Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Temporary changes to PEBB Continuation Coverage deadlines

Some deadlines in this document have 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 resolutions to:

- **Extend the enrollment deadline for PEBB Continuation Coverage to 30 days past the date the Governor ends the state of emergency.**
    - This means you may have extra time to enroll in PEBB Continuation Coverage. For example, if your last day to enroll 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 provide more information to you as it becomes available at **hca.wa.gov/coronavirus.**
- **Extend the maximum continuation coverage period to the last day of the second month after the date the Governor ends the state of emergency.**
    - This means that you may have PEBB Continuation Coverage longer than is described in this document.
    - If your continuation coverage period would have **ended between February 29 and the date that the state of emergency ends,** your coverage will continue to the last day of the second month after the date the state of emergency ends. For example, if your coverage period would have ended April 30, and the state of emergency ends on May 15, your coverage will be extended to July 31.
    - If your continuation coverage period would have **ended after the date the state of emergency ends, but before the two-month extension,** your coverage will only continue until the last day of the second month after the date the state of emergency ends. For example, if the state of emergency ends May 15, and your continuation coverage ends June 30, your coverage will be extended to July 31.
    - If your continuation coverage period ends **on the last day of the two-month extension (or later)**, your coverage **will not** be extended. For example, if your coverage is set to end on October 31, and the state of emergency ends on May 15, your coverage will not be extended. It is already set to end more than two months after the end of the state of emergency.

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 emergency resolutions at **hca.wa.gov/coronavirus**.

Washington State Health Care Authority

PUBLIC EMPLOYEES BENEFITS BOARD

2020 PEBB Continuation Coverage Election Notice

READ NOW

You are receiving this notice because your Public Employees Benefits Board (PEBB) Program coverage recently ended. This notice explains how you and your dependents can continue your PEBB coverage. To continue PEBB coverage, you must follow the instructions provided in this notice and complete the appropriate enclosed form(s). **The PEBB Program must receive your election form(s) no later than 60 days from the date PEBB health plan coverage ended or from the postmark date on this notice, whichever is later.** To continue life insurance under portability or conversion, complete the form sent to you by Metropolitan Life Insurance Company (MetLife). **MetLife must receive your form no later than 60 days after your employer-paid coverage ends. See Appendix A for details.**

For more information

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

Federal resources

The U.S. Department of Health and Human Services, through the Centers for Medicare & Medicaid Services (CMS), administers COBRA law as it applies to state government employers and their group health plans. For more information about your COBRA rights, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the CMS website at **cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/cobra_fact_sheet.html** or call toll free at 1-877-267-2323 and select option 6, extension 61565. You may also email CMS with questions at phig@cms.hhs.gov. For more information about health insurance options available through the Health Insurance Marketplace, visit **healthcare.gov**.

PEBB contact information

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

PEBB Program
1-800-200-1004 (toll free)
360-725-0440 (Olympia area)
711 (TRS)
Monday through Friday, 8 a.m. to 4:30 p.m.

hca.wa.gov/erb

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

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

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

Notify the PEBB Program of address changes

To protect your rights and the rights of your dependents, you must keep the PEBB Program informed of address changes for yourself and each of your dependents by calling us at 1-800-200-1004 (TRS:711) (select menu option 5), or notifying us in writing at the mailing address noted above. Please write the last four digits of your Social Security number on the notification letter so we can identify your account. You should also keep a copy of any notices you send to the PEBB Program for your records.

Where to find PEBB laws and rules

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

Table of Contents

Introduction

This notice contains important information about your and your dependents' right to continue Public Employees Benefits Board (PEBB) Program coverage, as well as other health coverage options that may be available to you, including:

- In Washington State:
  Washington Health Benefit Exchange
  wahbexchange.org or 1-855-923-4633 (TTY: 1-855-627-9604)
- Outside Washington State:
  Health Insurance Marketplace
  .healthcare.gov or 1-800-318-2596
  (TTY: 1-855-889-4325)

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

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

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

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

If you do not elect to continue coverage within these timelines, your PEBB coverage will end on the last day of the month you and your eligible dependents stop being eligible. If elected, PEBB Continuation Coverage (COBRA) or PEBB Continuation Coverage (Unpaid Leave) begins the first day of the month after the date your PEBB coverage ended.

To help process your enrollment faster, you should send your first premium payment and applicable premium surcharges with your election form(s). However, your first premium payment and applicable premium surcharges are due to HCA **no later than 45 days** after your 60-day election period ends.

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

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

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

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

How to Continue PEBB Coverage

What continuation coverage options are available?

The PEBB Program offers one or more ways for you and your dependents, if eligible, to continue PEBB coverage.

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

Premiums for the options above are on pages 14–15. To enroll, see "How do I elect PEBB Continuation Coverage?" on this page.

The PEBB Program also offers **PEBB retiree insurance coverage**—a continuation of PEBB health plan coverage available to employees and survivors who meet retiree eligibility and enrollment requirements. See "Am I eligible for PEBB retiree insurance coverage?" on page 5.

Who can elect PEBB Continuation Coverage?

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

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

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

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

How do I elect elect PEBB Continuation Coverage?

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

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

(continued)

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

If the PEBB Program does not receive your form(s) by the required 60-day deadline, your PEBB coverage will end on the last day of the month following the date of the qualifying event.

Mail to (if no payment enclosed):
PEBB Program
Health Care Authority
PO Box 42684
Olympia, WA 98504-2684

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

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

Are there other coverage options besides PEBB Continuation Coverage?

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

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

What is the Health Insurance Marketplace?

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

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

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

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

When can I enroll in Marketplace coverage?

You have 60 days from the time you lose your employer-based group health plan to enroll in the Marketplace (because losing your employer-based group health plan is a qualifying "special enrollment" event). **After 60 days, your special enrollment period ends and you may not be able to enroll; take action right away.** In addition, anyone can enroll in Marketplace coverage without a qualifying event during its open enrollment period.

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

Can I switch between PEBB Continuation Coverage and the Marketplace?

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

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

When your PEBB Continuation Coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if the Marketplace open enrollment period has ended.

If you sign up for Marketplace coverage instead of PEBB Continuation Coverage, you cannot switch to PEBB Continuation Coverage for any reason.

Can I enroll in another group health plan?

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

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

What factors should I consider when choosing coverage options?

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

- **Premiums**. Your previous health plan can charge up to 102 percent of total health plan premiums under COBRA rules. The PEBB Program charges 100 percent of the total health plan premiums for PEBB Continuation Coverage (COBRA) and PEBB Continuation Coverage (Unpaid Leave), as well as applicable tobacco use and spouse or state-registered domestic partner coverage premium surcharges. Other options, like coverage under a spouse's plan or through the Marketplace, may be less expensive.
- **Provider networks**. If you're currently getting care or treatment for a condition, a change in your health plan coverage may affect your access to a particular health care provider. You may want to check if your current health care providers participate in a health plan you're considering.
- **Drug formularies**. If you're currently taking prescription medications, a change in your health plan coverage may affect your prescription drug costs—and in some cases, your medication may not be covered by another plan. Check if your current medications are covered by the health plan you are considering.
- **Severance payments**. Under federal COBRA rules, if you lose your job and receive a severance package from your former employer, your former employer may offer to pay some or all of your PEBB Continuation Coverage (COBRA) payments for a period of time. In this scenario, contact the U.S. Department of

(continued)

Am I eligible for PEBB retiree insurance coverage?

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

- Retiring employees, including employees determined eligible for a disability retirement, and elected or full-time appointed officials leaving public office, as described in WAC 182-12-171, 182-12-180, and 182-12-211.
- Surviving dependents of emergency service personnel killed in the line of duty, as described in WAC 182-12-25
- Surviving dependents of employees, elected and full-time appointed officials, and retirees, as described in WAC 182-12-180 and 182-12-265.

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

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

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

Labor at 1-866-444-3272 (TTY: 1-877-889-5627) to discuss your options.

- **Where you live**. Some health plans limit their benefits to specific service or coverage areas. If you move to another area of the country, you may not be able to use your benefits. You may want to see if your health plan has a service or coverage area, or other similar limitations.
- **Other cost-sharing**. In addition to monthly premiums or contributions for health plan coverage, you probably pay out-of-pocket costs, such as copays, deductibles, coinsurance, or other fees when you receive health care services. Check what the cost-sharing requirements are for your health plan options. For example, one health plan option may have lower monthly premiums, but a higher deductible and higher copayments.

What if I decline PEBB Continuation Coverage?

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

How long can I remain on PEBB Continuation Coverage?

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

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

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

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

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

Employees

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

- Elect PEBB Continuation Coverage (COBRA) for up to 18 months; or
- Enroll in PEBB retiree insurance coverage, if the employee meets the retiree eligibility and procedural requirements described in WAC 182-12-171.

