losing eligibility for coverage under Medicaid or CHIP | Yes | Yes | Yes |
| Subscriber or a dependent becoming eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP | Yes | Yes | Yes |
| Subscriber or dependent becoming entitled to Medicare or losing eligibility under Medicare; or enrolling (or terminating enrollment) in a Medicare Part D plan | No | Yes | No |
| Subscriber's current health plan becoming unavailable because the subscriber or subscriber's dependent is no longer eligible for a health savings account (HSA) | No | Yes | Yes |
| 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) | No | Yes | Yes |

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

## How do I terminate coverage?

To terminate all or part of your PEBB retiree health plan coverage, you must submit your request in writing to:

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

**Fax** 360-725-0771

**Secure online message to hca.wa.gov/fuze-questions.** You must register for an account to use this feature. This helps protect your privacy and sensitive health information. To terminate coverage online, you must attach your written request to the secure message. We cannot terminate your coverage in response to a secure message alone.

Write your full name and the last four digits of your Social Security number on your request so we can identify your account.

Your coverage will terminate on the last day of the month in which the PEBB Program receives your written request (or a future date, if you requested one). If your written request is received on the first day of the month, coverage will terminate on the last day of the previous month. See exceptions below:

- If you are requesting to terminate dental coverage, you must have been enrolled for at least two years and the termination will include any covered dependents, who will lose both medical and dental coverage.
- If you are terminating medical coverage and you or a covered dependent is enrolled in a PEBB Medicare Advantage plan, you must also send a completed 2020 *PEBB Medicare Advantage Plan Disenrollment Form* (form D) to the Health Care Authority. PEBB retiree health plan coverage will terminate on the last day of the month when we receive Form D.

**If you terminate your PEBB retiree health plan coverage, you cannot enroll again later** unless you regain eligibility for PEBB insurance coverage, for example, by returning to employment in a PEBB or SEBB benefits-eligible position. If you terminate coverage, any enrolled dependents' coverage will also be terminated.

## When does PEBB insurance coverage end?

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

- When you or a dependent lose eligibility for PEBB retiree insurance coverage, coverage 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. The PEBB Program charges an entire month's premium for each calendar month of coverage. HCA will not prorate a premium if an enrollee dies or terminates their coverage before the end of the month.

## What are my options when coverage ends?

If you lose eligibility for PEBB retiree insurance coverage, you, your dependents, or both may be eligible to temporarily continue your PEBB health plan coverage under PEBB Continuation Coverage (COBRA) by self-paying the premiums and applicable premium surcharges.

If you or your dependent are eligible, the PEBB Program must receive the 2*020 PEBB Continuation Coverage (COBRA) Election/Change* form **no later than 60 days** from the date PEBB health plan coverage ended, or from the postmark date on the *PEBB Continuation Coverage Election Notice* booklet, whichever is later. If we don't receive your form by the required deadline, you will lose all rights to continue PEBB insurance coverage.

*(continued)*

# Making Changes in Coverage

Your dependents lose eligibility under PEBB retiree insurance coverage when you die. However, they may be eligible for PEBB retiree insurance coverage as surviving dependents, even if they were not covered at the time of your death. The PEBB Program must receive the required forms **no later than 60 days** after the date of your death.

Your spouse or state-registered domestic partner may continue PEBB retiree insurance coverage indefinitely as long as they pay premiums and applicable premium surcharges on time. Your other dependents may continue coverage until they are no longer eligible under PEBB Program rules. The surviving dependent must pay monthly premiums and applicable premium surcharges associated with PEBB retiree insurance coverage as they become due. If they remain unpaid for 60 days from the original due date, PEBB insurance coverage will be terminated back to the last day of the month for which the monthly premium and any applicable premium surcharges were paid.

If your spouse, state-registered domestic partner, or your spouse or partner's children are no longer eligible due to divorce or dissolution, they may continue coverage for up to 36 months under PEBB Continuation Coverage (COBRA).

For information about your rights and obligations, go to **hca.wa.gov/erb**, select *Forms & publications,* and search for *PEBB Continuation Coverage Election Notice.*

# Deferring Your Coverage

Deferring means postponing your PEBB retiree health plan coverage in a way that lets you keep your eligibility to enroll at a later date. To defer, you must meet the eligibility requirements for PEBB retiree insurance coverage and be enrolled in other qualified medical coverage. You may choose to defer your enrollment 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 PEBB retiree health plan coverage. When you apply for enrollment after your deferral, you must provide proof of continuous enrollment in one or more qualifying medical coverages (including start and end dates).

## How do I defer?

To defer your enrollment, you must:

- Return the required form(s) to the PEBB Program within the required timeline, and
- Be continuously enrolled in other qualified medical coverage, as described below.

If you defer enrollment in a PEBB retiree health plan, you may not continue enrollment in a PEBB dental plan during your deferral period. Retirees must enroll in medical to enroll in dental.

Except as stated below, if you defer enrollment in a PEBB retiree health plan, you must also defer enrollment for your dependents.

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

**You may defer enrollment in a PEBB retiree health plan:**

- If you are enrolled in a PEBB, a Washington state educational service district, or SEBB-sponsored medical plan as a dependent, including such coverage under COBRA or continuation coverage.
- Beginning January 1, 2001, if you are enrolled in employer-based group medical as an employee or the dependent of an employee, or such medical insurance continued under COBRA coverage or continuation coverage. This does not include 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. You will have a one-time opportunity to enroll in a PEBB retiree health plan.
- Beginning January 1, 2006, if you are enrolled in Medicare Part A and Part B and a Medicaid program that provides creditable coverage. To be considered creditable coverage, your Medicaid coverage must include coverage for medical and hospital benefits. Your eligible dependents who are not eligible for creditable coverage under Medicaid may continue PEBB retiree health plan enrollment.
- Beginning January 1, 2014, if you are not eligible for Medicare Part A and Part B you may defer enrollment in a PEBB retiree health plan if enrolled in qualified health plan coverage through a health benefit exchange established under the Affordable Care Act. This does not include Medicaid coverage, also known as Apple Health in Washington State. You will have a one-time opportunity to enroll or reenroll in a PEBB retiree health plan.
- Beginning July 17, 2018, if you are enrolled in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). You will have a one-time opportunity to enroll in a PEBB retiree health plan.

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# Deferring Your Coverage

**You must provide proof of continuous enrollment in one or more qualifying medical plan coverages to return to a PEBB retiree health plan after a deferral.** 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 return in the future.

## Required timelines for retirees to defer

To defer enrollment in a PEBB retiree health plan, you must submit the required forms to the PEBB Program requesting to defer.

- If you are a retiring or eligible separating employee or school employee, the PEBB Program must receive the *2020 PEBB Retiree Coverage Election Form* (form A) **no later than 60 days** after your 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 employer-paid coverage, COBRA coverage, or continuation coverage ends.
- If you are an employee or a school employee found eligible for disability retirement, see "Can I enroll retroactively due to a disability?" on page 16 for more information.
- If you are an eligible elected or full-time appointed official of the legislative or executive branch of state government leaving public office, the PEBB Program must receive the 2*020 PEBB Retiree Coverage Election Form* (form A) **no later than 60 days** after you leave office. The PEBB Program will defer your enrollment the first of the month after the date you leave office.
- If you are a retiree enrolled in PEBB retiree insurance coverage, the PEBB Program must receive the *2020 PEBB Retiree Coverage Change Form* (form E) and any other required forms before you defer coverage. Enrollment will be deferred effective the first of the month following the date the PEBB Program receives your forms. If we receive the forms on the first day of the month, enrollment will be deferred as of that day. When a member is enrolled in a PEBB Medicare Advantage Plan, enrollment in a PEBB retiree health plan will be deferred effective the first of the month following the date the *2020 PEBB Medicare Advantage Plan Disenrollment Form* (form D) is received.
- If you enrolled as a dependent in a medical plan sponsored by PEBB, a Washington state educational service district, or SEBB, or such coverage under 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 retiree must defer enrollment as described in WAC 182-12-205.
- If you met substantive eligibility requirements and your employer-paid coverage, COBRA coverage, or continuation coverage ended between January 1, 2001 and December 31, 2001, you were not required to have submitted a deferral form at that time. However, you must meet all other procedural requirements.

## Life insurance when coverage is deferred

If you have deferred your enrollment in a PEBB retiree health plan and become eligible for the employer contribution toward PEBB employee life insurance (for example, by returning to active employment status), you may keep or terminate your retiree term life insurance. To do either, call MetLife at 1-866-548-7139 as soon as possible to ensure you do not miss a deadline. Also notify the PEBB Program at 1-800-200-1004 (select option 6) so we can update your records.

If you become eligible for the employer contribution toward SEBB employee life insurance, call MetLife at 1-833-854-9624, and notify the PEBB Program.

If you later leave active employment status and you elected to terminate retiree term life insurance upon your deferral, you may choose to reelect retiree term life insurance. If you wish to do so, the PEBB Program must receive the required form(s) within the required timelines described in WAC 182-12-209. Contact the PEBB Program as soon as your PEBB employee life insurance coverage ends for the steps to do so.

## Deferral rights for survivors of employees or retirees

A surviving spouse, state-registered domestic partner, or child who is eligible for PEBB retiree insurance coverage as a survivor under WAC 182-12-180 or 182-12-265 may defer enrollment under one of the circumstances listed below. If a survivor defers enrollment in PEBB retiree health plan coverage, they may not continue enrollment in a PEBB dental plan.

- If a survivor is enrolled in a PEBB, a Washington state educational service district, or a SEBB sponsored medical plan as a dependent, including such coverage under COBRA or continuation coverage.
- Beginning January 1, 2001, if a survivor is enrolled in employer-based group medical as an employee or the dependent of an employee, or such medical insurance continued under COBRA coverage or continuation coverage.
- Beginning January 1, 2001, if a survivor is enrolled in medical coverage as a retiree or the dependent of a retiree in a TRICARE plan or the Federal Employees Health Benefits Program. These survivors will have a one-time opportunity to enroll in a PEBB retiree health plan.
- Beginning January 1, 2006, if a survivor is enrolled in Medicare Part A and Part B and a Medicaid program that provides creditable coverage. To be considered creditable coverage, the survivor's Medicaid coverage must include coverage for medical and hospital benefits. A survivor's eligible dependent(s) who are not eligible for creditable coverage under Medicaid may continue PEBB retiree health plan enrollment.
- Beginning January 1, 2014, survivors who are not eligible for Medicare Part A and Part B may defer enrollment in a PEBB retiree health plan if they are enrolled in qualified health plan coverage offered through a health benefit exchange established under the Affordable Care Act, not including Medicaid coverage (called Apple Health in Washington State). These survivors will have a one-time opportunity to enroll or reenroll in a PEBB retiree health plan.
- Beginning July 17, 2018, survivors who are enrolled in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). These survivors will have a one-time opportunity to enroll in a PEBB retiree health plan.

You must provide proof of continuous enrollment in one or more qualifying medical plan coverages to return to a PEBB retiree health plan after deferral.

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 return in the future.

## Required timelines for survivors of employees or retirees to defer

To defer enrollment in PEBB retiree health plan coverage, except as stated below, a survivor must submit a *2020 PEBB Retiree Coverage Election Form* (form A) to the PEBB Program:

- In the event of an employee's or a school employee's death, the PEBB Program must receive the form **no later than 60 days** after the date of the employee's or the school employee's death, or the date the survivor's PEBB, educational service district, or SEBB insurance coverage ends, whichever is later. Enrollment will be deferred as of the first of the month after the later of those two dates.
- In the event of a retiree's death, the PEBB Program must receive the form **no later than 60 days** after the retiree's death. Enrollment will be deferred as of the first of the month after the date of the retiree's death.

- If a survivor enrolls in PEBB retiree insurance coverage and becomes eligible to defer coverage, the PEBB Program must receive the *2020 PEBB Retiree Coverage Change Form* (form E) and any other required forms **before** the survivor's coverage will be deferred. Enrollment will be deferred as of the first of the month after the date the PEBB Program receives the forms. If we receive the forms on the first day of the month, enrollment will be

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deferred that day. When a member is enrolled in a PEBB Medicare Advantage Plan, then PEBB retiree health plan coverage will be deferred as of the first of the month after the date we receive the *2020 PEBB Medicare Advantage Plan Disenrollment Form* (form D).

## Deferral rights for survivors of emergency service personnel

A surviving spouse, state-registered domestic partner, or dependent child of emergency service personnel killed in the line of duty who is eligible for PEBB retiree insurance coverage under WAC 182-12-250 may defer enrollment under the circumstances listed below.

- If a survivor is enrolled in a PEBB Program, a Washington state educational service district, or a SEBB sponsored medical plan as a dependent, including coverage under COBRA or continuation coverage.
- Beginning January 1, 2001, if a survivor is enrolled in employer-based group medical as an employee or the dependent of an employee, or such medical coverage continued under COBRA coverage or continuation coverage.
- Beginning January 1, 2001, if a survivor is enrolled in medical coverage as a retiree or the dependent of a retiree in a TRICARE plan or the Federal Employees Health Benefits Program. These survivors will have a one-time opportunity to enroll in a PEBB retiree health plan.
- Beginning January 1, 2006, if a surviving dependent is enrolled in Medicare Part A and Part B and a Medicaid program that provides creditable coverage. To be considered creditable coverage, the surviving dependent's Medicaid coverage must include coverage for medical and hospital benefits. A survivor's eligible dependents who are not eligible for creditable coverage under Medicaid may continue PEBB retiree health plan enrollment.
- Beginning January 1, 2014, survivors who are not eligible for Medicare Part A and Part B may defer PEBB retiree health plan coverage if they are enrolled in qualified health plan coverage offered through a health benefit exchange established under the Affordable Care Act, not including Medicaid coverage (called Apple Health in Washington State). These survivors will have a one-time opportunity to enroll or reenroll in a PEBB retiree health plan.
- Beginning July 17, 2018, survivors who are enrolled in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). These survivors will have a one-time opportunity to enroll in a PEBB retiree health plan.

If a survivor defers enrollment in PEBB retiree health plan coverage, they may not enroll in a PEBB dental plan.

You must provide proof of continuous enrollment in one or more qualifying medical plan coverages to return to a PEBB retiree health plan after deferral. 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 return in the future.

To defer enrollment in PEBB retiree health plan coverage, except as noted below, a survivor must submit a *2020 PEBB Retiree Coverage Election Form* (form A) to the PEBB Program. The PEBB Program must receive the form n**o 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 through the emergency service worker's employer.
- The last day the survivor was covered under COBRA coverage from the emergency service worker's employer.

If a survivor enrolls in PEBB retiree insurance coverage and requests to defer coverage in the future, the PEBB Program must receive the *2020 PEBB Retiree Coverage Change Form* (form E) and any other required forms before the survivor's coverage will be deferred. Enrollment will be deferred as of the first of the month after the date the PEBB Program receives the forms.

If we receive the forms on the first day of the month, enrollment will be deferred that day. When a member is enrolled in a PEBB Medicare Advantage Plan, then PEBB retiree health plan coverage will be deferred effective the first of the month after the date the *2020 PEBB Medicare Advantage Plan Disenrollment Form* (form D) is received.

## How do I enroll after deferring PEBB retiree health plan coverage?

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

If a retiree or survivor deferred enrollment in PEBB retiree health plan coverage, they may enroll under the following circumstances, as long as they have been continuously enrolled in one or more qualifying medical coverages as required.

- **During any PEBB Program annual open enrollment (November 1 through 30).** The PEBB Program must receive the *2020 PEBB Retiree Coverage Election/Change Form* (form A-OE) and proof of continuous enrollment in one or more qualified medical coverages no later than November 30.
- **When other qualified medical coverage ends.** The PEBB Program must receive the *2020 PEBB Retiree Coverage Election Form* (form A) **no later than 60 days** after the date other qualifying medical coverage ends. Enrollment will begin the first day of the month after other qualifying medical coverage ends. Although a retiree or survivor has 60 days to enroll, they must pay premiums and applicable premium surcharges back to when other qualifying medical coverage ended. Proof of continuous enrollment in one or more qualifying medical coverages must list the dates the coverage began and ended.

**Note:** Some retirees or survivors defer PEBB retiree health plan coverage while enrolled in Medicare Part A **and** Part B and a Medicaid Program that provides creditable coverage. These members may enroll in a PEBB retiree health plan no later than the end of the calendar year in which their Medicaid coverage ends. See WAC 182-12-205 (6)(c)(iii) for more information.

A retiree or survivor has a one-time opportunity to enroll in PEBB medical and dental if they deferred enrollment in PEBB retiree health plan 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.

# Selecting a PEBB Medical Plan

When selecting a PEBB medical plan, your options are based on eligibility and where you live. You must consider which plans are available in your county and whether you and any dependents you wish to enroll are enrolled in Medicare Part A and Part B. Remember, if you cover dependents, everyone must enroll in the same medical and dental plans (with some exceptions, based on eligibility for Medicare Part A and Part B).

- **Eligibility.** You must be enrolled in Medicare Part A and Part B to enroll in a PEBB Medicare Advantage or PEBB Medicare Supplement plan. Also, not everyone qualifies to enroll in a CDHP with a health savings account (HSA) or a UMP Plus plan. See "Can I enroll in a CDHP or UMP Plus plan and Medicare Part A and Part B?" on page 21 and "What do I need to know about the consumer-directed health plans?" on page 35.
- **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" beginning on page 39.) Be sure to contact the plan(s) you're interested in to ask about provider availability in your county. If you move out of your plan's service area, you may need to change your plan; otherwise, you may have limited access to network providers and covered services. You must report your new address to the PEBB Program no **later than 60 days** after your move.

## How can I compare the plans?

All medical plans, except for Premera Blue Cross Medicare Supplement Plans F and G, cover the same basic health care services but vary in other ways, such as provider networks, premiums, out-of-pocket costs, and drug formularies.

When choosing a plan to best meet your needs, here are some things to consider:

- **Premiums.** Premiums vary by plan. A higher premium doesn't necessarily mean higher quality of care or better benefits; each plan has the same basic level of benefits (except Medicare Supplement Plans F and G). 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.
- **Deductibles.** Most medical plans, except Premera Blue Cross Medicare Supplement Plan F, and Kaiser Permanente NW and Kaiser Permanente WA's Medicare Advantage plans, require you to pay an annual deductible before the plan pays for covered services. Kaiser Permanente WA Classic, Value, and SoundChoice; and UMP Classic also have a separate annual deductible for some prescription drugs. Covered preventive care and certain other services are exempt from the medical plans' deductibles. This means you do not have to pay your deductible before the plan covers the service.
- **Coinsurance or copays.** Some plans require you to pay a fixed amount when you receive care, called a copay. Other plans require you to pay a percentage of an allowed fee, called a coinsurance.
- **Out-of-pocket limit.** The annual out-of-pocket limit is the most you pay in a calendar year for covered benefits. Kaiser Permanente WA Classic, Value, and SoundChoice; UMP Classic; and UMP Plus plans have separate out-of-pocket limits for prescription drugs. Once you have paid this amount, the plans pay 100 percent of allowed charges for most covered benefits for the rest of the calendar year. Certain charges incurred during the year (such as your annual deductible, copays, and coinsurance) count toward your out-of-pocket limit. There are a few costs that do not apply toward your annual out-of-pocket limit. Read each plan's certificate of coverage for specific details.
    - Monthly premiums and applicable premium surcharges
    - Charges above what the plan pays for a benefit
    - Charges above the plan's allowed amount paid to a provider
    - Charges for services or treatments the plan doesn't cover
    - Coinsurance for non-network providers
    - Prescription drug deductible and prescription drug coinsurance (Kaiser Permanente WA Classic, Value, and SoundChoice; UMP Classic; and UMP Plus only) count toward the separate prescription drug out-of-pocket maximum.

- **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. All plans allow self-referral to a participating provider for women's health care services.
- **Your provider.** If you want to see a particular doctor or health care provider, you should verify whether they are in the plan's network. Contact the plan before you join. Your dependents may choose from any available provider in the plan's network. After you join a plan, you may change your provider, although the rules vary by plan.
- **Network adequacy.** All health carriers in Washington State are required to maintain provider networks that provide enrollees reasonable access to covered services. Check the plans' provider directories to see how many providers are accepting new patients and what the average wait time is for an appointment. Beginning in 2020, for mental health and substance abuse treatment, carriers must also provide additional information on their websites to consumers on the ability to ensure timely access to care. For more information, see Engrossed Substitute House Bill 1099 (Brennen's Law) at **leg.wa.gov.**
- **Paperwork.** In general, PEBB plans don't require you to file claims. However, UMP Classic members may need to file a claim if they receive services from a non-network provider. CDHP members should also keep paperwork received from their provider or from qualified health care expenses to verify eligible payments or reimbursements from their health savings account.
- **Coordination with your other benefits.** If you are also covered through your spouse's or state-registered domestic partner's comprehensive group health coverage, call the medical and/or dental plan(s) directly to ask how they will coordinate benefits.

  All PEBB plans coordinate benefit payments with other group plans, Medicaid, and Medicare. This is called coordination of benefits. This coordination ensures benefit costs are more fairly distributed when a person is covered by more than one plan. However, the amount your PEBB medical plan pays for benefits will not change for a particular service or treatment, even if you or a dependent have an individual medical or dental policy covering that service or treatment.

  **Exception to coordination:** PEBB medical plans that cover prescription drugs will not coordinate prescription-drug coverage with Medicare Part D. All PEBB medical plans cover prescription drugs except Premera Blue Cross Medicare Supplement Plans F and G. If you enroll in a Medicare Part D plan, you must enroll in Plan G or lose your PEBB retiree health plan coverage.

You can compare some of the medical plans' benefits in this booklet on pages 43-50 and at **hca.wa.gov/pebb-retirees**.

## What is a value-based plan, and why should I choose one?

Value-based plans aim to provide high-quality care at a lower price. Providers have committed to follow evidence-based treatment practices, coordinate care with other providers in your plan's network, and meet certain measures about the quality of care they provide.

*(continued)*

# Selecting a PEBB Medical Plan

## What type of plan should I select?

Available plans by county are listed on pages 39-41. In general, the type of plan you choose depends on whether you are eligible for Medicare Parts A and B, and whether you qualify to enroll in a CDHP with an HSA.

The PEBB Program offers three types of medical plans:

- **Consumer-directed health plan (CDHP).** A CDHP lets you use a health savings account (HSA) to help pay for out-of-pocket medical expenses tax free, have a lower monthly premium than most plans, and a higher deductible and a higher out-of-pocket limit. You cannot enroll in a CDHP with an HSA if you or an enrolled dependent are enrolled in Medicare Part A or Part B.
- **Managed-care plans.** Managed-care plans may require you to select a primary care provider within its network to fulfill or coordinate all of your health care needs. You can change providers at any time, for any reason within the contracted network. The plan may not pay benefits if you see a non-contracted provider.
- **Preferred provider organization (PPO) plans.** PPOs allow you to self-refer to any approved provider type in most cases, but usually provide a higher level of coverage if the provider contracts with the plan.

## Medicare options

For members enrolled in Medicare Part A and Part B (see pages 49–50). Value-based plans noted in **bold.**

- **Kaiser Permanente NW Senior Advantage**
- **Kaiser Permanente WA Medicare Plan** (Medicare Advantage or Original Medicare coordination plan)
- Premera Blue Cross Medicare Supplement Plan G. (Plan F is closed to new members as of January 1, 2020.)
- UMP Classic (Medicare), administered by Regence BlueShield

## Non-Medicare options

For members not eligible for Medicare or enrolled in Part A only (see pages 39–40). Value-based plans noted in **bold.**

### Consumer-directed health plans (CDHPs)

*Not available if any member is enrolled in Medicare*

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

### 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 plans

- UMP Classic, administered by Regence BlueShield
- **UMP Plus–Puget Sound High Value Network,** administered by Regence BlueShield (not available if any member is enrolled in Medicare)
- **UMP Plus–UW Medicine Accountable Care Network,** administered by Regence BlueShield (not available if any member is enrolled in Medicare)

*Kaiser Foundation Health Plan of the Northwest offers plans in Clark and Cowlitz counties in WA and select counties in OR.

## What do I need to know about the consumer-directed health plans?

A consumer-directed health plan (CDHP) is a high-deductible health plan (HDHP) with a health savings account (HSA). 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 expenses and services that your health plans may not cover. See IRS *Publication 969 Health Savings Accounts and Other Tax Favored Health Plans* at **irs.gov** for details.

The HSA is set up by your health plan with HealthEquity, Inc. (the HSA trustee for Kaiser Permanente NW, Kaiser Permanente WA, and UMP) to pay for or reimburse your costs for qualified medical expenses.

### Who is eligible?

Some exclusions apply to a CDHP with an HSA. You cannot enroll in one if:

- You or your covered dependent(s) are enrolled in Medicare Part A or Part B or Medicaid.
- You are enrolled in another health plan that is not an HDHP—for example, on a spouse's or state-registered domestic partner's plan—unless the health plan coverage is limited coverage like dental, vision, or disability coverage.
- You or your spouse or state-registered domestic partner is enrolled in a health reimbursement arrangement (HRA), such as the Voluntary Employees' Beneficiary Association Medical Expense Plan (VEBA MEP), unless you take action to convert it to limited HRA coverage.
- You have CHAMPVA or a TRICARE plan.
- You enrolled in a Medical Flexible Spending Arrangement (FSA). This also applies if your spouse has a Medical FSA, even if you are not covering your spouse on your CDHP. This does not apply if the Medical FSA or HSA is a limited purpose account, or for a post-deductible Medical FSA.
- You are claimed as a dependent on someone else's tax return.

Other exclusions apply. To verify whether you qualify, check the HealthEquity *Complete HSA Guidebook* (at **healthequity.com/pebb** under Documents), IRS *Publication 969—Health Savings Accounts and Other Tax-Favored Health Plans* (at **irs.gov**), contact your tax advisor, or call HealthEquity toll-free at 1-877-873-8823.

### PEBB Program contributions

If you are HSA-eligible, the PEBB Program will contribute the following amounts to your HSA:

- $58.34 each month for an individual subscriber, up to $700.08 for the 2020 calendar year; or
- $116.67 each month for a subscriber with one or more enrolled dependents, up to $1,400.04 for the 2020 calendar year.
- $125 if you qualified for the SmartHealth wellness incentive in 2019.

The entire annual amount is not deposited to your HSA in January. Contributions from the PEBB Program go into your HSA in monthly installments over the year, and are deposited on the last day of each month. If eligible and you qualify for the SmartHealth wellness incentive, it is deposited at the end of January with your first HSA installment.

### Subscriber contributions

You can also choose to contribute to your HSA through direct deposits to HealthEquity, and you may be able to deduct your HSA contributions from your federal income taxes.

*(continued)*

*Kaiser Foundation Health Plan of the Northwest offers plans in Clark and Cowlitz counties in WA and select counties in OR.

The IRS has an annual limit for contributions from all sources into an HSA. In 2020, the annual HSA contribution limit is $3,550 (subscriber only) and $7,100 (you and one or more dependents). If you are age 55 or older, you may contribute up to $1,000 more per year in addition to these limits.

To ensure you do not go beyond the maximum allowable limit, calculate both the PEBB Program's contribution amount(s) for the year, the SmartHealth wellness incentive in January (if eligible and you qualify for it), and any amount you contribute during the year.

### Other features of the CDHP/HSA

- If you cover one or more dependents, you must pay the entire family deductible before the CDHP begins paying benefits.
- Your prescription drug costs count toward the annual deductible and out-of-pocket maximum if you enroll in the Kaiser Permanente NW* CDHP or Kaiser Permanente WA CDHP.
- Your HSA balance can grow over the years, earn interest, and build savings that you can use to pay for health care as needed and/or pay for Medicare Part B premiums.

### CDHP and Medicare do not mix

If you enroll in a CDHP and you or a covered dependent becomes eligible for Medicare Part A or Part B during the year, you must change to another non-CDHP PEBB medical plan, or remove the Medicare-eligible dependent from your PEBB coverage. The dependent will not qualify for continuation coverage through the PEBB Program. If you change your medical plan midyear, any payments you have made toward your annual deductible and out-of-pocket maximum may not apply to your new plan. See "Can I enroll in a CDHP or UMP Plus plan and Medicare Part A and Part B?" on page 21.

### What happens to my health savings account when I leave the CDHP?

If you choose a medical plan that is not a CDHP, you should know:

- You won't forfeit any unspent funds in your HSA after enrolling in a different plan. You can spend your HSA funds 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. Contact HealthEquity for details
- You must contact HealthEquity to stop automatic direct deposits to your HSA if you previously set this up.

### Are there special considerations if I enroll in a CDHP mid-year?

Yes. Enrolling in a CDHP and opening an HSA mid-year may limit the amount of contributions you can make in the first year. If you have any questions about this, talk to your tax advisor.

## What do I need to know about the Medicare Advantage and Medicare Supplement plans?

Medicare Advantage plans are available from Kaiser Permanente NW and Kaiser Permanente WA but are not available in every county. See "Medical Plans by County" on pages 39-41. If you or a covered dependent are enrolled in Medicare Part A and Part B and you choose Kaiser Permanente NW or Kaiser Permanente WA, you must enroll in the Medicare Advantage plan if they offer it in your county.