When the covered employee becomes entitled to Medicare **after** enrolling in PEBB Continuation Coverage (COBRA), the employee may:

- Continue health plan coverage under PEBB Continuation Coverage (COBRA) for the rest of the 18-month coverage period under PEBB Program rules; or
- Enroll in PEBB retiree insurance coverage, if the employee meets the retiree eligibility and procedural requirements described in WAC 182-12-171.

Dependents

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

For example, if a covered employee becomes entitled to Medicare eight months before their termination of employment or reduction in hours, and the employee's covered dependents elect PEBB Continuation Coverage (COBRA), the dependents may continue coverage for

28 more months after the PEBB Continuation Coverage [COBRA] enrollment date. (The 36 months allowed under PEBB Continuation Coverage (COBRA), minus the eight months the employee was entitled to Medicare before their termination of employment or reduction in hours, equals 28 months left.)

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

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

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

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

The employee may continue any combination of:

- Medical
- Dental
- Life insurance
- Accidental death and dismemberment (AD&D) insurance
- Long-term disability (LTD) insurance, only if employee is on USERRA or educational leave

An employee who is no longer eligible for PEBB Continuation Coverage (Unpaid Leave) as described above, but who has not use the maximum number of months allowed under federal COBRA rules, may continue medical, dental, or both for the remaining difference in months allowed under PEBB Continuation Coverage (COBRA). However, the employee cannot continue life, AD&D, and LTD insurance.

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

- Medical
- Dental
- Life insurance
- AD&D insurance

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

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

- Medical
- Dental
- Life insurance
- AD&D insurance

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

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

(continued)

Coverage (Unpaid Leave) generally can last for a maximum of 18 months as described in WAC 182-12-141. The employee may continue any combination of:

- Medical
- Dental
- Life insurance
- AD&D insurance

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

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

- Medical
- Dental
- Life insurance
- AD&D insurance

If the dismissal is upheld and the employee is no longer eligible for PEBB Continuation Coverage (Unpaid Leave), all insurance coverage will end at the end of the month in which the decision is entered or the date to which the premiums have been paid, whichever is later.

Employees whose dismissal is upheld and are no longer eligible as described above, and who have not used the maximum number of months allowed under federal COBRA rules, may continue medical, dental, or both for the remaining difference in months allowed under PEBB Continuation Coverage (COBRA). However, employees cannot continue life and AD&D insurance.

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

(a) When PEBB insurance coverage is lost due to the employee or retiree's death, divorce, or termination of a state-registered domestic partnership, or the dependent child losing eligibility (as described in WAC 182-12-260), PEBB Continuation Coverage (COBRA) can last up to 36 months.

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

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

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

You may be able to extend the maximum 18-month period of PEBB Continuation Coverage (COBRA) if you or a qualified dependent becomes disabled or a second qualifying event occurs. You must notify the PEBB Program of a disability or a second qualifying event to extend the continuation coverage period during the required timeframe. If you fail to provide the notice within the timeframe allowed, you will lose the right to extend continuation coverage.

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

of the covered employee's termination of employment or reduction of hours.

The disability must have started during the first 60 days of PEBB Continuation Coverage (COBRA) and must last at least until the end of the 18-month continuation coverage period.

The disability extension is available only if you notify the PEBB Program in writing and submit a *2020 PEBB Continuation Coverage (COBRA) Election/Change* form and a copy of the disability award letter from the Social Security Administration **no later than 60 days** after the last of the following events:

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

You must also provide this notice before the end of the initial 18 months of PEBB Continuation Coverage (COBRA) to be entitled to a disability extension. If the procedures in this notice are not followed, or if the notice is not submitted to the PEBB Program during the 60-day notice period and before the end of the initial 18 months of PEBB Continuation Coverage (COBRA), there will be no disability extension of PEBB Continuation Coverage (COBRA).

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

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

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

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

- Occur during the initial continuation coverage period resulting from termination of employment, reduction of hours, or the retiree's loss of PEBB retiree insurance coverage due to termination of employer group participation with PEBB health plan coverage;

AND

- Cause a qualified beneficiary* to lose coverage under PEBB Program rules if the first qualifying event had not occurred. This includes:
  - The employee's or retiree's death.
  - Divorce, annulment, or dissolution of marriage.
  - Termination of a state-registered domestic partnership.
  - The dependent child's loss of eligibility for coverage under PEBB Program rules.

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

(continued)

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

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

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

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

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

It must include:

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

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

If you are eligible for and elect to continue coverage under PEBB Continuation Coverage (Unpaid Leave), the maximum number of months allowed under PEBB Continuation Coverage (COBRA) are included in the maximum number of months allowed under PEBB Continuation Coverage (Unpaid Leave).

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

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

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

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

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

(a) Any required premium and applicable premium surcharge is not paid on time.

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

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

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

(2) Medicare entitlement or other group health plan coverage

As stated above on page 6 under PEBB Program rules, you may continue your health coverage through PEBB Continuation Coverage (COBRA) for the rest of your coverage period.

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

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

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

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

(3) A qualified beneficiary stops being disabled

If the Social Security Administration determines that a qualified beneficiary is no longer disabled, and you receive an 11-month extension of PEBB Continuation Coverage (COBRA), you must notify the PEBB Program in writing **no later than 30 days** after the Social Security Administration sends you notice of the determination. PEBB Continuation Coverage (COBRA) will end for all qualified beneficiaries either on the first day of the month that is more than 30 days after a final determination by the Social Security Administration, or the end of the coverage period that applies (without regard to the disability extension), whichever is later.

(4) Request to terminate coverage

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

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

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

How much does PEBB Continuation Coverage cost?

See monthly premiums for PEBB Continuation Coverage on pages 14–15. Generally, you are required to pay the entire cost of PEBB Continuation Coverage, similar to the total cost paid by both the employer and employee.

You will also be charged the tobacco use premium surcharge and spouse or state-registered domestic partner coverage premium surcharge in addition to your monthly medical premium if they apply to you. For more information, see "Premium surcharges" on pages 17–18.

When and how do I make payments?

First payment for PEBB Continuation Coverage

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

Your first premium payment must cover the cost of continuation coverage from the time your PEBB coverage ends through the end of the previous month and must include applicable premium surcharges. For example: Sue's employment ends on September 15, and she loses coverage on September 30. Sue elects PEBB Continuation Coverage (COBRA) on November 15. If the first payment is made in November, it must cover the premium and applicable premium surcharges for October. If Sue's first payment is made in December, it must cover premiums and applicable premium surcharges for October and November.

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

How to make monthly premium and applicable premium surcharge payments

(continued)

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

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

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

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

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

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

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

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

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

When premiums are considered paid

We consider your premiums and applicable premium surcharges paid on the date you mailed or hand delivered your payment to HCA at one of the addresses above, or submitted it through electronic debit service. If your check is returned due to insufficient funds or for any other reason, it is not considered paid.

Due dates for monthly PEBB Continuation Coverage and applicable premium surcharge payments

After you elect PEBB Continuation Coverage and make your first payment, your regular monthly payments for premiums and applicable premium surcharges are due on the 15th day of the month for that month's coverage. lf you make a premium payment on or before the 15th day of the current month, your PEBB coverage will continue for that month. If your monthly premium or applicable premium surcharges remain unpaid for 30 days, your premium payment will be delinquent and your account may be terminated depending on the amount owed.

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

Depending on your premium payment method, you may or may not receive an invoice for your PEBB Continuation Coverage premium and applicable premium surcharges as a reminder of your responsibility to make these payments on time. You must pay them on time, even if you do not receive an invoice.

Grace period for monthly premium payments

You are allowed a 30-day grace period from the date that your monthly premium or applicable premium surcharges become delinquent to pay the unpaid premium balance or premium surcharges. **If your monthly premium or applicable premium surcharges remain unpaid for 60 days from the original due date, your coverage will be terminated retroactive to the last day of the month for which the monthly premium and any applicable premium surcharges were paid.**

Monthly payments for continuing PEBB medical must be made to HCA, as well as premiums associated with continuing PEBB dental or long-term disability insurance coverage. Premiums associated with life and accidental death and dismemberment insurance coverage must be made to MetLife. After the first premium payment, premiums and applicable premium surcharges must be paid as they become due. They are considered delinquent (unpaid) if:

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

If paying the unpaid premium balance creates a hardship for you (and HCA agrees), you may request that HCA set up a payment plan for up to 12 months in duration.

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

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

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

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

Once your PEBB Continuation Coverage is terminated, you cannot reenroll.

2020 PEBB Continuation Coverage Monthly Premiums

To qualify for the Medicare premium, at least one member on your account must be enrolled in Medicare Part A and Part B. (Medicare premiums are not available to PEBB Continuation Coverage [Unpaid Leave] members.) For more information on this requirement, contact your medical plan's customer service department. For more premium information, contact the PEBB Program at 1-800-200-1004 (TRS: 711).