These plans contract with Medicare to provide all Medicare-covered benefits. However, most also cover the deductibles, coinsurance, and additional benefits not covered by Medicare. Neither the health plan nor Medicare will pay for services received outside of the plan's network except for authorized referrals and emergency care.

Kaiser Permanente WA also offers an Original Medicare plan for Medicare retirees who live in a county not served by the Kaiser Permanente WA Medicare Advantage plan.

Your enrollment in a Medicare Advantage plan is effective the first of the month after the PEBB Program receives your required enrollment forms, or as of your enrollment in both Medicare Parts A and B, whichever event occurs later, and may not be the same as your retirement date.

**Premera Blue Cross Medicare Supplement Plan F and Plan G** allow the use of any Medicare-contracted physician or hospital nationwide. These plans are designed to supplement your Original Medicare coverage by reducing most of your out-of-pocket expenses and providing additional benefits. They pay most Medicare deductibles, coinsurance, and copays covered by Medicare.

In Medicare Supplement plans, benefits such as vision, hearing exams, and routine physical exams may have limited coverage or may not be covered at all.

If you select Medicare Supplement Plan G, any enrolled members who are not entitled to Medicare will be enrolled in UMP Classic.

Medicare Supplement Plan G does not include prescription drug coverage. If you select this plan, you may have to enroll in a Medicare Part D plan to get your prescriptions, unless you have other creditable prescription drug coverage.

### Important change for 2020

Premera Blue Cross Medicare Supplement Plan F will not accept new enrollees effective January 1, 2020. The new option will be Premera Blue Cross Medicare Supplement Plan G. Current Plan F members can stay in the plan.

However, if you stay enrolled in Plan F and a member on the account becomes entitled to Medicare after January 1, 2020, you must either change your medical plan or remove your dependent from coverage to stay in Plan F. If you remove your dependent for this reason, they will not be eligible for PEBB Continuation Coverage.

If your dependent is enrolled in Plan F and you become eligible for Medicare on or after January 1, 2020, you will have to change to another PEBB medical plan for you and your dependent.

If you have questions about Plan G, call Premera Blue Cross at 1-800-817-3049. If you have questions about making a plan change, call the PEBB Program at 1-800-200-1004 (TRS: 711).

## How do PEBB medical plans with prescription drug coverage compare to Medicare Part D?

All PEBB medical plans, except Premera Blue Cross Medicare Supplement plans, have prescription drug coverage that is "creditable coverage." That means it is as good as or better than the standard Medicare prescription drug coverage (Medicare Part D).

These plans, on average for all members, meet at least the standard Medicare Part D coverage.

- You can keep your PEBB medical plan and not pay a late enrollment penalty if you decide to enroll in Medicare Part D prescription drug coverage later.
- You can enroll in a Medicare Part D plan when you first become entitled to Medicare, during the Medicare Part D open enrollment, or if you lose creditable prescription drug coverage through your current medical plan. Open enrollment for Medicare Part D occurs between October 15 and December 7.
- Joining Medicare Part D may affect your enrollment in the PEBB Program.

If you enroll in a Medicare Part D plan, you may only enroll in Premera Blue Cross Medicare Supplement Plan G. If you are enrolled in any other PEBB medical plan, you cannot enroll in a Medicare Part D plan and keep your PEBB medical plan. The PEBB Program does not offer a Medicare Part D plan and you are not required to enroll in it.

# How to Find the Summaries of Benefits and Coverage

The Affordable Care Act requires the PEBB Program and most medical plans (except Medicare plans) to provide a standardized comparison tool of medical plan benefits, terms, and conditions. This tool, called the *Summary of Benefits and Coverage* (SBC), allows plan applicants and members to compare things like:

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

The PEBB Program and medical plans must provide an SBC (or explain how to get one) at different times throughout the year, such as when someone applies for coverage, upon plan renewal, and when requested. The SBC is available from your medical plan in your preferred language.

To get an SBC from a PEBB medical plan, you can:

- Go to **hca.wa.gov/employee-retiree-benefits/retirees/benefits-and-coverage-plan** to view or print it online.
- Go to the plan's website to view or print it online.
- Request a paper copy at no charge:
  - For your current medical plan: Call your plan.
  - For other PEBB medical plans: Call the PEBB Program at 1-800-200-1004.

You can find the medical plans' websites and customer service phone numbers on pages 1-2 of this booklet.

# 2020 Medical Plans Available by County

## (Medicare and non-Medicare)

| Washington | | | |
|---|---|---|---|
| **Kaiser Permanente NW* Classic**<br>**Kaiser Permanente NW* Consumer-Directed Health Plan (CDHP)**<br>*These plans are not available to Medicare members.* | • Clark<br>• Cowlitz | | |
| **Kaiser Permanente NW Senior Advantage** | • Clark<br>• Cowlitz | • Skamania | • Wahkiakum (ZIP Codes 98612 and 98647) |
| **Kaiser Permanente WA Classic**<br>**Kaiser Permanente WA Consumer-Directed Health Plan (CDHP)**<br>**Kaiser Permanente WA Value**<br>*These plans are not available to Medicare members.* | • Benton<br>• Columbia<br>• Franklin<br>• Island<br>• King<br>• Kitsap | • Kittitas<br>• Lewis<br>• Mason<br>• Pierce<br>• Skagit<br>• Snohomish | • Spokane<br>• Thurston<br>• Walla Walla<br>• Whatcom<br>• Whitman<br>• Yakima |
| **Kaiser Permanente WA Medicare Advantage** | • Grays Harbor (ZIP Codes 98541, 98557, 98559, and 98568)<br>• Island<br>• King<br>• Kitsap | • Lewis<br>• Mason (ZIP Codes 98524, 98528, 98546, 98548, 98555, 98584, 98588, and 98592)<br>• Pierce | • Skagit<br>• Snohomish<br>• Spokane<br>• Thurston<br>• Whatcom |
| **Kaiser Permanente WA Original Medicare** | • Benton<br>• Columbia<br>• Franklin | • Kittitas<br>• Mason (ZIP Code 98560)<br>• Walla Walla | • Whitman<br>• Yakima |
| **Kaiser Permanente WA SoundChoice**<br>*This plan is not available to Medicare members.* | • King<br>• Kitsap | • Pierce<br>• Snohomish | • Spokane**<br>• Thurston |
| **Premera Blue Cross Medicare Supplement Plan F** | Available in all Washington counties and nationwide. | | |
| **Premera Blue Cross Medicare Supplement Plan G** | Available in all Washington counties and nationwide. | | |
| **UMP Classic** | Available in all Washington counties and worldwide. | | |
| **UMP Consumer-Directed Health Plan (CDHP)**<br>*This plan is not available to Medicare members.* | Available in all Washington counties and worldwide. | | |

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

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

*(continued)*

# 2020 Medical Plans Available by County

## (Medicare and non-Medicare)

*continued from previous page*

| Washington (continued) | | | |
|---|---|---|---|
| **UMP Plus—Puget Sound High Value Network**<br>*This plan is not available to Medicare members.* | • King<br>• Kitsap | • Pierce<br>• Snohomish | • Thurston<br>• Yakima |
| **UMP Plus—UW Medicine Accountable Care Network**<br>*This plan is not available to Medicare members.* | • King<br>• Kitsap | • Pierce<br>• Skagit | • Snohomish<br>• Spokane<br>• Thurston |

| Oregon | | | |
|---|---|---|---|
| **Kaiser Permanente NW* Classic**<br>**Kaiser Permanente NW* Consumer-Directed Health Plan (CDHP)**<br>*These plans are not available to Medicare members.* | • Benton (ZIP Codes 97330, 97331, 97333, 97339, 97370, and 97456)<br>• Clackamas<br>• Columbia<br>• Hood River (ZIP Code 97014) | • Lane (ZIP Codes 97401, 97402, 97403, 97404, 97405, 97408, 97409, 97419, 97424, 97426, 97431, 97437, 97438, 97440, 97448, 97451, 97452, 97454, 97455, 97461, 97475, 97477, 97478, 97487, and 97489) | • Linn (ZIP Codes 97321, 97322, 97335, 97348, 97355, 97358, 97360, 97374, 97377, 97389, and 97446)<br>• Marion<br>• Multnomah<br>• Polk<br>• Washington<br>• Yamhill |
| **Kaiser Permanente NW Senior Advantage** | • Benton (ZIP Codes 97330, 97331, 97333, 97339, and 97370)<br>• Clackamas<br>• Columbia | • Hood River<br>• Linn (ZIP Codes 97321, 97322, 97335, 97355, 97358, 97360, 97374, and 97389) | • Marion<br>• Multnomah<br>• Polk<br>• Washington<br>• Yamhill |
| **Premera Blue Cross Medicare Supplement Plan F** | Available in all Oregon counties and nationwide. | | |
| **Premera Blue Cross Medicare Supplement Plan G** | Available in all Oregon counties and nationwide. | | |
| **UMP Classic** | Available in all Oregon counties and nationwide. | | |
| **UMP Consumer-Directed Health Plan (CDHP)**<br>*This plan is not available to Medicare members.* | Available in all Oregon counties and nationwide. | | |

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

*continued from previous page*

| Idaho | |
|---|---|
| **Premera Blue Cross Medicare Supplement Plan F** | Available in all Idaho counties and nationwide. |
| **Premera Blue Cross Medicare Supplement Plan G** | Available in all Idaho counties and nationwide. |
| **UMP Classic** | Available in all Idaho counties and worldwide. |
| **UMP Consumer-Directed Health Plan (CDHP)**<br>*This plan is not available to Medicare members.* | Available in all Idaho counties and worldwide. |

If you move out of your plan's service area, you may need to change plans. You must report your new address to the PEBB Program **no later than 60 days** after your move. See how to report an address change at **hca.wa.gov/retirees-contact-plan.**

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# 2020 Medical Benefits Cost Comparison

The chart below briefly compares the per-visit costs of some in-network benefits for PEBB medical plans. Some copays and coinsurance do not apply until after you have paid your annual deductible. Call the plans directly for more information on specific benefits, including preauthorization requirements and exclusions.

| **Annual Costs** (You pay) | **Medical deductible** Applies to medical out-of-pocket limit | **Medical out-of-pocket limit**[1] (See separate prescription drug out-of-pocket limit for some plans.) | **Prescription drug deductible** | **Prescription drug out-of-pocket limit**[1] |
|---|---|---|---|---|
| **Kaiser Foundation Health Plan of the Northwest** | | | | |
| **Kaiser Permanente NW Classic**[2] | $300/person<br>$900/family | $2,000/person • $4,000/family<br>Your deductible, copays, and coinsurance for most covered services apply. | None | Prescription drug copays and coinsurance apply to the medical out-of-pocket limit. |
| **Kaiser Permanente NW CDHP**[2] | $1,400/person<br>$2,800/family* | $5,100/person • $10,200/family<br>Your deductible, copays, and coinsurance for most covered services apply. | Prescription drug costs apply toward medical deductible. | |
| **Kaiser Foundation Health Plan of Washington** | | | | |
| **Kaiser Permanente WA Classic** | $175/person<br>$525/family | $2,000/person • $4,000/family<br>Your deductible, copays, and coinsurance for all covered services apply. | $100/person<br>$300/family<br>(Tier 2 and 3 drugs only) | $2,000/person<br>$8,000/family<br>Your prescription drug deductible and coinsurance for all covered prescription drugs apply. |
| **Kaiser Permanente WA CDHP** Individual | $1,400/person | $5,100/person<br>Your deductible and coinsurance for all covered services apply. | Prescription drug costs apply toward medical deductible. | Prescription drug copays and coinsurance apply to the medical out-of-pocket limit. |
| **Kaiser Permanente WA CDHP** Family | $2,800/person<br>$2,800/family* | $5,100/person • $10,200/family<br>Your deductible and coinsurance for all covered services apply. | | |
| **Kaiser Permanente WA SoundChoice** | $125/person<br>$375/family | $2,000/person • $4,000/family<br>Your deductible, copays, and coinsurance for all covered services apply. | $100/person<br>$300/family<br>Does not apply to value and Tier 1 drugs | $2,000/person<br>$8,000/family<br>Your prescription drug deductible and coinsurance for all covered prescription drugs apply. |
| **Kaiser Permanente WA Value** | $250/person<br>$750/family | $3,000/person • $6,000/family<br>Your deductible, copays, and coinsurance for all covered services apply. | | |
| **Uniform Medical Plan (UMP)**[3] | | | | |
| **UMP Classic** | $250/person<br>$750/family | $2,000/person • $4,000/family<br>Your deductible, copays, and coinsurance for most covered medical services apply. | $100/person<br>$300/family<br>(Tier 2 drugs only) | $2,000/person<br>$4,000/family<br>Your prescription drug deductible and coinsurance for all covered prescription drugs apply. |
| **UMP CDHP** | $1,400/person<br>$2,800/family* | $4,200/person • $8,400/family<br>($6,900 per person in a family)[3]<br>Your deductible and coinsurance for most covered services apply. | Prescription drug costs apply toward medical deductible. | Prescription coinsurance applies to the medical out-of-pocket limit. |
| **UMP Plus–PSHVN** | $125/person<br>$375/family | $2,000/person • $4,000/family<br>Your deductible, copays, and coinsurance for most covered medical services apply. | None | $2,000/person<br>$4,000/family<br>Your coinsurance for all covered prescription drugs applies. |
| **UMP Plus–UW Medicine ACN** | | | | |

*Must meet family combined deductible (medical and prescription drug) before plan pays benefits.