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

Medicare medical plan premiums								
For members enrolled in Medicare Part A and Part B	**Subscriber only**	**Subscriber and spouse[2]**		**Subscriber and child(ren)**		**Subscriber, spouse[2], 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	$342.75	$1,053.35‡‡	$680.44	$875.70‡‡	$680.44	$1,586.29‡‡	$1,213.39‡‡	$1,018.13
Kaiser Permanente WA Classic	N/A	$1,091.13	N/A‡	$904.36	N/A‡	$1,651.45	$1,243.34	N/A‡
Kaiser Permanente WA Medicare Plan	$344.04	N/A‡	$683.02	N/A‡	$683.02	N/A‡	N/A‡	$1,022.00
Kaiser Permanente WA SoundChoice	N/A	$957.47	N/A‡	$804.11	N/A‡	$1,417.55	$1,143.09	N/A‡
Kaiser Permanente WA Value	N/A	$1,014.69	N/A‡	$847.03	N/A‡	$1,517.68	$1,186.01	N/A‡
UMP Classic	$503.54	$1,178.20	$1,002.02	$1,009.53	$1,002.02	$1,684.19	$1,508.01	$1,500.50

[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.

Premera Blue Cross Medicare Supplement Plan F and Plan G premiums

	Subscriber only	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	$215.55	$895.27	$581.96	$431.10	$726.60	$1,401.26	$1,093.01	$942.15
Plan F Under age 65, eligible by disability	$366.41	$1,046.13	$581.96	$732.82	$877.46	$1,552.12	$1,093.01	$1,243.87
Plan G Age 65 or older, eligible by age	$185.00	$864.72	$499.50	$370.00	$696.05	$1,370.71	$1,010.55	$881.05
Plan G Under age 65, eligible by disability	$314.50	$994.22	$499.50	$629.00	$825.55	$1,500.21	$1,010.55	$1,140.05

[1]Or state-registered domestic partner

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

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 UMP Classic.

For more guidance on whether these premium surcharges apply to you, see the *2020 PEBB Premium Surcharge Attestation Help Sheet* at **hca.wa.gov/erb.**

Dental plan premiums	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

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).

Premium Surcharges

The following premium surcharges may apply to PEBB subscribers who:

- Are enrolled in a PEBB medical plan;

AND

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

Tobacco use premium surcharge

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

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

OR

- You do not attest to the tobacco use premium surcharge as required under PEBB Program rules.

To determine whether the tobacco use premium surcharge applies to your account, use the *2020 PEBB Premium Surcharge Attestation Help Sheet* (found on page 51) and use it to attest to the surcharge on the *2020 PEBB Continuation Coverage (COBRA) Election/Change* form or the *2020 PEBB Continuation Coverage (Unpaid Leave) Election/Change* form. The PEBB Program must receive the form by the required deadline.

Note: 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.**

To report a change

If you or your enrolled dependents' tobacco use status changes (or you or your dependents have enrolled in or accessed one of the tobacco cessation resources mentioned in the *2020 PEBB Premium Surcharge Attestation Help Sheet*), you may report the change by:

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

OR

- Submitting a *2020 PEBB Premium Surcharge Attestation Change Form* (found at **hca.wa.gov/erb** under *Forms & publications*) to the PEBB Program.

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

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

Spouse or state-registered domestic partner coverage premium surcharge

Note: If you do not enroll a spouse or state-registered domestic partner on your PEBB medical plan, or if you are enrolled in Medicare Part A and Part B as your primary coverage, this surcharge does not apply to you.

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

- You have a spouse or state-registered domestic partner enrolled on your PEBB medical, and they have chosen not to enroll in another employer-based group medical that is comparable to PEBB's Uniform Medical Plan (UMP) Classic. (This is true regardless of whether you enroll in UMP Classic.)

OR

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

If you enroll a spouse or state-registered domestic

partner on your PEBB medical plan, use the *2020 PEBB Premium Surcharge Attestation Help Sheet* (found on page 51) to determine whether the spouse or state-registered domestic partner coverage premium surcharge applies to your account. Then respond by submitting the *2020 PEBB Continuation Coverage (COBRA) Election/Change* form or *2020 PEBB Continuation Coverage (Unpaid Leave) Election/Change* form. The PEBB Program must receive the form by the required deadline.

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

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

You must update your attestation by either submitting the required *2020 PEBB Premium Surcharge Attestation Change Form* or logging in to PEBB My Account at **hca.wa.gov/my-account** and following the instructions. If your attestation is not received within the PEBB Program's timelines, you will be charged the monthly $50 premium surcharge (in addition to your monthly medical premium) for the full plan year. **You will then only be able to change your attestation if your spouse or state-registered domestic partner's employer-based group medical status changes during the year.**

To report a change

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

- When an event creates a special open enrollment to add a spouse or state-registered domestic partner to your PEBB medical, such as marriage or state-registered domestic partnership. A full list of events that allow you to add a spouse or state-registered domestic partner is available on the *2020 PEBB Continuation Coverage (COBRA) Election/Change* form or *2020 PEBB Continuation Coverage (Unpaid Leave) Election/Change* form.
- When you regain eligibility for the employer contribution for PEBB benefits.
- When there is a change in your spouse's or state-registered domestic partner's employer-based group medical.

If adding or removing a spouse or state-registered domestic partner from your PEBB medical, you must report the change by submitting a *2020 PEBB Continuation Coverage (COBRA) Election/Change* form or *2020 PEBB Continuation Coverage (Unpaid Leave) Election/Change* form. In some cases, you must provide proof of the qualifying event.

To change your current attestation (without adding or removing your spouse or state-registered domestic partner from PEBB medical), submit a *2020 PEBB Premium Surcharge Attestation Change Form* (at **hca.wa.gov/erb** under *Forms & publications*) to the PEBB Program.

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

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

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

SmartHealth

SmartHealth is Washington State's voluntary wellness program that supports you on your journey toward living well. This PEBB benefit is offered at no cost to you.

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 for SmartHealth?

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.

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 SmartHealth wellness incentives each year: a $25 Amazon.com gift card* and a $125 wellness incentive.

To get the $25 Amazon.com gift card*, eligible subscribers must complete the SmartHealth Well-being Assessment (WBA) and claim the gift card on SmartHealth before December 31, 2020. To get the $125 wellness incentive, you must complete program requirements by your deadline and still be enrolled in PEBB medical coverage as a subscriber in 2021. The $125 wellness incentive is applied in January 2021.

How the wellness incentive applies depends on what type of PEBB medical plan you choose:

- **Consumer-directed health plans (CDHP):** A one-time deposit into the subscriber's health savings account (HSA).
- **All other medical plans:** A reduction to the subscriber's PEBB medical plan deductible.

How do I qualify?

Complete these three steps within the deadlines to qualify for both wellness incentives.

1. Go to **smarthealth.hca.wa.gov**
   a. If you have never registered, click *Get Started*
   b. If you have already registered, click Sign In
2. Complete the SmartHealth Well-being Assessment (WBA) to qualify for the $25 Amazon.com gift card.
   a. You earn 800 points for completing the WBA. You can claim the gift card code the same day on SmartHealth.
   b. Join and track fun activities to earn at least 2,000 total points by your deadline to qualify for a $125 wellness incentive (applied in January 2021).

The SmartHealth contracted vendor, Limeade, will work with a subscriber who cannot complete a wellness incentive requirement in order to provide an alternative requirement that will allow the subscriber to qualify for and earn the wellness incentive or waive the requirement. See Administrative Policy 91-1 at **hca.wa.gov/pebb-rules** for details.

Note: If a subscriber qualifies for the $125 wellness incentive in 2020, and enrolls in Medicare Part A and Part B while enrolled in a PEBB medical plan after January 1, 2021, they will still receive the incentive in 2021.

**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 is **December 31, 2020.**

Your deadline to qualify for and claim the $125 wellness incentive depends on your PEBB medical effective date.

- If you are continuing enrollment in PEBB medical or are a new subscriber with a PEBB medical effective date from January to September, your deadline is **November 30, 2020**.
- If your PEBB medical effective date is from October to December, your deadline is December 31, 2020.

What if I don't have internet access?

Contact SmartHealth Customer Service to participate in SmartHealth by phone. Call 1-855-750-8866 toll-free Monday through Friday, 7 a.m. to 7 p.m. Pacific Time.