*(continued)*

# 2020 Medical Benefits Cost Comparison

| **Benefits** (You pay) | **Ambulance** Air or ground, per trip | **Diagnostic tests, laboratory, and x-rays** | **Durable medical equipment, supplies, and prosthetics** | **Emergency room** (Copay waived if admitted) | **Hearing** | | **Home health** |
|---|---|---|---|---|---|---|---|
| | | | | | Routine annual exam | Hardware | |
| **Kaiser Foundation Health Plan of the Northwest** | | | | | | | |
| **Kaiser Permanente NW Classic**[2] | 15%[4] | $10[4] | 20%[1] | 15%[4] | $35 | You pay any amount over $800 every 36 months for hearing aid and rental/repair combined. | 15%[4] |
| **Kaiser Permanente NW CDHP**[2] | 15%[4] | 15%[4] | 20%[4] | 15%[4] | $30[4] | You pay any amount over $800 every 36 months after deductible has been met for hearing aid and rental/repair combined. | 15%[4] |
| **Kaiser Foundation Health Plan of Washington** | | | | | | | |
| **Kaiser Permanente WA Classic** | 20% | $0[4] MRI/CT/PET scan $30[4] | 20% | $250[1] | Primary care $15[1] Specialist $30[4] | You pay any amount over $800 every 36 months for hearing aid and rental/repair combined. | $0 |
| **Kaiser Permanente WA CDHP** | 10%[4] | 10%[4] | 10%[4] | 10%[4] | 10%[4] | | 10%[1] |
| **Kaiser Permanente WA SoundChoice** | 20% | 15%[4] | 15%[4] | $75 + 15%[4] | Primary care $0 Specialist 15%[4] | | 15%[4] |
| **Kaiser Permanente WA Value** | 20% | $0[4] MRI/CT/PET scan $50[4] | 20% | $300[4] | Primary care $30[4] Specialist $50[4] | | $0 |
| **Uniform Medical Plan (UMP)**[3] | | | | | | | |
| **UMP Classic** | 20% | 15% | 15% | $75 + 15% | $0 | You pay any amount over $800 every three calendar years for hearing aid and rental/repair combined. (CDHP is subject to deductible.) | 15% |
| **UMP CDHP** | 20% | 15% | 15% | 15% | 15% | | 15% |
| **UMP Plus– PSHVN** | 20% | 15% | 15% | $75 + 15% | $0 | | 15% |
| **UMP Plus– UW Medicine ACN** | 20% | 15% | 15% | $75 + 15% | $0 | | 15% |

[1] Premiums, charges for services in excess of a benefit, charges in excess of the plan's allowed amount, coinsurance for out-of-network providers (UMP)[3], and charges for non-covered services do not apply to the out-of-pocket limits. Non-covered services include, but are not limited to, member costs above the vision and hearing aid hardware maximums.

[2] Kaiser Foundation Health Plan of the Northwest, offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon.

[3] UMP Classic and UMP CDHP members who see an out-of-network provider will pay 40% coinsurance of the plan's allowed amount for most services, plus any amount the provider charges over the allowed amount (known as balance billing). UMP Plus members will pay 50% coinsurance for out-of-network providers and any amount the out-of-network provider charges over the plan's allowed amount.

[4] Amount you pay after deductible.

| Benefits (You pay) | Hospital services | | Office visit | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Inpatient | Outpatient | Primary care | Urgent care | Specialist | Mental health | Chemo-therapy | Radiation |
| **Kaiser Foundation Health Plan of the Northwest** | | | | | | | | |
| **Kaiser Permanente NW Classic**[2] | 15%[4] | 15%[4] | $25 | $45 | $35 | $25 | $0 | $0 |
| **Kaiser Permanente NW CDHP**[2] | 15%[4] | 15%[4] | $20[4] | $40[4] | $30[4] | $20[4] | $0 | $0 |
| **Kaiser Foundation Health Plan of Washington** | | | | | | | | |
| **Kaiser Permanente WA Classic** | $150/day up to $750 maximum/ admission[4] | $150[4] | $15[4] | $15[4] | $30[4] | $15[4] | $30[4] | $30[4] |
| **Kaiser Permanente WA CDHP** | 10%[4] | 10%[4] | 10%[4] | 10%[4] | 10%[4] | 10%[4] | 10%[4] | 10%[4] |
| **Kaiser Permanente WA SoundChoice** | $500/admission[4] | 15%[4] | $0 | 15%[4] | 15%[4] | 15%[4] | 15%[4] | 15%[4] |
| **Kaiser Permanente WA Value** | $250/day up to $1,250 maximum/ admission[4] | $200[4] | $30[4] | $30[4] | $50[4] | $30[4] | $50[4] | $50[4] |
| **Uniform Medical Plan (UMP)**[3] | | | | | | | | |
| **UMP Classic** | $200/day up to $600 maximum/year per person + 15% professional fees | 15% | 15% | 15% | 15% | 15% | 15% | 15% |
| **UMP CDHP** | 15% | 15% | 15% | 15% | 15% | 15% | 15% | 15% |
| **UMP Plus– PSHVN** | $200/day up to $600 maximum/year per person + 15% professional fees | 15% | $0 | 15% | 15% | 15% | 15% | 15% |
| **UMP Plus– UW Medicine ACN** | $200/day up to $600 maximum/year per person + 15% professional fees | 15% | $0 | 15% | 15% | 15% | 15% | 15% |

*(continued)*

# 2020 Medical Benefits Cost Comparison

| **Benefits** (You pay) | **Physical, occupational, and speech therapy** (per-visit cost for 60 visits/year combined) | **Prescription drugs** **Retail Pharmacy** (up to a 30-day supply) | | | | | |
|---|---|---|---|---|---|---|---|
| | | Value Tier | Tier 1 | Tier 2 | Tier 3 | Tier 4 | Tier 5 |
| **Kaiser Foundation Health Plan of the Northwest** | | | | | | | |
| **Kaiser Permanente NW Classic**[2] | $35 | — | $15 | $40 | $75 | 50% up to $150 | — |
| **Kaiser Permanente NW CDHP**[2] | $30[4] | — | $15[4] | $40[4] | $75[4] | 50% up to $150[4] | — |
| **Kaiser Foundation Health Plan of Washington** | | | | | | | |
| **Kaiser Permanente WA Classic** | $30[4] | $5 | $20 | $40[4] | 50% up to $250[4] | — | — |
| **Kaiser Permanente WA CDHP** | 10%[4] | $5[4] | $20[4] | $40[4] | 50% up to $250[4] | — | — |
| **Kaiser Permanente WA SoundChoice** | 15%*[4] | $5 | $15 | $60[4] | 50%[4] | $150[4] | 50% up to $400[4] |
| **Kaiser Permanente WA Value** | $50[4] | $5 | $25 | $50[4] | 50%[4] | $150[4] | 50% up to $400[4] |
| **Uniform Medical Plan (UMP)** | | | | | | | |
| **UMP Classic** | 15% | 5% up to $10 | 10% up to $25 | 30% up to $75 | — | — | — |
| **UMP CDHP** | 15% | 15% | 15% | 15% | — | — | — |
| **UMP Plus– PSHVN** | 15% | 5% up to $10 | 10% up to $25 | 30% up to $75 | — | — | — |
| **UMP Plus– UW Medicine ACN** | 15% | 5% up to $10 | 10% up to $25 | 30% up to $75 | — | — | — |

*Massage no longer included. Now a separate benefit with 16 visits per year.

| **Benefits** (You pay) | **Prescription drugs** **Mail order** (up to a 90-day supply unless otherwise noted) | | | | |
|---|---|---|---|---|---|
| | Value tier | Tier 1 | Tier 2 | Tier 3 | Tier 4 |
| **Kaiser Foundation Health Plan of the Northwest** | | | | | |
| **Kaiser Permanente NW Classic**[2] | — | $30 | $80 | $150 | 50% up to $150 |
| **Kaiser Permanente NW CDHP**[2] | — | $30[4] | $80[4] | $150[4] | 50% up to $150[4] |
| **Kaiser Foundation Health Plan of Washington** | | | | | |
| **Kaiser Permanente WA Classic** | $10 | $40 | $80[4] | 50% up to $750[4] | — |
| **Kaiser Permanente WA CDHP** | $10[4] | $40[4] | $80[4] | 50% up to $750[4] | — |
| **Kaiser Permanente WA SoundChoice** | $10 | $30 | $120[4] | 50%[4] | — |
| **Kaiser Permanente WA Value** | $10 | $50 | $100[4] | 50%[4] | — |
| **Uniform Medical Plan (UMP)**[3] | | | | | |
| **UMP Classic** | 5% up to $30 | 10% up to $75 | 30% up to $225 | — | — |
| **UMP CDHP** | 15% | 15% | 15% | — | — |
| **UMP Plus–PSHVN** | 5% up to $30 | 10% up to $75 | 30% up to $225 | — | — |
| **UMP Plus–UW Medicine ACN** | 5% up to $30 | 10% up to $75 | 30% up to $225 | — | — |

*(continued)*

| **Benefits** (You pay) | **Preventive care** See certificate of coverage or check with plan for full list of services. | **Spinal manipulations** | **Vision care**[5] | |
|---|---|---|---|---|
| | | | Exam (annual) | Glasses and contact lenses |
| **Kaiser Foundation Health Plan of the Northwest** | | | | |
| **Kaiser Permanente NW Classic**[2] | $0 | $35[4] Maximum 12 visits/year additional visits require prior authorization | $25 | You pay any amount over $150 every 24 months for frames, lenses, and contacts combined. |
| **Kaiser Permanente NW CDHP**[2] | $0 | $30[4] Maximum 12 visits/year additional visits require prior authorization | $20[4] | |
| **Kaiser Foundation Health Plan of Washington** | | | | |
| **Kaiser Permanente WA Classic** | $0 | $15[4] Maximum 10 visits/year | $15[4] | You pay any amount over $150 every 24 months for frames, lenses, and contacts combined. |
| **Kaiser Permanente WA CDHP** | $0 | 10%[4] Maximum 10 visits/year | 10%[4] | |
| **Kaiser Permanente WA SoundChoice** | $0 | $0 Maximum 10 visits/year | $0 | |
| **Kaiser Permanente WA Value** | $0 | $30[4] Maximum 10 visits/year | $30[4] | |
| **Uniform Medical Plan (UMP)**[3] | | | | |
| **UMP Classic** | $0 | 15% Maximum 10 visits/year | $0 You pay any amount over $65 for contact lens fitting fees. | You pay any amount over $150 every two calendar years for frames, lenses, and contacts combined. |
| **UMP CDHP** | $0 | 15% Maximum 10 visits/year | | |
| **UMP Plus–PSHVN** | $0 | 15% Maximum 10 visits/year | | |
| **UMP Plus–UW Medicine ACN** | $0 | 15% Maximum 10 visits/year | | |

[5] Contact your plan about costs for children's vision care.

# 2020 Medicare Benefits Cost Comparison

The chart below briefly compares the per-visit costs of some in-network benefits for PEBB medical plans. Some copays and coinsurance do not apply until after you have paid your annual deductible. Call the plans directly for more information on specific benefits, including preauthorization requirements and exclusions. Kaiser Permanente NW and Kaiser Permanente WA offer Medicare Advantage plans, but not in all areas. If you are in an area where a Medicare Advantage plan is not available, your plan will enroll you in its Medicare coordination plan.

| Annual Costs | Kaiser Permanente NW Senior Advantage | Kaiser Permanente WA Medicare Plan | | UMP Classic |
|---|---|---|---|---|
| | | Medicare Advantage | Original Medicare (coordinates with Medicare) | Medicare |
| | You pay | You pay | | You pay |
| **Medical deductible** | $0 | $0 | $250/person<br>$750/family | $250/person<br>$750/family |
| **Medical out-of-pocket limit**[1]<br>(See separate prescription drug out-of-pocket limit for UMP Classic) | $1,500/person<br>Your copays and coinsurance for most covered services apply (except prescription drug costs). | $2,500/person<br>Your copays and coinsurance for most covered services apply (except prescription drug costs). | $2,000/person<br>$4,000/family<br>Your medical deductible, copays, and coinsurance for all covered services apply. | $2,500/person<br>$5,000/family<br>Your medical deductible, copays, and coinsurance for most covered services apply. |
| **Prescription drug deductible** | None | None | None | $100/person<br>$300/family<br>(Tier 2) |
| **Prescription drug out-of-pocket limit**[1] | None | None | Prescription copays and coinsurance apply to the medical out-of-pocket limit. | $2,000/person<br>$4,000/family<br>Your prescription drug deductible and coinsurance for all covered prescription drugs apply. |

[1] Premiums, charges for services in excess of a benefit, charges in excess of the plan's allowed amount, coinsurance for out-of-network providers (UMP Classic), and charges for non-covered services do not apply to the out-of-pocket limits. Non-covered services include, but are not limited to, member costs above the vision and hearing aid hardware maximums.

| Benefits | Kaiser Permanente NW Senior Advantage | Kaiser Permanente WA Medicare Plan | | UMP Classic |
|---|---|---|---|---|
| | | Medicare Advantage | Original Medicare (coordinates with Medicare) | Medicare |
| | You pay | You pay | | You pay |
| **Ambulance**<br>Per trip, air or ground | $50 | $150 | 20% | 20% |
| **Diagnostic tests, laboratory, and x-rays** | $0 | $0 | $0<br>MRI/CT/PET scan $30 | 15% |
| **Durable medical equipment, supplies, and prosthetics** | $0 | 20% | 20% | 15% |
| **Emergency room**<br>Copay waived if admitted | $50 | $65 | $250 | $75 + 15% |
| **Hearing**<br>Routine annual exam | $30 | $20 | Primary care $15<br>Specialist $30 | $0 |
| Hardware | You pay any amount over $800 every 36 months for hearing aid rental/repair combined. | | | You pay amount over $800 every three calendar years for hearing aid rental/repair combined. |

*(continued)*

# 2020 Medicare Benefits Cost Comparison

| Benefits | Kaiser Permanente NW Senior Advantage | Kaiser Permanente WA Medicare Plan | | UMP Classic |
|---|---|---|---|---|
| | | Medicare Advantage | Original Medicare (coordinates with Medicare) | Medicare |
| | You pay | You pay | | You pay |
| **Hospital services** Inpatient | $500/admission | $200/day for the first 5 days, up to $1,000 maximum/ admission | $150/day, up to $750 maximum/ admission | $200/day, up to $600 maximum/ admission + 15% professional fees |
| Outpatient | $50 | $200 | $150 | 15% |
| **Office visit** | $30 | | | |
| Primary care | | $20 | $15 | 15% |
| Urgent care | $35 | $20 | $15 | 15% |
| Specialist | $30 | $20 | $30 | 15% |
| Mental health | $30 | $20 | $15 | 15% |
| Chemotherapy | $0 | $0 | $30 | 15% |
| Radiation | $0 | $0 | $30 | 15% |
| **Physical, occupational, and speech therapy** | $30 | $20 | $30 (Per-visit cost for 60 visits/year combined) | 15% (60 combined visits per year) |
| **Prescription drugs** | — | | | |
| Retail pharmacy (up to a 30-day supply) — includes Medicare-approved diabetic disposable supplies | | | | |
| Value tier | | — | $5 | 5% up to $10 |
| Tier 1 | $20 | $20 | $20 | 10% up to $25 |
| Tier 2 | $40 | $40 | $40 | 30% up to $75 |
| Tier 3 | — | 50% up to $250 | 50% up to $250 | n/a |
| Tier 4 (preventive) | — | $0 | $0 | n/a |
| Mail order (up to a 90-day supply) | — | | | |
| Value tier | | — | $10 | 5% up to $30 |
| Tier 1 | $40 | $40 | $40 | 10% up to $75 |
| Tier 2 | $80 | $80 | $80 | 30% up to $225 |
| Tier 3 | — | 50% up to $750 | 50% up to $750 | n/a |
| **Preventive care** | $0 | $0 | $0 | $0 |
| | See certificate of coverage or check with plan for full list of services. | | | |
| **Spinal manipulations** | $30 up to 12 visits per year; additional visits require prior authorization | $20 | $15 | 15% |
| **Vision care**[2] Exam (annual) | $30 | $20 | $15 | $0 You pay any amount over $65 for contact lens fitting fees. |
| Glasses and contact lenses | You pay any amount over $150 once within a two calendar year period for frames, lenses and contacts combined. | You pay any amount over $150 every 24 months (or two calendar years for UMP) for frames, lenses, and contacts combined. | | |

[2] Contact your plan about copays and limits for children's vision care.

## Outline of Medicare Supplement Coverage
**Washington State Health Care Authority**

PREMERA | BLUE CROSS

**See Outlines of Coverage sections for detail about all plans.** This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan A available.

**Basic Benefits included in all plans:**

- **Hospitalization:** Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses:** Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require subscribers to pay a portion of Part B coinsurance or co-payments.
- **Blood:** First three pints of blood each year.
- **Hospice:** Part A coinsurance

| Plan A | Plan B | Plan C | Plan D | Plan F & Plan F* | Plan G | Plan K | Plan L | Plan M | Plan N |
|---|---|---|---|---|---|---|---|---|---|
| Basic benefits, including 100% Part B coinsurance | Basic benefits, including 100% Part B coinsurance | Basic benefits, including 100% Part B coinsurance | Basic benefits, including 100% Part B coinsurance | Basic benefits, including 100% Part B coinsurance | Basic benefits, including 100% Part B coinsurance | Hospitalization & preventive care paid at 100%; other basic benefits paid at 50% | Hospitalization & preventive care paid at 100%; other basic benefits paid at 75% | Basic benefits, including 100% Part B coinsurance | Basic including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER |
| | | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | 50% Skilled Nursing Facility Coinsurance | 75% Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance |
| | Part A Deductible | Part A Deductible | Part A Deductible | Part A Deductible | Part A Deductible | 50% Part A Deductible | 75% Part A Deductible | 50% Part A Deductible | Part A Deductible |
| | | Part B Deductible | | Part B Deductible | | | | | |
| | | | | Part B Excess (100%) | Part B Excess (100%) | | | | |
| | | Foreign Travel Emergency | Foreign Travel Emergency | Foreign Travel Emergency | Foreign Travel Emergency | | | Foreign Travel Emergency | Foreign Travel Emergency |
| | | | | | | Out of pocket limit $5,240 paid at 100% after limit reached | Out of pocket limit $2,620 paid at 100% after limit reached | | |

*Plan F also has an option called High Deductible Plan F. This high deductible plan pays the same benefits as plan F after one has paid a calendar year $2,300 deductible. Benefits from High Deductible Plan F will not begin until the out-of-pocket expenses exceed $2,300. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the contract. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

**Washington State Health Care Authority**

## SUBSCRIPTION CHARGES AND PAYMENT INFORMATION

(Rates effective January 1, 2020)

**Eligible By Reason Of Age Subscription Charges - Per Month**

| PEBB Retiree | PEBB Retiree & Spouse | State Resident | State Resident & Spouse |
|---|---|---|---|
| Plan G $97.56 | Plan G $190.06 | Plan G $185.00 | Plan G $370.00 |

**Eligible By Reason Of Disability Subscription Charges - Per Month**

| PEBB Retiree | PEBB Retiree & Spouse | State Resident | State Resident & Spouse |
|---|---|---|---|
| Plan G $162.31 | Plan G $319.56 | Plan G $314.50 | Plan G $629.00 |

Please Note: The subscription charge amount charged is the same for all plan subscribers with certificates like yours. However, the actual amount a plan subscriber pays can vary depending on if and how much the group contributes toward a particular class of subscribers' subscription charges.

### SUBSCRIPTION CHARGE INFORMATION

We (Premera) can only raise your subscription charges if we raise the subscription charges for all certificates like yours in this state.

## DISCLOSURES

Use this outline to compare benefits and subscription charges among plans.

### READ YOUR CERTIFICATE VERY CAREFULLY

This is only an outline describing your certificate's most important features. The Group policy is the insurance contract. You must read the certificate itself to understand all of the rights and duties of both you and your Medicare supplement carrier.

### RIGHT TO RETURN CERTIFICATE

If you find that you are not satisfied with your certificate, you may return it to 7001 220th St. S.W., Mountlake Terrace, Washington 98043-2124. If you send the certificate back to us within 30 days after you receive it, we will treat the certificate as if it had never been issued and all of your payments will be returned.

### CERTIFICATE REPLACEMENT

If you are replacing another health insurance certificate, do *NOT* cancel it until you have actually received your new certificate and are sure you want to keep it.

### NOTICE

This certificate may not fully cover all of your medical costs. Neither Premera nor its producers are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult *Medicare and You* for more details.

### COMPLETE ANSWERS ARE VERY IMPORTANT

Be sure to answer truthfully and completely all questions. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

## G PLAN G: MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

| SERVICES | MEDICARE PAYS | PLAN G PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** Semi-private room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,364 | $1,364 (Part A Deductible) | $0 |
| 61st through 90th day | All but $341 a day | $341 a day | $0 |
| 91st day and after: (while using 60 lifetime reserve days) | All but $682 a day | $682 a day | $0 |
| Once lifetime reserve days are used: • Additional 365 days | $0 | 100% of Medicare eligible expenses | $0*** |
| • Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st through 100th day | All but $170.50 a day | Up to $170.50 a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** | | | |
| You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited copayment / coinsurance for outpatient drugs and inpatient respite care | Medicare copayment / coinsurance | $0 |

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the carrier stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the plan's Basic Benefits. During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN G (continued):**

## G MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $185 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN G PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES**<br>In or out of the Hospital and Outpatient Hospital Treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. | | | |
| First $185 of Medicare approved amounts* | $0 | $0 | $185 (Part B Deductible) |
| Remainder of Medicare approved amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges** (above Medicare approved amounts) | $0 | 100% | $0 |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $185 of Medicare approved amounts* | $0 | $0 | $185 (Part B Deductible) |
| Remainder of Medicare approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** | | | |
| Tests for diagnostic services | 100% | $0 | $0 |
| **MEDICARE (PARTS A & B)** | | | |
| **HOME HEALTH CARE** - Medicare approved services | | | |
| **Medically Necessary Skilled Care Services and Medical Supplies** | 100% | $0 | $0 |
| **Durable Medical Equipment** | | | |
| First $185 of Medicare approved amounts* | $0 | $0 | $185 (Part B Deductible) |
| Remainder of Medicare approved amounts | 80% | 20% | $0 |
| **OTHER BENEFITS - NOT COVERED BY MEDICARE** | | | |
| **FOREIGN TRAVEL** - Not covered by Medicare<br>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA | | | |
| First $250 each calendar year | $0 | $0 | $250 |
| Remainder of charges | $0 | 80% to a lifetime maximum benefit of $50,000 | 20% and amounts over the $50,000 lifetime maximum |

## Discrimination is Against the Law

Premera Blue Cross complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Premera:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
Civil Rights Coordinator — Complaints and Appeals
PO Box 91102, Seattle, WA 98111
Toll free 855-332-4535, Fax 425-918-5592,
TTY 800-842-5357
Email AppealsDepartmentInquiries@Premera.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services,
200 Independence Ave SW, Room 509F, HHH Building
Washington, D.C. 20201, 1-800-368-1019,
800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

## Getting Help in Other Languages

**This Notice has Important Information.** This notice may have important information about your application or coverage through Premera Blue Cross. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 800-722-1471 (TTY: 800-842-5357).

**አማሪኛ (Amharic):**
ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የ Premera Blue Cross ሽፋን አስፈላጊ መረጃ ሊኖረው ይችላል። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀኖች ሊኖሩ ይችላሉ። የጤናን ሽፋንዎን ለመጠበቅና በአከፋፈል እርዳታ ለማግኘት በተውሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያገኙ እና ያለምንም ክፍያ በቋንቋዎ እርዳታ እንዲያገኙ መብት አለዎት።በስልክ ቁጥር 800-722-1471 (TTY: 800-842-5357) ይደውሉ።

**العربية (Arabic):**
**يحوي هذا الإشعار معلومات هامة.** قد يحوي هذا الإشعار معلومات مهمة بخصوص طلبك أو التغطية التي تريد الحصول عليها من خلال Premera Blue Cross. قد تكون هناك تواريخ مهمة في هذا الإشعار. وقد تحتاج لاتخاذ إجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة في دفع التكاليف. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك دون تكبد أية تكلفة.
اتصل بـ(TTY: 800-842-5357) 800-722-1471

**中文 (Chinese):**
**本通知有重要的訊息。**本通知可能有關於您透過 Premera Blue Cross 提交的申請或保險的重要訊息。本通知內可能有重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 800-722-1471
(TTY: 800-842-5357)。

**Oromoo (Cushite):**
**Beeksisni kun odeeffannoo barbaachisaa qaba.** Beeksisti kun sagantaa yookan karaa Premera Blue Cross tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qabaachuu danda'a. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa 800-722-1471 (TTY: 800-842-5357) tii bilbilaa.

**Français (French):**
**Cet avis a d'importantes informations.** Cet avis peut avoir d'importantes informations sur votre demande ou la couverture par l'intermédiaire de Premera Blue Cross. Le présent avis peut contenir des dates clés. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez le 800-722-1471 (TTY: 800-842-5357).

**Kreyòl ayisyen (Creole):**
**Avi sila a gen Enfòmasyon Enpòtan ladann**. Avi sila a kapab genyen enfòmasyon enpòtan konsènan aplikasyon w lan oswa konsènan kouvèti asirans lan atravè Premera Blue Cross. Kapab genyen dat ki enpòtan nan avi sila a. Ou ka gen pou pran kèk aksyon avan sèten dat limit pou ka kenbe kouvèti asirans sante w la oswa pou yo ka ede w avèk depans yo. Se dwa w pou resevwa enfòmasyon sa a ak asistans nan lang ou pale a, san ou pa gen pou peye pou sa. Rele nan 800-722-1471 (TTY: 800-842-5357).

**Deutsche (German):**
**Diese Benachrichtigung enthält wichtige Informationen.** Diese Benachrichtigung enthält unter Umständen wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Premera Blue Cross. Suchen Sie nach eventuellen wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 800-722-1471 (TTY: 800-842-5357).

**Hmoob (Hmong): Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb.** Tej zaum tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog koj qhov kev pab cuam los ntawm Premera Blue Cross. Tej zaum muaj cov hnub tseem ceeb uas sau rau hauv daim ntawv no. Tej zaum koj kuj yuav tau ua qee yam uas peb kom koj ua tsis pub dhau cov caij nyoog uas teev tseg rau hauv daim ntawv no mas koj thiaj yuav tau txais kev pab cuam kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom lawv muab cov ntshiab lus no uas tau muab sau ua koj hom lus pub dawb rau koj. Hu rau 800-722-1471 (TTY: 800-842-5357).

**Iloko (Ilocano): Daytoy a Pakdaar ket naglaon iti Napateg nga Impormasion.** Daytoy a pakdaar mabalin nga adda ket naglaon iti napateg nga impormasion maipanggep iti apliksayonyo wenno coverage babaen iti Premera Blue Cross. Daytoy ket mabalin dagiti importante a petsa iti daytoy a pakdaar. Mabalin nga adda rumbeng nga aramidenyo nga addang sakbay dagiti partikular a naituding nga aldaw tapno mapagtalinaedyo ti coverage ti salun-atyo wenno tulong kadagiti gastos. Adda karbenganyo a mangala iti daytoy nga impormasion ken tulong iti bukodyo a pagsasao nga awan ti bayadanyo. Tumawag iti numero nga 800-722-1471 (TTY: 800-842-5357).

**Italiano (Italian): Questo avviso contiene informazioni importanti.** Questo avviso può contenere informazioni importanti sulla tua domanda o copertura attraverso Premera Blue Cross. Potrebbero esserci date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente. Chiama 800-722-1471 (TTY: 800-842-5357).

**日本語 (Japanese): この通知には重要な情報が含まれています。**この通知には、Premera Blue Cross の申請または補償範囲に関する重要な情報が含まれている場合があります。この通知に記載されている可能性がある重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。800-722-1471 (TTY: 800-842-5357)までお電話ください。

한국어 **(Korean):**
본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Premera Blue Cross 를 통한 커버리지에 관한 정보를 포함하고 있을 수 있습니다. 본 통지서에는 핵심이 되는 날짜들이 있을 수 있습니다. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 800-722-1471 (TTY: 800-842-5357) 로 전화하십시오.

ລາວ **(Lao):**
**ແຈ້ງການນີ້ມີຂໍ້ມູນສຳຄັນ**. ແຈ້ງການນີ້ອາດຈະມີຂໍ້ມູນສຳຄັນກ່ຽວກັບຄຳຮ້ອງສະໝັກ ຫຼື ຄວາມຄຸ້ມຄອງປະກັນໄພຂອງທ່ານຜ່ານ Premera Blue Cross. ອາດຈະມີວັນທີສຳຄັນໃນແຈ້ງການນີ້. ທ່ານອາດຈະຈຳເປັນຕ້ອງດຳເນີນການຕາມກຳນົດເວລາສະເພາະເພື່ອຮັກສາຄວາມຄຸ້ມຄອງປະກັນສຸຂະພາບ ຫຼື ຄວາມຊ່ວຍເຫຼືອເລື່ອງຄ່າໃຊ້ຈ່າຍຂອງທ່ານໄວ້. ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໃຫ້ໂທຫາ 800-722-1471 (TTY: 800-842-5357).