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 Attn: HCA ADA/Nondiscrimination Coordinator PO Box 42704 Olympia, WA 98504-2704 1-855-682-0787 (TRS: 711) | Fax 360-507-9234 **compliance@hca.wa.gov** **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 Attn: Member Relations Department 500 NE Multnomah, Suite 100 Portland, OR 97232 503-813-2000 (TRS: 711) | Fax 503-813-3985
Kaiser Foundation Health Plan of Washington	Kaiser Foundation Health Plan of Washington Civil Rights Coordinator Quality GNE-D1E-07 PO Box 9812 Renton, WA 98057 1-866-648-1928 or 206-630-0107 (TRS: 711) | Fax 206-901-6205 **kp.org/wa/feedback**
Premera Blue Cross (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 Attn: Civil Rights Coordinator - Complaints and Appeals PO Box 91102 Seattle, WA 98111 1-855-332-4535 (TTY: 1-800-842-5357) | Fax 425-918-5592 **AppealsDepartmentInquiries@Premera.com**

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

[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፣ የደምወዝ፣ 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، مجانا. 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။ အငြိမ်စားယူထားသူများ၊ အစုံလှ ဝန်ထမ်းများ အကျိုးခံစားခွင့် ဘုတ်အဖွဲ့ (PEBB) နှင့် ကျောင်းဝန်ထမ်းများ အကျိုးခံစားခွင့် ဘုတ်အဖွဲ့ (SEBB) အဖွဲ့ဝင်များ၊ Health Care Authority ထံ 1-800-200-1004 (TRS: 711) တွင် ဆက်သွယ်ပါ။

[Cambodian] សេវាជំនួយផ្នែកភាសា រួមទាំងអ្នកបកប្រែ និងការបកប្រែឯកសារបោះពុម្ព មានផ្តល់ជូនដោយឥតគិតថ្លៃ។ និយោជិត៖ ទាក់ទងបុគ្គលិក បញ្ជីបើកប្រាក់ខែ ឬការិយាល័យអត្ថប្រយោជន៍របស់អ្នក។ និវត្តជន សមាជិកវ៉ាប់រងបន្តនៃក្រុមប្រឹក្សាភិបាលផ្តល់អត្ថប្រយោជន៍ដល់បុគ្គលិកសាធារណៈ (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

[Laoțian] ບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ , ລວມເຖິງ ນາພາສາ ແລະການແປ ເອກະສານ, ແມ່ນມີໃຫ້ໂດ‌ບໍ່ເສັຽຄ່າ . ພະນັກງານ: ຂໍໃຫ້ຕິດຕໍ່ພະແນກບຸກຄະລາກອນ, ບັນຊີຄ່າຈ້າງ, ຫຼື ຫ້ອງການ ສິດຜົນປະໂຫດຕ່າງໆ . ຜູ້ອອກກິນເບ້ັຽບໍານານ, 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 ਦੁਭਾਸ਼ੀਏ 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).

Appendix A:
PEBB Continuation Coverage (COBRA)

Complete the *2020 PEBB Continuation Coverage (COBRA) Election/Change* form if the qualifying event is one of the following:

Employee:

- Your employment ended for any reason other than gross misconduct.
- Your hours of employment were reduced below the number of hours required to be eligible for the employer contribution toward PEBB health plan coverage.

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

Spouse:

- Your spouse (the employee or retiree) died. **Note:** You may qualify for PEBB Continuation Coverage (COBRA) or PEBB retiree insurance coverage.
- Your spouse's (the employee's) hours of employment were reduced.
- Your spouse's (the employee's) employment ended for any reason other than gross misconduct.
- You and your spouse (the employee or retiree) have experienced a divorce, annulment, or dissolution.

State-registered domestic partner:

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

Dependent child:

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

State-registered domestic partner's child:

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

Retiree or retiree's dependent:

- You are a retiree and your employer group ends participation in PEBB health plan coverage.
- You are a retiree and the Department of Retirement Systems has determined that you are no longer disabled, so your pension has stopped.
- You are a retiree and you or your dependent did not meet the procedural requirement to enroll or stay enrolled in Medicare Part A and Part B as required by PEBB Program rules.

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

Medical and dental benefits

You may elect to continue only the coverage that you were enrolled in on the day before the qualifying event (medical, dental, or both) by self-paying the premiums. Unless you make a separate election and elect to enroll separately, eligible dependents you elect to cover will be enrolled in the same PEBB medical and or PEBB dental plan you elect. To enroll, complete the enclosed *2020 PEBB Continuation Coverage (COBRA) Election/Change* form and submit it to the PEBB Program at the address shown on the form.

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

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

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

If you are eligible for this option, Navia Benefit Solutions will mail a COBRA election notice to you. Navia Benefit Solutions must receive your election **no later than 60 days** from the postmark date on Navia's COBRA election notice. You can find more information in the *2020 PEBB Medical Flexible Spending Arrangement Enrollment Guide* at **pebb.naviabenefits.com**. You may also contact Navia Benefit Solutions at 1-800-669-3539 or **customerservice@naviabenefits.com**.

Life insurance benefits

You may elect to continue life insurance one of two ways: portability or conversion

Portability coverage

If you become ineligible for PEBB Program coverage for any reason, and your Basic, Supplemental, and Dependent Term Life Insurance under MetLife terminates, you will have an opportunity to continue group term coverage ("portability") under a different policy, subject to plan design and state availability.

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

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

Conversion coverage

Generally, you can convert your group term life insurance to an individual whole life insurance policy if your coverage terminates due to loss of eligibility for employer-sponsored coverage. Conversion is available on all group life insurance coverages. MetLife will send conversion information to you, which will include instructions on how to continue coverage.

Washington State Health Care Authority

PUBLIC EMPLOYEES BENEFITS BOARD

2020 PEBB Continuation Coverage (COBRA) Election/Change

- **Type or print clearly in dark ink.** Inaccurate, incomplete, or illegible information may delay coverage.
- We must receive this form **no later than 60 days** from the date your PEBB health plan coverage ends or from the postmark date on the *PEBB Continuation Coverage Election Notice* sent to you, whichever is later.
- Your first premium payment and applicable premium surcharges are due to the Health Care Authority (HCA) **no later than 45 days** after your 60-day election period ends as described above. Premiums and applicable premium surcharges are due back to the date your other coverage ended. If we do not receive your payment within this 45-day timeframe, you will not be enrolled, and you will lose your right to PEBB Continuation Coverage.
- List eligible dependents you wish to cover or remove from coverage. This form replaces all *PEBB Continuation Coverage (COBRA) Election/Change* forms submitted in the past.
- If adding a dependent child with a disability age 26 or older, or an extended dependent, you must also include the required dependent certification form.
- All forms and documents are available at **hca.wa.gov/erb** under *Forms & publications* or by calling 1-800-200-1004 (TRS: 711) and selecting option 5.

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

Section 1: Subscriber Information

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

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

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

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

You may continue coverage you were enrolled in on the day your PEBB health plan coverage ended. If you have PEBB life insurance you wish to port or convert, call MetLife at 1-866-548-7139.

If you are enrolled in a Medical Flexible Spending Arrangement (FSA) and would like to continue it, contact Navia Benefit Solutions at 1-800-669-3539. You must elect to continue your Medical FSA **no later than 60 days** from the date on Navia's election notice, which was mailed to you.

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

Include reason _____ Terminate date _____

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

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

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

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

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

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

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

Part A (hospital) ❑ Yes ❑ No If yes, effective date _____

Part B (medical) ❑ Yes ❑ No If yes, effective date _____

If yes, proof is required. Attach a copy of your Medicare card to this form. Write your full name and the last four digits of your Social Security number on the copy. **Note:** You could face penalties if you don't enroll in Medicare Part A and Part B when you become eligible. Federal rules do not allow you to waive Medicare while on COBRA coverage.

2020 PEBB Continuation Coverage (COBRA) Election/Change

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

Premium surcharges only apply to subscribers who are not enrolled in Medicare Part A and Part B.

Tobacco use premium surcharge
The PEBB Program requires a monthly $25-per-account surcharge in addition to your monthly medical premium if you or a dependent (age 13 or older) enrolled on your PEBB medical plan uses a tobacco product. Tobacco use is defined as any use of tobacco products within the past two months except for religious or ceremonial use. If you check **Yes** or leave this section blank, you will be charged the monthly $25 premium surcharge. See the *2020 PEBB Premium Surcharge Attestation Help Sheet* available at **hca.wa.gov/erb** for instructions on how to respond.

Does the tobacco use premium surcharge apply to you? Check one:
❑ **YES, I am subject to the $25 premium surcharge.** I have used tobacco products in the past two months.
❑ **NO, I am not subject to the $25 premium surcharge.** I have not used tobacco products in the past two months, or I have enrolled in or accessed one of the tobacco cessation resources noted in the *2020 PEBB Premium Surcharge Attestation Help Sheet.*

Section 2: Spouse or state-registered domestic partner information

- List an eligible spouse or state-registered domestic partner, as defined by Washington Administrative Code 182-12-109, you wish to cover or remove from coverage.
- Dependents cannot be enrolled in two PEBB medical or dental accounts at the same time.
- If adding a state-registered domestic partner, you must also provide proof of their eligibility within the PEBB Program's enrollment timelines, or they will not be enrolled.
- A list of documents we will accept to verify the dependent's eligibility is available at **hca.wa.gov/erb**.