ភាសាខ្មែរ **(Khmer):**
**សេចក្តីជូនដំណឹងនេះមានព័ត៌មានយ៉ាងសំខាន់។**
សេចក្តីជូនដំណឹងនេះប្រហែលជាមានព័ត៌មានយ៉ាងសំខាន់អំពីទម្រង់បែបបទ ឬការរ៉ាប់រងរបស់អ្នកតាមរយៈ Premera Blue Cross ។ ប្រហែលជាមានកាលបរិច្ឆេទសំខាន់នៅក្នុងសេចក្តីជូនដំណឹងនេះ។ អ្នកប្រហែលជាត្រូវការបញ្ចេញសមត្ថភាព ដល់កំណត់ថ្ងៃជាក់ច្បាស់នានា ដើម្បីនឹងរក្សាទុកការធានារ៉ាប់រងសុខភាពរបស់អ្នក ឬប្រាក់ជំនួយចេញថ្លៃ។ អ្នកមានសិទ្ធិទទួលព័ត៌មាននេះ និងជំនួយនៅក្នុងភាសារបស់អ្នកដោយមិនអស់លុយឡើយ។ សូមទូរស័ព្ទ 800-722-1471 (TTY: 800-842-5357)។

**ਪੰਜਾਬੀ (Punjabi):**
**ਇਸ ਨੋਟਿਸ ਵਿਚ ਖਾਸ ਜਾਣਕਾਰੀ ਹੈ.** ਇਸ ਨੋਟਿਸ ਵਿਚ Premera Blue Cross ਵਲੋਂ ਤੁਹਾਡੀ ਕਵਰੇਜ ਅਤੇ ਅਰਜੀ ਬਾਰੇ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਹੋ ਸਕਦੀ ਹੈ . ਇਸ ਨੋਜਿਸ ਜਵਚ ਖਾਸ ਤਾਰੀਖਾ ਹੋ ਸਕਦੀਆਂ ਹਨ. ਜੇਕਰ ਤੁਸੀ ਜਸਹਤ ਕਵਰੇਜ ਰਿੱਖਣੀ ਹੋਵੇ ਜਾ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱਚ ਮਦਦ ਦੇ ਇਛੁੱਕ ਹੋ ਤਾਂ ਤੁਹਾਨੂੰ ਅੰਤਮ ਤਾਰੀਖ਼ ਤੋਂ ਪਹਿਲਾਂ ਕੁੱਝ ਖਾਸ ਕਦਮ ਚੁੱਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ ,ਤੁਹਾਨੂੰ ਮੁਫ਼ਤ ਵਿੱਚ ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ ,ਕਾਲ 800-722-1471 (TTY: 800-842-5357).

**فارسی (Farsi):**
این اعلامیه حاوی اطلاعات مهم میباشد .این اعلامیه ممکن است حاوی اطلاعات مهم درباره فرم تقاضا و یا پوشش بیمه ای شما از طریقPremera Blue Cross باشد. به تاریخ های مهم در این اعلامیه توجه نمایید .شما ممکن است برای حفظ پوشش بیمه تان یا کمک در پرداخت هزینه های درمانی تان، به تاریخ های مشخصی برای انجام کارهای خاصی احتیاج داشته باشید .شما حق این را دارید که این اطلاعات و کمک را به زبان خود به طور رایگان دریافت نمایید. برای کسب اطلاعات با شماره 800-722-1471 (کاربران TTY تماس باشماره 800-842-5357) تماس برقرار نمایید.

**Polskie (Polish):**
**To ogłoszenie może zawierać ważne informacje.** To ogłoszenie może zawierać ważne informacje odnośnie Państwa wniosku lub zakresu świadczeń poprzez Premera Blue Cross. Prosimy zwrócic uwagę na kluczowe daty, które mogą być zawarte w tym ogłoszeniu aby nie przekroczyć terminów w przypadku utrzymania polisy ubezpieczeniowej lub pomocy związanej z kosztami. Macie Państwo prawo do bezpłatnej informacji we własnym języku. Zadzwońcie pod 800-722-1471 (TTY: 800-842-5357).

**Português (Portuguese):**
**Este aviso contém informações importantes.** Este aviso poderá conter informações importantes a respeito de sua aplicação ou cobertura por meio do Premera Blue Cross. Poderão existir datas importantes neste aviso. Talvez seja necessário que você tome providências dentro de determinados prazos para manter sua cobertura de saúde ou ajuda de custos. Você tem o direito de obter esta informação e ajuda em seu idioma e sem custos. Ligue para 800-722-1471 (TTY: 800-842-5357).

**Română (Romanian):**
**Prezenta notificare conține informații importante.** Această notificare poate conține informații importante privind cererea sau acoperirea asigurării dumneavoastre de sănătate prin Premera Blue Cross. Pot exista date cheie în această notificare. Este posibil să fie nevoie să acționați până la anumite termene limită pentru a vă menține acoperirea asigurării de sănătate sau asistența privitoare la costuri. Aveți dreptul de a obține gratuit aceste informații și ajutor în limba dumneavoastră. Sunați la 800-722-1471 (TTY: 800-842-5357).

**Русский (Russian):**
**Настоящее уведомление содержит важную информацию.** Это уведомление может содержать важную информацию о вашем заявлении или страховом покрытии через Premera Blue Cross. В настоящем уведомлении могут быть указаны ключевые даты. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 800-722-1471 (TTY: 800-842-5357).

**Fa'asamoa (Samoan):**
**Atonu ua iai i lenei fa'asilasilaga ni fa'amatalaga e sili ona taua e tatau ona e malamalama i ai.** O lenei fa'asilasilaga o se fesoasoani e fa'amatala atili i ai i le tulaga o le polokalame, Premera Blue Cross, ua e tau fia maua atu i ai. Fa'amolemole, ia e iloilo fa'alelei i aso fa'apitoa olo'o iai i lenei fa'asilasilaga taua. Masalo o le'a iai ni feau e tatau ona e faia ao le'i aulia le aso ua ta'ua i lenei fa'asilasilaga ina ia e iai pea ma maua fesoasoani mai ai i le polokalame a le Malo olo'o e iai i ai. Olo'o iai iate oe le aia tatau e maua atu i lenei fa'asilasilaga ma lenei fa'matalaga i legagana e te malamalama i ai aunoa ma se togiga tupe. Vili atu i le telefoni 800-722-1471 (TTY: 800-842-5357).

**Español (Spanish):**
**Este Aviso contiene información importante.** Es posible que este aviso contenga información importante acerca de su solicitud o cobertura a través de Premera Blue Cross. Es posible que haya fechas clave en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 800-722-1471 (TTY: 800-842-5357).

**Tagalog (Tagalog):**
**Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon.** Ang paunawa na ito ay maaaring naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Premera Blue Cross. Maaaring may mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 800-722-1471 (TTY: 800-842-5357).

**ไทย (Thai):**
ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้อาจมีข้อมูลที่สำคัญเกี่ยวกับการการสมัครหรือขอบเขตประกันสุขภาพของคุณผ่าน Premera Blue Cross และอาจมีกำหนดการในประกาศนี้ คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 800-722-1471 (TTY: 800-842-5357)

**Український (Ukrainian):**
**Це повідомлення містить важливу інформацію.** Це повідомлення може містити важливу інформацію про Ваше звернення щодо страхувального покриття через Premera Blue Cross. Зверніть увагу на ключові дати, які можуть бути вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону 800-722-1471 (TTY: 800-842-5357).

**Tiếng Việt (Vietnamese):**
**Thông báo này cung cấp thông tin quan trọng.** Thông báo này có thông tin quan trọng về đơn xin tham gia hoặc hợp đồng bảo hiểm của quý vị qua chương trình Premera Blue Cross. Xin xem ngày quan trọng trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 800-722-1471 (TTY: 800-842-5357).

# Selecting a PEBB Dental Plan

To enroll in dental, you must enroll in medical. You and any dependents must enroll in the same PEBB dental plan. Once enrolled, you must keep dental coverage for at least two years unless you defer or terminate enrollment as allowed under PEBB Program rules. If you terminate dental coverage for your dependents, they will also lose medical coverage. You may change retiree dental plans within those two years.

**Dental Plan Options**
Make sure you contact the dental plan to confirm that your dentist is part of the specific plan network and plan group.

| Plan Name | Plan Type | Plan Administrator | Plan Network | Plan Group |
|---|---|---|---|---|
| DeltaCare Plan | Managed-care plan | Delta Dental of Washington | DeltaCare | Group 3100 |
| Willamette Dental Group Plan | Managed-care plan | Willamette Dental of Washington, Inc. | Willamette Dental Group, P.C. | WA82 |
| Uniform Dental Plan (UDP) | Preferred-provider plan | Delta Dental of Washington | Delta Dental PPO | Group 3000 |

## How do the DeltaCare and Willamette Dental Group plans work?

DeltaCare is administered by Delta Dental of Washington. Its network is DeltaCare PEBB (Group 3100).

Willamette Dental Group is underwritten by Willamette Dental of Washington, Inc. Its network is Willamette Dental Group, P.C., with dental offices in Washington, Oregon, and Idaho (Group WA82).

DeltaCare and Willamette Dental Group are managed care plans. You must select and receive care from a primary care dental provider in that plan's network. Your primary care dental provider must give you a referral to see a specialist. You may change network providers at any time. Before enrolling, call the plan to make sure your dentist is in the plan's network. If you choose DeltaCare or Willamette Dental and seek services from a dentist not in the plan's network, the plan will not pay your dental 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. You pay a set amount (copay) when you receive dental services. Neither plan has an annual maximum that they pay for covered benefits (some specific exceptions apply).

## How does Uniform Dental Plan (UDP) work?

UDP is administered by Delta Dental of Washington. Its network is Delta Dental PPO (Group 3000).

UDP is a preferred-provider organization (PPO) plan. You can choose any dental provider and change providers at any time. More than three out of four dentists in Washington State participate with this PPO.

When you see a network provider, your out-of-pocket expenses are generally lower than if you chose a provider who is not part of this 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.

*(continued)*

## Before you select a plan or provider, keep these things in mind

**DeltaCare and Willamette Dental Group are managed-care plans.** You must choose a primary dental provider within their networks. If you do not, the plan will assign you one. These plans will not pay claims if you see a provider outside of their network. Before you enroll in one of these plans, be sure to check whether they have providers near you.

**UDP is a preferred-provider plan.** You may choose any dental provider, but will generally have lower out-of-pocket costs if you see network providers.

**Check with the plan (not your dentist)** to see if your dentist is in the plan's network and group. Make sure you correctly identify your dental plan's network and group number (see table on previous page). You can call the dental plan's customer service number (listed in the front of this booklet), or use their online directory.

Identify your dental plan choice on your PEBB enrollment or change form.

# 2020 Dental Benefits Comparison

For information on specific benefits and exclusions, refer to the dental plan's certificate of coverage or contact the plan directly. A PPO refers to a preferred-provider organization (network).

| Annual Costs | Preferred-provider plan | Managed-care plans | |
|---|---|---|---|
| | **Uniform Dental Plan (UDP)** *(Group 3000 Delta Dental PPO)* | **DeltaCare** *(Group 3100)* | **Willamette Dental Group** *(Group WA82)* |
| **Deductible** | You pay $50/person, $150/family | None | |
| **Plan maximum** (See specific benefit maximums below) | You pay amounts over $1,750 | No general plan maximum | |

| Benefits | Preferred-provider plan | Managed-care plans | |
|---|---|---|---|
| | **Uniform Dental Plan (UDP)** *(Group 3000 Delta Dental PPO)* | **DeltaCare** *(Group 3100)* | **Willamette Dental Group** *(Group WA82)* |
| | **You pay after deductible:** | **You pay:** | |
| **Dentures** | 50% PPO and out of state; 60% non-PPO | $140 for complete upper or lower | |
| **Root canals** (endodontics) | 20% PPO and out of state; 30% non-PPO | $100 to $150 | |
| **Nonsurgical TMJ** | 30% of costs until plan has paid $500 for PPO, out of state, or non-PPO; then any amount over $500 in member's lifetime | **DeltaCare:** 30% of costs, then any amount after plan has paid $1,000 per year, then any amount over $5,000 in member's lifetime<br>**Willamette Dental Group:** Any amount over $1,000 per year and $5,000 in member's lifetime | |
| **Oral surgery** | 20% PPO and out of state; 30% non-PPO | $10 to $50 to extract a tooth | |
| **Orthodontia** | 50% of costs until plan has paid $1,750 for PPO, out of state, or non-PPO; then any amount over $1,750 in member's lifetime (deductible doesn't apply) | Up to $1,500 copay per case | |
| **Orthognathic surgery** | 30% of costs until plan has paid $5,000 for PPO, out of state, or non-PPO; then any amount over $5,000 in member's lifetime | 30% of costs until plan has paid $5,000; then any amount over $5,000 in member's lifetime | |
| **Periodontic services** (treatment of gum disease) | 20% PPO and out of state; 30% non-PPO | $15 to $100 | |
| **Preventive/diagnostic** (deductible doesn't apply) | $0 PPO; 10% out of state; 20% non-PPO | $0 | |
| **Restorative fillings** | 20% PPO and out of state; 30% non-PPO | $10 to $50 | |
| **Restorative crowns** | 50% PPO and out of state; 60% non-PPO | $100 to $175 | |

# Life Insurance

## Can I purchase life insurance when I retire?

The PEBB Program provides life insurance to eligible members through Metropolitan Life Insurance Company (MetLife). As a PEBB retiree, you may be eligible to purchase retiree term life insurance on a self-pay basis.

## How do I continue my employee life insurance coverage?

If your PEBB employee life insurance 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.

## Who qualifies for PEBB retiree term life insurance?

Retiree term life insurance is available to subscribers who meet the eligibility and procedural requirements defined in WAC 182-12-209. Eligibility is the same as for medical and dental plans, except retiree term life insurance is only available to those who:

- Meet the PEBB Program's retiree eligibility requirements and had life insurance through the PEBB or SEBB Program as an employee; and
- Are not on a waiver of premium due to disability; and
- Return the required forms to the PEBB Program **no later than 60 days** after the date their PEBB or SEBB employee life insurance ended. (See "How do I enroll?" in the next column for details.) For elected or full-time appointed officials described in WAC 182-12-180(1), the PEBB Program must receive the required forms **no later than 60 days** after they leave public office.

Your dependents are not eligible for retiree term life insurance, and you cannot have a break in life insurance coverage.

## What amount of insurance can I buy?

Eligible PEBB retirees have the option to buy $5,000, $10,000, $15,000, or $20,000 of PEBB retiree term life insurance coverage.

## How do I enroll?

Complete the *2020 PEBB Retiree Coverage Election Form* (form A) and the MetLife *Enrollment/Change Form for Retiree Plan* to elect PEBB retiree term life insurance. The PEBB Program must receive these forms **no later than 60 days** after your PEBB or SEBB employee life insurance ends. For elected or full-time appointed officials described in WAC 182-12-180 (1), the PEBB Program must receive the required forms **no later than 60 days** after the official leaves public office.

If you enroll when eligible and pay premiums on time, insurance becomes effective the first day of the month after the date your PEBB or SEBB employee life insurance coverage ends.

## Who can I name as my beneficiary?

You may name any beneficiary you wish when you complete the MetLife *Enrollment/Change Form for Retiree Plan.* If you should die with no named living beneficiary, payment will generally be made to your survivors in this order:

1. Spouse or state-registered domestic partner
2. Children
3. Parents
4. Siblings
5. Estate

If you are married and wish to name someone other than your spouse or state-registered domestic partner as a beneficiary, or if you have special estate planning needs, you should seek legal and tax advice before naming a beneficiary on your MetLife *Enrollment/Change Form for Retiree Plan*.