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

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

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

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

If terminating coverage, include reason _____ Termination date _____
If removing a spouse or state-registered domestic partner due to a divorce or dissolution of state-registered domestic partnership, attach a copy of the divorce decree or dissolution of state-registered domestic partnership.

Covered by another group medical plan? ❑ Yes ❑ No If yes, effective date _____
Covered by another group dental plan? ❑ Yes ❑ No If yes, effective date _____

Disabled under Title II (OASDI) of the Social Security Act? ❑ Yes ❑ No If yes, effective date _____
Disabled under Title XVI (SSI) of the Social Security Act? ❑ Yes ❑ No If yes, effective date _____

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

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

If yes, proof is required. Attach a copy of your spouse or state-registered domestic partner's Medicare card to this form. Write your full name and the last four digits of your Social Security number on the copy. **Note:** You could face penalties if you don't enroll in Medicare Part A and Part B when you become eligible. Federal rules do not allow you to waive Medicare while on COBRA coverage.

Premium surcharges only apply to subscribers who are not enrolled in Medicare Part A and Part B.

Tobacco Use Premium Surcharge—if enrolling in medical coverage

Does the tobacco use premium surcharge apply to your spouse or state-registered domestic partner? Check one:
❑ **YES, I am subject to the $25 premium surcharge.** This person has used tobacco products in the past two months.
❑ **NO, I am not subject to the $25 premium surcharge.** This person has not used tobacco products in the past two months, or has enrolled in or accessed one of the tobacco cessation resources noted in the *2020 PEBB Premium Surcharge Attestation Help Sheet.*

2020 PEBB Continuation Coverage (COBRA) Election/Change

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

Spouse or state-registered domestic partner coverage premium surcharge

The PEBB Program requires a monthly $50 premium surcharge in addition to your monthly medical premium if you are enrolling your spouse or state-registered domestic partner in PEBB medical and they have chosen not to enroll in another employer-based group medical that is comparable to PEBB's Uniform Medical Plan Classic. See the *2020 PEBB Premium Surcharge Attestation Help Sheet* for instructions on how to respond. If you check **Yes** below or leave this section blank, you will be charged the monthly $50 premium surcharge.

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

❑ **Yes, I am subject to the $50 premium surcharge.** I used the *2020 PEBB Premium Surcharge Attestation Help Sheet* and completed the *2020 Spousal Plan Calculator* online.

❑ **No, I am not subject to the $50 premium surcharge.** I used the *2020 PEBB Premium Surcharge Attestation Help Sheet* and if needed, completed the *2020 Spousal Plan Calculator* online.

If NO, which questions on the *2020 PEBB Premium Surcharge Attestation Help Sheet* did you check NO (if any)? Check all that apply. Question 1 is not applicable.

❑ Question 2 ❑ Question 3 ❑ Question 4 ❑ Question 5 ❑ Question 6

❑ **PEBB Program to help determine if the premium surcharge applies.** I used the *2020 PEBB Premium Surcharge Attestation Help Sheet* and am submitting a printed *2020 PEBB Spousal Plan Calculator.*

Section 3: Dependent information

List eligible dependents including children as defined in WAC 182-12-260(3). Use additional forms for more dependents.

- List eligible dependents you wish to cover or remove from coverage.
- Dependents cannot be enrolled in two PEBB medical or dental accounts at the same time.
- If adding a state-registered domestic partner's child, extended dependent, or other non-qualified tax dependent, also attach a *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).
- If enrolling an extended dependent, also attach a *2020 PEBB Extended Dependent Certification* form.
- If enrolling a dependent child with a disability age 26 or older, also attach a *2020 PEBB Certification of a Dependent Child With a Disability* form and return as instructed on the form.

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

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

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

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

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

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

If terminating coverage, include reason _____ Termination date _____

Covered by another group medical plan? ❑ Yes ❑ No If yes, effective date _____

Covered by another group dental plan? ❑ Yes ❑ No If yes, effective date _____

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

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

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

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

Part A (hospital) ❑ Yes ❑ No If yes, effective date _____

Part B (medical) ❑ Yes ❑ No If yes, effective date _____

If yes, proof is required. Attach a copy of your dependent's Medicare card to this form. Write your full name and the last four digits of your Social Security number on the copy. **Note:** You could face penalties if you don't enroll in Medicare Part A and Part B when you become eligible. Federal rules do not allow you to waive Medicare while on COBRA coverage.

Tobacco use premium surcharge – if enrolling in medical coverage

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

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

❑ **NO, I am not subject to the $25 premium surcharge.** This dependent has not used tobacco products in the past two months, or has enrolled in or accessed one of the tobacco cessation resources noted in the *2020 PEBB Premium Surcharge Attestation Help Sheet.*

(continued)

2020 PEBB Continuation Coverage (COBRA) Election/Change

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

Section 3: Dependent Information *(continued)*

B

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

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

Date of birth (mm/dd/yyyy)

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

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

If terminating coverage, include reason _____ Termination date _____

Covered by another group medical plan? ❑ Yes ❑ No If yes, effective date _____

Covered by another group dental plan? ❑ Yes ❑ No If yes, effective date _____

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

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

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

Enrolled in Medicare Part(s) A and/or B?
Part A (hospital) ❑ Yes ❑ No If yes, effective date _____
Part B (medical) ❑ Yes ❑ No If yes, effective date _____

If yes, proof is required. Attach a copy of your dependent's Medicare card to this form. Write your full name and the last four digits of your Social Security number on the copy. **Note:** You could face penalties if you don't enroll in Medicare Part A and Part B when you become eligible. Federal rules do not allow you to waive Medicare while on COBRA coverage.

Tobacco use premium surcharge – if enrolling in medical coverage
Does the tobacco use premium surcharge apply to this dependent? Check one:
❑ **YES, I am subject to the $25 premium surcharge.** This dependent has used tobacco products in the past two months.
❑ **NO, I am not subject to the $25 premium surcharge.** This dependent has not used tobacco products in the past two months, or has enrolled in or accessed one of the tobacco cessation resources noted in the *2020 PEBB Premium Surcharge Attestation Help Sheet.*

Section 4: Changes to an existing account

Are you making changes to an existing account?

❑ **Yes** If yes, what changes? *(Check all that apply in the sections below.)*
❑ **No** If no, go to Section 5.

Changes you can make anytime

Give date of event/change _____

❑ Name change ❑ Address change ❑ Terminate medical coverage ❑ Terminate dental coverage

❑ Remove dependent(s) from coverage due to loss of eligibility (divorce, dissolution of state-registered domestic partnership or legal union, death, or other loss of eligibility for PEBB benefits). **We must receive this form no later than 60 days after the last day of the month the dependent loses eligibility for health plan coverage.** If applicable, provide former dependent's new address: _____

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

All changes become effective January 1 of the following year. Check the box(es) next to the change requested.

❑ Add dependent(s) or remove dependents ❑ Change medical plan ❑ Change dental plan

(continued)

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

Section 4: Changes to an existing account *(continued)*

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

The PEBB Program only allows changes outside of annual open enrollment when an event creates a special open enrollment.

We must receive this form and proof of the event no later than 60 days after the event occurs. In most cases, the enrollment or change will be effective the first day of the month after the date of the event or the date we receive the form, whichever is later.
Give date of event _____ Check the box next to the corresponding event(s) below.

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

- ❑ Marriage, registering a state-registered domestic partnership, birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption.
- ❑ Child becomes eligible as an extended dependent through legal custody or legal guardianship. Also complete a *2020 PEBB Extended Dependent Certification* form available at **hca.wa.gov/erb**.
- ❑ Subscriber or dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act.
- ❑ Subscriber has a change in employment status that affects the subscriber's eligibility for their employer contribution toward their employer-based group health plan.
- ❑ Subscriber's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan.
- ❑ A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber.
- ❑ Subscriber or dependent becomes entitled to or loses eligibility for Medicaid or a state Children's Health Insurance Program (CHIP).
- ❑ Subscriber or dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.

Add dependent(s):

- ❑ Subscriber or dependent has a change in enrollment under another employer-based group health plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment.
- ❑ Subscriber's dependent moves from another country to live within the United States or moving from inside the United States to live in another country and that change in residence resulted in the dependent losing their health insurance.

Change medical plan and/or change dental plan:

- ❑ Subscriber or dependent has a change in residence that affects health plan availability.
- ❑ Subscriber or dependent becomes entitled to or loses eligibility for Medicare, or enrolls in or terminates enrollment in a Medicare Part D plan.
- ❑ Subscriber or dependent's current health plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account.
- ❑ Subscriber or dependent experiences a disruption of care 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).

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

(continued)

2020 PEBB Continuation Coverage (COBRA) Election/Change

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

Section 5: Medical plan selection *Check appropriate box(es).*

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

Kaiser Foundation Health Plan of the Northwest[1]
- ❑ Kaiser Permanente NW Classic[2]
- ❑ Kaiser Permanente NW Consumer-Directed Health Plan [2,5]
- ❑ Kaiser Permanente NW Senior Advantage[3]

Kaiser Foundation Health Plan of Washington[1]
- ❑ Kaiser Permanente WA Classic[7]
- ❑ Kaiser Permanente WA Consumer-Directed Health Plan[5]
- ❑ Kaiser Permanente WA Medicare Plan[3,4]
- ❑ Kaiser Permanente WA SoundChoice[6,7]
- ❑ Kaiser Permanente WA Value[7]

❑ **Premera Blue Cross Medicare Supplement Plan G**[8]

Uniform Medical Plan, administered by Regence BlueShield
- ❑ UMP Classic
- ❑ UMP Consumer-Directed Health Plan[5]

UMP Plus (select a network)
- ❑ UMP Plus–Puget Sound High Value Network[1,5]
- ❑ UMP Plus–UW Medicine Accountable Care Network [1,5]

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

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

[3] These Medicare Advantage plans are available in certain counties to Medicare members. Also complete and attach the *2020 PEBB Medicare Advantage Plan Election Form* (form C) if you live in a county where Medicare Advantage is available. (See **hca.wa.gov/erb** for medical plans available by county.)

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

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

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

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

[8] Also submit the *Group Medicare Supplement Enrollment Application* (form B) to enroll in Medicare Supplement Plan G.

Section 6: Dental plan selection *Check only one.*

Before you select a dental plan, call the plan to make sure your provider accepts the specific plan and plan group. The plans' contact information is located at the end of this form.

Preferred Provider Organization (PPO)

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

Managed-Care Plans (limited network)

❑ **DeltaCare** (Group #3100), administered by Delta Dental of Washington. You will select and receive care from a primary care dental provider in the DeltaCare network. Before you enroll, call DeltaCare at 1-800-650-1583 to verify your provider accepts the specific plan network and plan group.

❑ **Willamette Dental of Washington, Inc.** (Group WA82) You will select and receive care from a primary care dental provider in the Willamette Dental Group Plan. Before you enroll, call 1-855-433-6825 to verify your provider is in the Willamette Dental Group network.

(continued)

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

Section 7: Signature *Required*

I have received and read the *PEBB Continuation Coverage Election Notice*, including appendices. By submitting this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not update this information within the timelines in PEBB Program rules, to the extent permitted by federal and state laws, I must repay any claims paid by my health plan(s). My dependents and I may also lose PEBB benefits as of the last day of the month we were eligible. To the extent permitted by law, the PEBB Program may retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility, or do not fully pay premiums when due. In addition, I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of benefits.

If I send payment, this does not mean that I will be automatically enrolled in PEBB health plan coverage. The PEBB Program will verify eligibility for my dependents and me. If we do not qualify, I will receive a refund.

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

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

This form replaces all *PEBB Continuation Coverage (COBRA) Election/Change* forms submitted to the PEBB Program in the past.

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

Subscriber's signature_____ **Date** _____

Please sign and date this form.

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

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

2020 PEBB Program medical contractors

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

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

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

2020 PEBB Program dental contractors

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

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

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

Washington State Health Care Authority

PUBLIC EMPLOYEES BENEFITS BOARD

C

2020 Medicare Advantage Plan Election Form

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

Section 1: Subscriber information

Medical effective date (mm/dd/yyyy)				
Social Security number	Last name (as it appears on Medicare card)	First name	Middle initial	Sex ❑ M ❑ F
Permanent residential street address (required)	City	State	ZIP Code	
Mailing address (if different than above) Apt./unit number	City	State	ZIP Code	
County of residence	Date of birth (mm/dd/yyyy)	❑ Married (mm/dd/yyyy)	❑ State-registered domestic partnership/legal union (mm/dd/yyyy)	Home phone number (with area code)

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

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

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

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

Section 3: Plan choice

Kaiser Foundation Health Plan of the Northwest
❑ Kaiser Permanente NW Senior Advantage

Kaiser Foundation Health Plan of Washington
❑ Kaiser Permanente WA Medicare Advantage

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

(continued)

Please return this form by mail to:

Washington State Health Care Authority

PO Box 42684

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

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

Signature and authorization

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

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

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

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

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

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

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

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

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

Signature of authorized representative	**Date**

Name	**Relationship to retiree**
Address	**Phone**

Statement of Understanding

I understand that beginning on my effective date with the Medicare Advantage plan I have selected on the first page of this form, all medical services, with the exception of emergency or out-of-area urgently needed services, must be provided or arranged for by the plan. Services rendered without prior authorization from my Medicare Advantage plan will not be reimbursed by the plan or Medicare, except for emergency services anywhere in the world or urgently needed services outside the plan's service area (or services provided under unusual and extraordinary circumstances when I am in the service area but my contracting medical group is temporarily unavailable or inaccessible).

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

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

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

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

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

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

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

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

I understand that upon confirmation from CMS, the Medicare Advantage plan will send me written notice of my effective date of enrollment. As of my enrollment effective date, all of my routine health care must be provided for by plan-contracting medical providers. Note: Until you have received written notification of your effective date, you should not drop any supplemental insurance you have in effect now.

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

Please contact the plans listed below if you need information in another language or format.

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

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

2020 PEBB MEDICAL CONTRACTORS

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

Kaiser Foundation Health Plan of Washington
601 Union St., Suite 3100, Seattle, WA 98101-1374
1-888-901-4600 or TTY: 1-800-833-6388

Appendix B:
PEBB Continuation Coverage (Unpaid Leave)

Complete the *2020 PEBB Continuation Coverage (Unpaid Leave) Election/Change* form if you are an employee who will lose your PEBB insurance coverage because of one of the following events:

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

** You may also be entitled to continue long-term disability coverage. See page 41 for information on continuing long-term disability (LTD) coverage while on USERRA or approved educational leave.*

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

Medical and dental benefits

You may elect to continue only the coverage you were enrolled in on the day before the qualifying event (medical, dental, or both) by self-paying the premiums. Your enrolled eligible dependents will be enrolled in the same PEBB medical and or PEBB dental plan that you elect. If you do not elect PEBB Continuation Coverage (Unpaid Leave), your dependent(s) may not enroll independently because they do not have independent election rights to PEBB Continuation Coverage (Unpaid Leave). To enroll, complete the enclosed *2020 PEBB Continuation Coverage (Unpaid Leave) Election/ Change* form and submit it to the PEBB Program at the address shown at the end of the form.

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

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

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

If you are eligible for this option, your election must be received by Navia Benefit Solutions **no later than 60 days** from the date your health plan coverage ends or from the postmark date on this notice, whichever is later. You can find more information in Navia Benefits Solutions' *2020 PEBB Medical Flexible Spending Arrangement Enrollment Guide* at **pebb.naviabenefits.com**. You may also contact Navia Benefit Solutions at 1-800-669-3539 or **customerservice@naviabenefits.com**.

If you are eligible for this option, your election must be received by Navia Benefit Solutions **no later than 60 days** from the date your health plan coverage ends or from the postmark date on this notice, whichever is later. You can find more information in Navia Benefits Solutions' *2020 PEBB Medical Flexible Spending Arrangement Enrollment Guide* at **pebb.naviabenefits.com**. You may also contact Navia Benefit Solutions at 1-800-669-3539 or **customerservice@naviabenefits.com**.

Life and accidental death and dismemberment (AD&D) insurance

You may choose to continue all or part of your life and accidental death and dismemberment (AD&D) insurance coverage while on PEBB Continuation Coverage (Unpaid Leave). lf you choose to continue any part of your supplemental life and AD&D insurance coverage, you must also continue the $35,000 basic life insurance and $5,000 basic AD&D insurance at a cost of $3.95 per month.

If you do not continue your life insurance coverage and wish to reenroll when you return to work, you may need to submit evidence of insurability (Statement of Health) depending on the coverage you elected. All enrollment forms must be submitted to MetLife for processing.

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

Please note the following:

If you wish to continue spouse/state-registered domestic partner coverage

The amount of supplemental spouse/state-registered domestic partner life insurance coverage continued cannot exceed 50 percent of the employee supplemental life insurance coverage in force.

If you continue coverage while on active military duty

If you are called to active military duty in the uniformed services as defined under the Uniformed Services Employment and Reemployment Rights Act (USERRA), you may extend life insurance coverage to a maximum of 29 months after your active duty began.

lf you do not choose to continue your life and AD&D insurance coverage under one of the following options, all life and AD&D insurance coverage, including basic life insurance and basic AD&D insurance coverage paid by your employer, will end at the end of the month in which you begin active duty. There are two options for extending life and AD&D insurance coverage:

1. You can use agency-approved annual or military leave to maintain a minimum of eight hours pay status each month. Employer-sponsored basic life insurance and basic AD&D insurance will be continued. You are responsible for paying the premium for any supplemental life and AD&D coverage.
2. You can self-pay your life and AD&D insurance coverage by completing the *2020 PEBB Continuation Coverage (Unpaid Leave) Election/Change* form. You must make your premium payments directly to MetLife.