You can review and update your beneficiary information to ensure your benefits are paid according to your wishes. Either go online to **mybenefits.metlife.com/wapebb** or call MetLife at 1-866-548-7139.

## How do my survivors file a claim?

If you die, your beneficiary should call MetLife at 1-866-548-7139. Your beneficiary 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 insurance certificate?

The information provided in this guide is only a brief summary of the retiree term life insurance plan. If you would like a copy of the complete insurance certificate, contact MetLife Customer Service at 1-866-548-7139 or visit **metlife.com/wshca-retirees**.

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

You have the option to convert if your life insurance:

- Ends because:
  - This group policy ends, provided you have been enrolled in life insurance for at least five continuous years; or
  - This group policy is amended to end all life insurance for an eligible class of which you are a member, provided you have been enrolled for at least five continuous years; or
- Is reduced due to a change to this group policy.

If you decide not to convert a reduction in the amount of your life insurance as described above, you will not have the option to convert that amount at a later date.

Contact MetLife at 1-866-548-7139 for more information about your conversion options.

# SmartHealth (for non-Medicare subscribers only)

SmartHealth is Washington State's voluntary wellness program that supports you on your journey toward living well. The secure website offers fun activities designed to help you reach your wellness goals, such as sleeping better, eating healthier, exercising, planning for retirement, and more. As you progress on your wellness journey, you can qualify for SmartHealth wellness incentives.

## Who is eligible?

Generally, non-Medicare subscribers and their spouses or state-registered domestic partners enrolled in PEBB medical coverage can participate in SmartHealth. However, only the subscriber can qualify for financial wellness incentives.

**Note:** If you defer PEBB medical coverage, you will not have access to SmartHealth.

Subscribers enrolled in Medicare Part A and Part B are not eligible to participate in SmartHealth. If you become eligible for Medicare Part A and Part B, you will no longer be able to access the SmartHealth website to earn points toward the wellness incentives.

## What are the wellness incentives?

Eligible non-Medicare subscribers can qualify for both wellness incentives:

1. A $25 Amazon.com gift card*
2. Either a $125 reduction in the subscriber's 2021 PEBB medical deductible, or a one-time deposit of $125 into the subscriber's health savings account (if enrolled in a PEBB consumer-directed health plan in 2021)

## How do I qualify for the wellness incentives?

To qualify for the $25 Amazon.com gift card* wellness incentive, you must:

- Not be enrolled in Medicare Part A and Part B.
- Complete the SmartHealth Well-being Assessment and claim the gift card by December 31, 2020.

To qualify for the $125 wellness incentive, you must:

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

To receive the incentive in 2021, the subscriber must still be enrolled in a PEBB medical plan in 2021.

If you earned the $125 wellness incentive in 2020, and enroll in Medicare Part A and Part B while enrolled in a PEBB medical plan after January 1, 2021, you will still receive the incentive in 2021.

The PEBB Program will work with a subscriber who cannot complete a wellness incentive requirement to provide an alternate requirement that will allow the subscriber to qualify for the wellness incentive, or will waive the requirement.

## How do I get started?

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

1. Go to **smarthealth.hca.wa.gov** and select *Get started* to walk through the activation process.
2. Take the SmartHealth Well-being Assessment (required to qualify and earn the wellness incentives). After completing the Well-being Assessment, you earn the $25 gift card wellness incentive. **Note:** If you don't have internet access, call SmartHealth Customer Service toll-free at 1-855-750-8866 (Monday through Friday, 7 a.m. to 7 p.m. Pacific Time) to complete the Well-being Assessment by phone. You do not earn SmartHealth points for completing your PEBB medical plan's health assessment.
3. Complete other activities on SmartHealth's website to earn 2,000 total points by the applicable deadline to qualify for the $125 wellness incentive.

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

## What are the deadlines?

The deadline to qualify for and claim the $25 Amazon.com gift card wellness incentive is December 31, 2020.

The deadline to meet the requirements for the $125 wellness incentive depends on when you start PEBB benefits:

- If you are continuing enrollment in PEBB medical or are a new subscriber with a PEBB medical effective date in January through September, your deadline to qualify for the wellness incentive is November 30, 2020.
- If your PEBB medical effective date is in October through December, your deadline to qualify for the wellness incentive is December 31, 2020.

# Auto and Home Insurance

The PEBB Program offers voluntary auto and home insurance through its agreement with Liberty Mutual Insurance Company, one of the largest property and casualty insurance providers in the country.

## What does Liberty Mutual offer?

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

- **Discounts** based on your driving record, age, auto safety features, and more.
- **A 12-month guarantee** on competitive rates.
- **Convenient payment options**—including automatic pension deduction (for employees), electronic funds transfer (EFT), or direct billing at home.
- **Prompt claims service** with access to local representatives.

## When can I enroll?

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

## How do I enroll?

You can request a quote for auto or home insurance from Liberty Mutual one of three ways (be sure to 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).
- Call or visit one of the local offices (see table at right).
- Look for auto/home insurance under *Additional benefits* at **hca.wa.gov/pebb-retirees**.

If you are already a Liberty Mutual policyholder and would like to save based on your group affiliation, just call one of the local offices to find out how they can convert your policy at your next renewal.

**Note:** 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.

| Contact a local Liberty Mutual office (mention client #8250): | |
|---|---|
| **Bellevue** | **1-800-253-5602**<br>11711 SE 8th St., Suite 220<br>Bellevue, WA 98005 |
| **Spokane** | **1-800-208-3044**<br>24041 E Mission Ave.<br>Liberty Lake, WA 99019 |
| **Tukwila** | **1-800-922-7013**<br>14900 Interurban Ave., Suite 142<br>Tukwila, WA 98168 |
| **Olympia** | **1-360-705-0600**<br>400 Union Ave. SE, Suite 253<br>Olympia, WA 98501 |
| **Portland, OR** | **1-800-248-8320**<br>4949 SW Meadows Rd., Suite 650<br>Lake Oswego, OR 97035 |
| **Outside Washington** | **1-800-706-5525** |

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

# PEBB Program Nondiscrimination Notice and Language Access Services

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

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

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

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

| **If you believe this organization has failed to provide language access services or discriminated in another way…** | **You can file a grievance with:** |
|---|---|
| **PEBB Program** | Health Care Authority Enterprise Risk Management Office<br>Attn: HCA ADA/Nondiscrimination Coordinator<br>PO Box 42704<br>Olympia, WA 98504-2704<br>1-855-682-0787 (TRS: 711) \| Fax 360-507-9234<br>**compliance@hca.wa.gov**<br>**hca.wa.gov/about-hca/non-discrimination-statement** |
| **PEBB MEDICAL PLANS** | |
| **Kaiser Foundation Health Plan of the Northwest** | Kaiser Foundation Health Plan of the Northwest<br>Attn: Member Relations Department<br>500 NE Multnomah, Suite 100<br>Portland, OR 97232<br>503-813-2000 (TRS: 711) \| Fax 503-813-3985 |
| **Kaiser Foundation Health Plan of Washington** | Kaiser Foundation Health Plan of Washington<br>Civil Rights Coordinator<br>Quality GNE-D1E-07<br>PO Box 9812<br>Renton, WA 98057<br>1-866-648-1928 or 206-630-0107 (TRS: 711) \| Fax 206-901-6205<br>**kp.org/wa/feedback** |
| **Premera Blue Cross**<br>(for discrimination concerns about PEBB Medicare Supplement plans and the Centers of Excellence Program for UMP Classic and UMP Consumer-Directed Health Plan [CDHP] members) | Premera Blue Cross<br>Attn: Civil Rights Coordinator - Complaints and Appeals<br>PO Box 91102<br>Seattle, WA 98111<br>1-855-332-4535 (TTY: 1-800-842-5357) \| Fax 425-918-5592<br>**AppealsDepartmentInquiries@Premera.com** |

| If you believe this organization has failed to provide language access services or discriminated in another way… | You can file a grievance with: |
|---|---|
| **Regence BlueShield**<br>(for discrimination concerns about UMP Classic, UMP CDHP, and UMP Plus) | Regence BlueShield<br>Civil Rights Coordinator<br>MS: CS B32B, PO Box 1271<br>Portland, OR 97207-1271<br>1-888-344-6347 (TRS: 711)<br>**CS@regence.com** |
| **Regence BlueShield**<br>(for discrimination concerns about UMP Classic for Medicare members) | Regence BlueShield<br>Civil Rights Coordinator<br>MS: B32AG, PO Box 1827<br>Medford, OR 97501<br>1-866-749-0355 (TRS: 711) \| Fax 1-888-309-8784<br>**medicareappeals@regence.com** |
| **Washington State Rx Services**<br>(for discrimination concerns about prescription drug benefits for Uniform Medical Plan [UMP]) | Washington State Rx Services<br>Attn: Appeals Unit<br>PO Box 40168<br>Portland, OR 97204-0168<br>1-888-361-1611 (TRS: 711) \| Fax 1-866-923-0412<br>**compliance@modahealth.com** |
| **PEBB DENTAL PLANS** | |
| **Delta Dental**<br>(for discrimination concerns about DeltaCare and the Uniform Dental Plan) | Delta Dental<br>Attn: Compliance/Privacy Officer<br>PO Box 75983<br>Seattle, WA 98175<br>1-800-554-1907 (TTY: 1-800-833-6384) \| Fax 509-685-6662<br>**memberappeals@deltadentalwa.com** |
| **Willamette Dental of Washington, Inc.**<br>(for discrimination concerns about Willamette Dental Group Plan) | Willamette Dental of Washington, Inc.<br>Attn: Member Services<br>6950 NE Campus Way<br>Hillsboro, OR 97124<br>1-855-433-6825 (TRS: 711) \| Fax 503-952-2684<br>**memberservices@willamettedental.com** |

You can also file a civil rights complaint with:

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

Washington State Health Care Authority

[English] Language assistance services, including interpreters and translation of printed materials, are available free of charge. Employees: Contact your personnel, payroll, or benefits office. Retirees, PEBB and SEBB Continuation Coverage members: Call the Health Care Authority at 1-800-200-1004 (TRS: 711).

[Amharic] የድምጽ እገዛ አገልግሎት፣ ተርጓሚዎችን እና የተተረጎሙ የታተሙ ጽሁፎችን ጨምሮ፣ በነጻ እዚህ ይገኛል። ሰራተኞች: የፐርሶኔል፣ የደመወዝ፣ ወይም የጥቅማጥቅም ቢሮውን ያናግሩ። ጡረተኞች፣ የማህበረሰብ ሰራተኞች የጥቅማጥቅም ቦርድ (PEBB) እና የትምህርት ቤት ሰራተኞች የጥቅማጥቅም ቦርድ (SEBB) ቀጣይ ሽፋን አባላት: የHealth Care Authorityን በ 1-800-200-1004 (TRS: 711) ደውለው ያነጋግሩ።

[Arabic] تتوفر المساعدة اللغوية، بما في ذلك الترجمة الفورية وترجمة المواد المطبوعة، مجانًا. الموظفون: الاتصال مع شؤون الموظفين و الرواتب و مكتب المزايا. المتقاعدون، وعضاء متابعة تغطية هيئة مزايا الموظفين الحكوميين (PEBB)، هيئة مزايا موظفي المدارس (SEBB): الاتصال على Health Care Authority على الرقم: 1-800-200-1004 (TRS: 711).

[Burmese] စကားပြန်များ၊ ပုံနှိပ်ထားသည့် စာရွက်စာတမ်းများကို ဘာသာပြန်ပေးမှုများ အပါအဝင် ဘာသာစကား အထောက်အကူပြု ဝန်ဆောင်မှုများကို အခမဲ့ စီစဉ်ဆောင်ရွက်ပေးနေပါသည်။ ဝန်ထမ်းများသည် မိမိ၏ ဝန်ထမ်း၊ လစာထုတ်ပေးသည့် ရုံး သို့မဟုတ် အကျိုးခံစားခွင့်များ စီစဉ်ပေးသည့်ရုံးကို ဆက်သွယ်ပါ။ အငြိမ်းစားယူထားသူများ၊ အစိုးရ ဝန်ထမ်းများ အကျိုးခံစားခွင့် ဘုတ်အဖွဲ့ (PEBB) နှင့် ကျောင်းဝန်ထမ်းများ အကျိုးခံစားခွင့် ဘုတ်အဖွဲ့ (SEBB) အာမခံ ဆက်လက်ခံစားရေး အဖွဲ့ဝင်များ Health Care Authority ထံ 1-800-200-1004 (TRS: 711) တွင် ဆက်သွယ်ပါ။

[Cambodian] សេវាជំនួយផ្នែកភាសា រួមទាំងអ្នកបកប្រែ និងការបកប្រែឯកសារបោះពុម្ព មានផ្តល់ជូនដោយឥតគិតថ្លៃ។ និយោជិត៖ ទាក់ទងបុគ្គលិក បញ្ជីបើកប្រាក់ខែ ឬការិយាល័យអត្ថប្រយោជន៍របស់អ្នក។ និវត្តជន សមាជិកវិបុលភាពនៃក្រុមប្រឹក្សាភិបាលផ្តល់អត្ថប្រយោជន៍ដល់បុគ្គលិកសាធារណៈ (PEBB) និងក្រុមប្រឹក្សាភិបាលផ្តល់អត្ថប្រយោជន៍ដល់បុគ្គលិកសាលារៀន (SEBB) សូមហៅទូរស័ព្ទទៅ Health Care Authority តាមរយៈលេខ 1-800-200-1004 (TRS: 711)។

[Chinese] 可免費提供語言援助服務，包括口譯及列印資料翻譯服務。僱員：請洽人事部、薪資部或福利辦公室。退休人員、(PEBB) 及學校職工福利委員會 (SEBB) 續保會員：請致電 1-800-200-1004 (TRS: 711) 聯絡 Health Care Authority。

[Korean] 통역 및 번역된 인쇄물을 포함한 언어 지원 서비스를 무료로 제공해드리고 있습니다. 고용인: 귀하의 인사부, 경리부, 복지혜택부서에 문의하여 주십시오. 은퇴자, 공무원복지혜택위원회 (PEBB) 및 교직원복지혜택위원회 (SEBB) 연속 보장 회원 Health Care Authority 전화번호 1-800-200-1004 (TRS: 711)로 문의하여 주십시오.