If you return to full-time employment status before the end of the 29 months in which you began active duty, you may reinstate your original coverage without evidence of insurability (Statement of Health). If you return to full-time employment status after the end of 29 months, and choose to enroll in life insurance coverage, you may be required to provide a Statement of Health.

Reinstating life insurance when you return to work

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

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

Long-term disability insurance coverage

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

Continuing LTD insurance coverage while on USERRA or educational leave

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

Reinstatement requirements

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

(continued)

USERRA or educational leave only			All other types of leave
You discontinued LTD insurance coverage while on leave	**You self-paid for LTD insurance coverage under PEBB Continuation Coverage (Unpaid Leave) and you return to active work immediately following your leave period**	**You self-paid for LTD insurance coverage under PEBB Continuation Coverage (Unpaid Leave) but did not return to active work immediately following your leave period**	**You were not eligible to continue LTD insurance coverage under PEBB Continuation Coverage (Unpaid Leave)**
To apply for supplemental LTD insurance coverage, your employer must receive your PEBB *Long Term Disability Enrollment/Change Form,* and The Standard Insurance Company must receive your PEBB *Long Term Disability Evidence of Insurability Form* **no later than 31 days** after you regain eligibility for the employer contribution. Your insurance will not become effective until approved by The Standard Insurance Company.	**If you become eligible for the employer contribution immediately following your leave during the first 29 months, your LTD insurance coverage does not end.** You do not have to submit any forms to continue the amount of coverage you had during PEBB Continuation Coverage (Unpaid Leave). **If you wish to increase your waiting period for supplemental LTD insurance coverage—**your employer must receive your PEBB *Long Term Disability Enrollment/ Change Form* **no later than 31 days** after you regain eligibility for the employer contribution. **If you wish to decrease your waiting period for supplemental LTD insurance coverage—**your employer must receive your completed PEBB *Long Term Disability Enrollment/Change Form* and The Standard Insurance Company must receive your completed PEBB *Long Term Disability Evidence of Insurability Form* after you regain eligibility for the employer contribution. The decreased waiting period would not become effective until approved by The Standard Insurance Company. Otherwise, you will continue to be enrolled in the same level of basic and supplemental LTD insurance coverage you had under PEBB Continuation Coverage (Unpaid Leave).	**If you do not immediately return to work after your approved leave period and your insurance ends—**you are eligible to enroll in basic and supplemental LTD insurance coverage the first day of the month after the day you regain eligibility for the employer contribution for PEBB benefits. Your employer must receive your PEBB *Long Term Disability Enrollment/Change Form* and The Standard Insurance Company must receive your PEBB *Long Term Disability Evidence of Insurability Form* **no later than 31 days** after becoming eligible for PEBB benefits.	Your basic and supplemental LTD insurance coverage is reinstated the first day of the month you regain eligibility for the employer contribution, to the same level of coverage you were enrolled in before your leave. You do not have to submit any forms per WAC 182-08-197 (3)(b)(ii).

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

2020 PEBB Continuation Coverage (Unpaid Leave) Election/Change

- **Type or print clearly in dark ink.** Inaccurate, incomplete, or illegible information may delay coverage.
- We must receive this form **no later than 60 days** from the date your PEBB health plan coverage ends or from the postmark date on the *PEBB Continuation Coverage Election Notice* sent to you, whichever is later.
- Your first premium payment and applicable premium surcharges are due to the Health Care Authority (HCA) **no later than 45 days** after your 60-day election period ends as described above. Premiums and applicable premium surcharges are due back to the date your other coverage ended. If we do not receive your payment within this 45-day timeframe, you will not be enrolled, and you will lose your right to PEBB Continuation Coverage.
- List eligible dependents you wish to cover or remove from coverage. This form replaces all *Continuation Coverage (Unpaid Leave) Election/Change forms* submitted in the past.
- If adding a dependent child with a disability age 26 or older, or an extended dependent, you must also include the required dependent certification form.

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

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

- ❑ Applying for disability retirement
- ❑ Layoff
- ❑ USERRA (military) leave
  Date called to duty in the uniformed services _____
- ❑ Reversion employee (for reasons other than a layoff)
- ❑ Approved Leave Without Pay (LWOP)
- ❑ Workers' compensation
- ❑ Approved educational leave
- ❑ Faculty between periods of eligibility
- ❑ Seasonal employee off-season
- ❑ Employee appealing a dismissal action

Section 1: Subscriber Information

Date employer coverage ended

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

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

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

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

If you are enrolled in a Medical Flexible Spending Arrangement and would like to continue it, contact Navia Benefit Solutions at 1-800-669-3539 **no later than 60 days** after the mailing date on the *PEBB Continuation Coverage Election Notice*.

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

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

Include reason _____ Termination date _____

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

(continued)

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

Section 1: Subscriber Information *(continued)*

Tobacco use premium surcharge

The PEBB Program requires a monthly $25-per-account premium surcharge in addition to your monthly medical premium if you or a dependent (age 13 or older) enrolled on your PEBB medical uses a tobacco product. Tobacco use is defined as any use of tobacco products within the past two months except for religious or ceremonial use. **If you check YES or leave this section blank, you will be charged the $25 premium surcharge.** See the *2020 PEBB Premium Surcharge Attestation Help Sheet* at **hca.wa.gov/erb** for instructions on how to respond.

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

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

❑ **NO, I am not subject to the $25 premium surcharge.** I have not used tobacco products in the past two months, or I have enrolled in or accessed one of the tobacco cessation resources noted in the *2020 PEBB Premium Surcharge Attestation Help Sheet.*

Section 2: Spouse or state-registered domestic partner information

- List an eligible spouse or state-registered domestic partner, as defined by Washington Administrative Code 182-12-109, you wish to cover or remove from coverage.
- Dependents cannot be enrolled in two PEBB medical or dental accounts at the same time.
- If adding a state-registered domestic partner, you must also provide proof of their eligibility within the PEBB Program's enrollment timelines, or they will not be enrolled. A list of documents we will accept to verify the dependent's eligibility is available at **hca.wa.gov/erb**.

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

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

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

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

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

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

If terminating coverage, include reason _____ Termination date _____
Attach a copy of divorce decree or dissolution of state-registered domestic partnership if removing them for this reason. To terminate life insurance, contact MetLife at 1-866-548-7139.

Tobacco use premium surcharge—if enrolling in medical coverage

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

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

❑ **NO, I am not subject to the $25 premium surcharge.** This dependent has not used tobacco products in the past two months, or has enrolled in or accessed one of the tobacco cessation resources noted in the *2020 PEBB Premium Surcharge Attestation Help Sheet*.

Spouse or state-registered domestic partner coverage premium surcharge

The PEBB Program requires a $50 premium surcharge in addition to your monthly medical premium if you are enrolling your spouse or state-registered domestic partner in PEBB medical and they have chosen not to enroll in another employer-based group medical that is comparable to PEBB's Uniform Medical Plan Classic. See the *2020 PEBB Premium Surcharge Attestation Help Sheet* for instructions on how to respond. **If you check YES below or leave this section blank, you will be charged the $50 premium surcharge.**

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

❑ **Yes, I am subject to the $50 premium surcharge.** I used the *2020 PEBB Premium Surcharge Attestation Help Sheet* and completed the *2020 PEBB Spousal Plan Calculator* online.

❑ **No, I am not subject to the $50 premium surcharge.** I used the *2020 PEBB Premium Surcharge Attestation Help Sheet* and if needed, completed the *2020 PEBB Spousal Plan Calculator* online.

If NO, which questions on the *2020 PEBB Premium Surcharge Attestation Help Sheet* did you check NO (if any)? Check all that apply.
Question 1 is not applicable. ❑ Question 2 ❑ Question 3 ❑ Question 4 ❑ Question 5 ❑ Question 6

❑ **The PEBB Program to help determine if premium surcharge applies.** I used the *2020 PEBB Premium Surcharge Attestation Help Sheet* and am submitting a printed *2020 PEBB Spousal Plan Calculator.*

2020 PEBB Continuation Coverage (Unpaid Leave) Election/Change

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

Section 3: Dependent information

List eligible dependents, including children as defined in WAC 182-12-260(3), you wish to cover or remove from coverage. Use additional forms for more dependents.

- Dependents cannot be enrolled in two PEBB medical or dental accounts at the same time.
- If adding a state-registered domestic partner's child, extended dependent, or other non-qualified tax dependent, also attach a *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).
- If enrolling an extended dependent, also attach a *2020 PEBB Extended Dependent Certification* form.
- If enrolling a dependent child with a disability age 26 or older, also submit a *2020 PEBB Certification of a Dependent Child With a Disability* form and return as instructed on the form. Read the *2020 PEBB Employee Enrollment Guide* for eligibility information.
- To terminate life insurance, contact MetLife at 1-866-548-7139.