[Laotian] ບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ , ລວມເຖິງ ນາຍພາສາ ແລະການແປ ເອກະສານ, ແມ່ນມີໃຫ້ໂດຍບໍ່ເສັຽຄ່າ . ພະນັກງານ: ຂໍໃຫ້ຕິດຕໍ່ພະແນກບຸກຄະລາກອນ, ບັນຊີຄ່າຈ້າງ, ຫຼື ຫ້ອງການ ສິດຜົນປະໂຫດຕ່າງໆ . ຜູ້ອອກກິນເບັ ຽບໍານານ, ສະມາຊິກຜູ້ຮັບການຄຸ້ມ ຄອງຕໍ່ເນື່ອງຂອງໂຄງການ ການຈັດການດູແລສິດຜົນປະໂຫດສໍາລັບລູກຈ້າງຂອງ ຣັຖ (PEBB) ແລະ ໂຄງການການຈັດການດູ ແລສິດຜົນປະໂຫດສໍາລັບລູກຈ້າງຂອງ ໂຮງຮຽນ (SEBB): ໂທຣຕິດຕໍ່ອົງການ Health Care Authority ທີ່ເບີໂທຣ 1-800-200-1004 (TRS: 711).

[Oromo] Tajaajila deeggarsa afaanii, afaan hiikuu fi waraqawwan afaan barbaachiseti hiikuu, kafaltii kamiyu malee. Mindeffamtonni: Nama isin to'atu, galmee kaffaltii, yookiin biiroo fayyadamtan qunnama. Sorooma, miseensota Cufuu Itti fufiinsan Boordii Fayyadamtoota Mindeffamtoota Uumattaa (PEBB) fi Boordii Fayyadamtoota Mindeffamtoota mana Barumsa (SEBB): Health Care Authority bilbila 1-800-200-1004 (TRS: 711).

[Persian] خدمات کمک زبانی، شامل مترجم شفاهی و ترجمه مطالب چاپی، به صورت رایگان ارائه می‌شود. کارمندان: با دفتر پرسنل، حسابداری یا مزایای خود تماس بگیرید. بازنشستگان، اعضای پوشش مستمر هیئت عمومی مزایای کارمندان (PEBB) و هیئت مزایای کارمندان مدرسه (SEBB): با Health Care Authority به شماره 1-800-200-1004 (TRS: 711) تماس بگیرید.

[Punjabi] ਭਾਸ਼ਾ ਸਬੰਧੀ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ, ਜਿੰਨਾਂ ਵਿੱਚ ਦੁਭਾਸ਼ਿਏ ਅਤੇ ਪ੍ਰਿੰਟ ਕੀਤੀ ਹੋ ਸਮੱਗਰੀ ਦਾ ਅਨੁਵਾਦ ਕਰਨਾ ਸ਼ਾਮਲ ਹੈ, ਮੁਫ਼ਤ ਉਪਲੱਬਧ ਹਨ। ਕਰਮਚਾਰੀ: ਆਪਣੇ ਅਮਲੇ, ਤਨਖ਼ਾਹ ਜਾਂ ਫ਼ਾਇਦੀਆਂ ਦੇ ਦਫਤਰ ਨਾਲ ਸੰਪਰਕ ਕਰੋ। ਰਿਟਾਇਰ ਹੋ ਚੁੱਕੇ, PEBB ਅਤੇ SEBB ਜਾਰੀ ਰੱਖਣ ਵਾਲੇ ਕਵਰੇਜ਼ ਸਦੱਸ: Health Care Authority (ਹੈਲਥ ਕੇਅਰ ਅਥਾਰਿਟੀ) ਨੂੰ 1-800-200-1004 (TRS: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

[Romanian] Sunt disponibile în mod gratuit servicii de asistență lingvistică, inclusiv interpreții și traducerea materialelor tipărite. Angajați: contactați-vă biroul de personal, de plată a salariilor sau de beneficii. Membri pensionari, ai PEBB și ai SEBB acoperiți în continuare: apelați Health Care Authority la numărul de telefon 1-800-200-1004 (TRS: 711).

[Russian] Услуги языковой поддержки, включая устных переводчиков и перевод печатных материалов, предоставляются бесплатно. Сотрудникам: свяжитесь с вашим отделом кадров, отделом выплаты заработной платы или выплаты льгот и пособий. Пенсионеры, продление договора страхования для членов PEBB и SEBB: свяжитесь с Health Care Authority по номеру 1-800-200-1004 (TRS: 711).

[Somali] Adeegyada kaalmada luuqada, waxaa kamid ah turjumaad iyo turjubaan wixii daabacan, waxaana lagu heli karaa bilaash. Shaqaalaha: Waxaad la xidhiidhaa xafiiskaaga shaqaalaha, mushahar, ama gunooyin. Dib uga noqosho, PEBB iyo SEBB Usii Wadida Caymiska ee xubnaha: Kala Hadal Health Care Authority 1-800-200-1004 (TRS: 711).

[Spanish] Los servicios de asistencia lingüística, incluidos los intérpretes y la traducción de los materiales impresos, están disponibles de forma gratuita. Empleados: Comuníquense con su oficina de personal, de nómina o de beneficios. Jubilados, miembros de la PEBB y de la SEBB: Llamen a Health Care Authority al 1-800-200-1004 (TRS: 711).

[Swahili] Huduma za usaidizi wa lugha, ikiwemo wakalimani na tafsiri ya nyenzo zilizochapishwa, zinapatikana bila malipo. Waajiriwa: Wasiliana na ofisi yako ya wafanyakazi, malipo au manufaa. Wastaafu, wanachama wa PEBB na SEBB Continuation Coverage: Wasiliana na Health Care Authority kwa nambari 1-800-200-1004 (TRS: 711).

[Tagalog] Makakakuha ng mga walang bayad na mga serbisyo ng tulong sa wika, kasama ang mga interpreter at pagsasalin-wika ng mga naka-print na materyal. Mga empleyado: Makipag-ugnayan sa iyong opisina ng personnel, payroll, o mga benepisyo. Mga retirado, mga miyembro ng Pagpapatuloy ng Coverage ng PEBB at SEBB: Tawagan ang Health Care Authority sa 1-800-200-1004 (TRS: 711).

[Tigrigna] ናይ ቋንቋ ሓገዝ ግልጋሎታት ፣ ብሕትመት ናይ ዘለዉ ጽሑፋት ትርጉምን መተርጎምትን ሓዊሱ፣ ብዘይ ምንም ክፍሊት ንህብ ኢና። ቅፅረኛታት፦ ምስ ናይ ሰራሕተኛ ጉዳያት ኣስፈፃሚ ቢሮ፣ ምስ ቢሮ ክፍሊት መሃያ፣ ወይ ከዓ ምስ ቢሮ ጥቅማ ጥቅሚ ተራኽቡ። ጡረተኛታት፣ ናይ ህዝቢ ሰራሕተኛታት ጥቅሚ ቦርድ (PEBB)ን ናይ ትምህርቲ ትካላት ሰራሕተኛታት ጥቅሚ ቦርድ (SEBB) ኣባላት ዝኾንኩም፦ ናብ Health Care Authority በዚ 1-800-200-1004 (TRS: 711) ቁፅሪ እዚ ይደውሉ።

[Ukrainian] Послуги мовної підтримки, включаючи усних перекладачів і переклад друкованих матеріалів, надаються безкоштовно. Співробітникам: Зв'яжіться з вашим відділом кадрів, відділом виплати заробітної плати або виплати пільг і допомог. Пенсіонери, продовження договору страхування для членів Ради з виплати пільг та допомоги для державних службовців (PEBB) і Ради з виплати пільг та допомоги шкільним працівникам (SEBB): зв'яжіться з Health Care Authority за номером 1-800-200-1004 (TRS: 711).

[Vietnamese] Chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ, bao gồm thông dịch và biên dịch các tài liệu in. Nhân viên: Liên hệ với văn phòng phụ trách nhân sự, bảng lương hoặc chế độ phúc lợi. Người về hưu, hội viên hưởng Quyền Lợi Liên Tục của Ủy Ban Quyền Lợi Nhân Viên Chính Phủ (PEBB) và Ủy Ban Quyền Lợi Nhân Viên Giáo Dục (SEBB): Xin gọi đến Health Care Authority theo số 1-800-200-1004 (TRS: 711).

# Which retiree forms should I complete?

**Please use dark ink to complete the form(s).**

## Enrolling when first eligible or after deferring (postponing) coverage

Use the *2020 PEBB Retiree Coverage Election Form* (form A). Read the instruction sheet attached to the form for details.

**Step 1.** Check the enclosed *2020 PEBB Medical Plans Available by County* to find the plans available to you based on your home address.

**Step 2.** Find your medical plan choice using the table on the next page. Complete the form(s) listed there in addition to Form A. Include all eligible dependents you wish to enroll.

**Step 3.** Submit the form(s) to the PEBB Program. We must receive your form(s) and any other requested documents, such as proof of dependent eligibility, by the deadline.

## Deferring (postponing) enrollment when you're first eligible

Use the *2020 PEBB Retiree Coverage Election Form* (form A). Read the instruction sheet attached to the form for details.

**Step 1.** Complete all sections marked "Required," as well as Sections 1 and 7. Also complete Sections 5 and 6 if they apply to you. **Note:** You must maintain continuous enrollment in qualifying medical coverage if you wish to enroll in a PEBB retiree health plan in the future.

**Step 2.** Submit the form to the PEBB Program. We must receive it by the deadline listed in the instructions sheet that applies to you.

### Need help with Form A?

Check out our online tutorial for Form A at **hca.wa.gov/pebb-retirees**. It walks you through the form at your own pace while offering specific help for each section.

## Making changes to your existing account

Use the *2020 PEBB Retiree Coverage Change Form* (form E). Read the instruction sheet attached to the form for details.

**Step 1.** If you are changing medical plans, check the enclosed *2020 PEBB Medical Plans Available by County* to make sure the new plan is available based on your home address.

**Step 2.** Find your medical plan choice in the table on the next page. Complete the form(s) listed there in addition to Form E. Include all eligible dependents you wish to enroll or continue covering.

**Step 3.** Submit the form(s) and any other requested documents to the PEBB Program by the deadline.

## Deferring or terminating your coverage after you have already enrolled

Use the *2020 PEBB Retiree Coverage Change Form* (form E). Read the instruction sheet attached to the form for details.

**Step 1.** Complete Sections 1, 2, and 8 on Form E. If deferring, you must maintain continuous enrollment in qualifying medical coverage if you wish to enroll in a PEBB retiree health plan in the future.

**Step 2.** If you or a dependent is enrolled in a Medicare Advantage plan, also complete the *2020 PEBB Medicare Advantage Plan Disenrollment Form* (form D).

**Step 3.** Submit the forms to the PEBB Program. Your PEBB retiree health plan coverage will end on the last day of the month in which the PEBB Program receives all of your completed forms. If the forms arrive on the first day of the month, coverage will end on the previous day.

## Find the action you are taking. Choose your plan and complete the form(s) listed.

| If you are enrolling for the first time, deferring when you first become eligible, or enrolling after deferring: | |
|---|---|
| **To enroll in these plans or defer:** | **Use:** |
| • Kaiser Permanente NW* Classic or Consumer Directed Health Plan (CDHP)<br>• Kaiser Permanente WA Classic, CDHP, Original Medicare, SoundChoice, or Value<br>• Uniform Medical Plan (UMP) Classic, UMP CDHP<br>• UMP Plus–Puget Sound High Value Network (PSHVN) or UMP Plus–UW Medicine Accountable Care Network (ACN) | **Form A only** |
| **To enroll in these plans:** | **Use:** |
| • Kaiser Permanente NW Senior Advantage<br>• Kaiser Permanente WA Medicare Advantage | **Forms A and C** |
| • Premera Blue Cross Medicare Supplement Plan G | **Forms A and B** |

| If you are making changes, deferring, or terminating coverage (after you have already enrolled): | |
|---|---|
| **To terminate, remove a dependent, or defer from these plans:** | **Use:** |
| • Kaiser Permanente NW Senior Advantage<br>• Kaiser Permanente WA Medicare Advantage | **Forms E and D** |
| **To make changes or switch to these plans, terminate coverage, or defer:** | **Use:** |
| • Kaiser Permanente NW* Classic or CDHP<br>• Kaiser Permanente WA Classic, CDHP, Original Medicare, SoundChoice, or Value<br>• UMP Classic, UMP CDHP<br>• UMP Plus–PSHVN or UMP Plus–UW Medicine ACN | **Form E**<br>Also include **Form D** if switching out of Kaiser Permanente Medicare or Senior Advantage. |
| **To make changes or switch to these plans:** | **Use:** |
| • Kaiser Permanente NW Senior Advantage<br>• Kaiser Permanente WA Medicare Advantage | **Forms E and C** |
| • Premera Blue Cross Medicare Supplement Plan G | **Forms E and B**<br>Also include **Form D** if switching out of Kaiser Permanente Medicare or Senior Advantage. |

**Kaiser Foundation Health Plan of the Northwest offers plans in Clark and Cowlitz counties in WA and select counties in OR.*

## These forms may also be required if enrolling a dependent

| If enrolling a: | Also complete this form: |
|---|---|
| **State-registered domestic partner or their child, an extended dependent, or other non-qualified tax dependent** | *2020 PEBB Declaration of Tax Status* |
| **Dependent child with a disability** | *2020 PEBB Certification of a Child With a Disability* |
| **Extended (legal) dependent child** | *2020 PEBB Extended Dependent Certification* |

If you have questions or need additional forms, visit **hca.wa.gov/pebb-retirees** under *Forms & publications*, or call the PEBB Program at 1-800-200-1004 and select menu option 6 to request them.

# Retiree Forms Section

**2020 Retiree Election/Change (form A)**
**hca.wa.gov/assets/pebb/51-403F-retiree-election-form-2020.pdf**

**2020 Premium Surcharge Help Sheet**
**hca.wa.gov/assets/pebb/50-226-pebb-premium-surcharge-attestation-help-sheet-2020.pdf**

**Premera  Blue Cross Group Medicare Supplement Enrollment Application (form B)**
**hca.wa.gov/assets/pebb/premera-formb-2020.pdf**

**2020 Medicare Advantage Plan Election form (Form C)**
**hca.wa.gov/assets/pebb/51-576-medicare-advantage-election-form-2020.pdf**

**PEBB Medicare Advantage Plan Disenrollment Form (Form D)**
**hca.wa.gov/assets/pebb/51-556-medicare-advantage-disenrollment-form-2020.pdf**

**MetLife Retiree Enrollment/Change form**
**hca.wa.gov/assets/pebb/metlife-retiree-enrollment-change-form-2020.pdf**

**Electronic Debit Service Agreement**
**hca.wa.gov/assets/pebb/42-450-pebb-electronic-debit-service-agreement-2020.pdf**