A

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

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

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

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

If terminating coverage, include reason _____ Termination date _____

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

❑ **YES, I am subject to the $25 premium surcharge.** This dependent has used tobacco products in the past two months.
❑ **NO, I am not subject to the $25 premium surcharge.** This dependent has not used tobacco products in the past two months, or has enrolled in or accessed one of the tobacco cessation resources noted in the *2020 Premium Surcharge Attestation Help Sheet*.

B

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

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

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

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

If terminating coverage, include reason _____ Termination date _____

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

❑ **YES, I am subject to the $25 premium surcharge.** This dependent has used tobacco products in the past two months.
❑ **NO, I am not subject to the $25 premium surcharge.** This dependent has not used tobacco products in the past two months, or has enrolled in or accessed one of the tobacco cessation resources noted in the *2020 PEBB Premium Surcharge Attestation Help Sheet*.

C

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

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

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

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

If terminating coverage, include reason _____ Termination date _____

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

❑ **YES, I am subject to the $25 premium surcharge.** This dependent has used tobacco products in the past two months.
❑ **NO, I am not subject to the $25 premium surcharge.** This dependent has not used tobacco products in the past two months, or has enrolled in or accessed one of the tobacco cessation resources noted in the *2020 PEBB Premium Surcharge Attestation Help Sheet*.

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

Section 4: Changes to an existing account

Are you making changes to an existing account?

❑ **Yes** **If yes, what changes?** *(Check all that apply in the section below.)* ❑ **No** **If no, go to Section 5.**

Changes you can make anytime *Give date of event/change* _____

❑ Name change ❑ Address change ❑ Terminate medical coverage ❑ Terminate dental coverage

❑ Remove dependent(s) from coverage due to loss of eligibility (divorce, dissolution of state-registered domestic partnership or legal union, death, or other loss of eligibility for PEBB benefits.) Your personnel, payroll, or benefits office must receive this form **no later than 60 days** after the last day of the month the dependent loses eligibility. If applicable, provide former dependent's new address: _____ To terminate life insurance, contact MetLife at 1-866-548-7139.

Additional changes you can make during the PEBB Program's annual open enrollment (November 1–30)

All changes become effective January 1 of the following year.

Check the box(es) next to the change requested. ❑ Add or remove dependent(s) ❑ Change medical plan ❑ Change dental plan

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

The PEBB Program only allows changes outside of annual open enrollment when an event creates a special open enrollment. **The PEBB Program must receive this form and proof of the event no later than 60 days after the event occurs.**

In most cases, the enrollment or change will be effective the first day of the month after the event date or the date the form is received, whichever is later. Give date of event _____

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

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

❑ Marriage, registering a state-registered domestic partnership, birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption.

❑ Child becomes eligible as an extended dependent through legal custody or legal guardianship. Also complete a *2020 PEBB Extended Dependent Certification* form available at **hca.wa.gov/erb**.

❑ Subscriber or dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act.

❑ Subscriber has a change in employment status that affects the subscriber's eligibility for their employer contribution toward their employer-based group health plan.

❑ Subscriber's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan.

❑ A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber.

❑ Subscriber or dependent becomes entitled to or loses eligibility for Medicaid or a state Children's Health Insurance Program (CHIP).

❑ Subscriber or dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.

Add dependent(s):

❑ Subscriber or dependent has a change in enrollment under another employer-based group health plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment.

❑ A dependent moves from another country to live within the United States or moves from inside the United States to live in another country, and that change resulted in the dependent losing their health insurance.

Change medical plan and/or change dental plan:

❑ Subscriber or dependent has a change in residence that affects health plan availability.

❑ Subscriber or dependent becomes entitled to or loses eligibility for Medicare, or enrolls in or terminates enrollment in a Medicare Part D plan.

❑ Subscriber or dependent's current health plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account.

❑ Subscriber or dependent experiences a disruption of care 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).

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

(continued)

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

Section 5: Medical plan selection *Check only one.*

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

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

Kaiser Foundation Health Plan of Washington[1]
- ❑ Kaiser Permanente WA Classic
- ❑ Kaiser Permanente WA Consumer-Directed Health Plan
- ❑ Kaiser Permanente WA SoundChoice[3]
- ❑ Kaiser Permanente WA Value

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

[1] These plans have a specific service area. If you move out of the service area, you must change your plan; otherwise, you will have limited access to network providers and covered services. You must notify the PEBB Program **no later than 60 days** after you move.

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

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

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

Before you select a dental plan, call the plan to make sure your provider accepts the specific plan and plan group. The plans' contact information is located on page 7.

Preferred Provider Organization (PPO)

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

Managed-Care Plans (limited network)

- ❑ **DeltaCare** (Group #3100), administered by Delta Dental of Washington. You will select and receive care from a primary care dental provider in the DeltaCare network. Before you enroll, call DeltaCare at 1-800-650-1583 to verify your provider accepts the specific plan network and plan group.
- ❑ **Willamette Dental of Washington, Inc.** (Group WA82) You will select and receive care from a primary care dental provider in the Willamette Dental Group Plan. Before you enroll, call 1-855-433-6825 to verify your provider is in the Willamette Dental Group network.

(continued)

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

Section 7: Life and Accidental Death & Dismemberment (AD&D) Insurance

❑ **YES, I wish to continue** the life and AD&D insurance I had as an active employee. I understand I will need to pay MetLife for Basic Life Insurance and Basic AD&D Insurance in addition to any supplemental life and AD&D insurance I have while on PEBB Continuation Coverage (Unpaid Leave). If you wish to decrease your life and/or AD&D insurance amounts while on PEBB Continuation Coverage (Unpaid Leave), please call MetLife at 1-866-548-7139.

❑ **NO, I do not wish to continue** the life and AD&D insurance I had as an employee. I understand I must reapply for supplemental life insurance and submit evidence of insurability to MetLife when I regain eligibility. I understand that MetLife must receive my completed MetLife Enrollment/Change form through **mybenefits.metlife.com/wapebb** no later than 31 days after the date I regain eligibility.

Section 8: Long-Term Disability (LTD) Insurance

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

Current enrollment with employing agency

❑ **Basic LTD coverage** ($2.10/month)

❑ **Supplemental LTD coverage (select a waiting period)**

❑ 90-Day ❑ 180-Day ❑ 300-Day ❑ 120-Day ❑ 240-Day ❑ 360-Day

Desired enrollment while self-paying

❑ I wish to keep the same coverage I had as an employee. _____ *(initials)*

❑ I wish to keep the same Basic LTD insurance I had as an employee, and increase the supplemental LTD insurance waiting period. I understand that I must reapply for the lower waiting period under supplemental LTD insurance and submit evidence of insurability to The Standard for approval when I regain eligibility for the employer contribution. I understand that my employing agency must receive the required enrollment forms **no later than 31 days** after the date I regain eligibility. _____ *(initials)*

❑ I do **not** wish to keep the LTD insurance I had as an employee. I understand that I must reapply for the supplemental LTD insurance and submit evidence of insurability to The Standard for approval when I regain eligibility for the employer contribution. I understand that my employing agency must receive the required enrollment forms **no later than 31 days** after the date I regain eligibility. _____ *(initials)*

(continued)

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

Section 9: Signature

I have received and read the *PEBB Continuation Coverage Election Notice*, including any appendices. By submitting this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not update this information within the timelines in PEBB Program rules, to the extent permitted by federal and state laws, I must repay any claims paid by my health plan(s). My dependents and I may also lose PEBB benefits as of the last day of the month we were eligible. To the extent permitted by law, the PEBB Program may retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility, or do not fully pay premiums when due. In addition, I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of benefits.

If I send payment, this does not mean that I will be automatically enrolled in PEBB insurance coverage. The PEBB Program will verify eligibility for my dependents and me. If we do not qualify, I will receive a refund.

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

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

This form replaces all *PEBB Continuation Coverage (Unpaid Leave) Election/Change* forms I have submitted to the PEBB Program in the past.

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

Subscriber's signature _____ **Date** _____

Please sign and date this form.

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

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

2020 PEBB Program medical contractors

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

Kaiser Foundation Health Plan of Washington
601 Union St., Suite 3100, Seattle, WA 98101
1-866-648-1928 or TTY: 1-800-833-6388

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

2020 PEBB Program life insurance contractor

Metropolitan Life insurance company (MetLife)
MetLife Recordkeeping Center
PO Box 14406, Lexington, KY 40512
1-866-548-7139

2020 PEBB Program dental contractors

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

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

Willamette Dental of Washington, Inc.
6950 NE Campus Way, Hillsboro, OR 97124-5611
1-855-4DENTAL (1-855-433-6825)

2020 PEBB Program long-term disability insurance contractor

The Standard Insurance Company
900 SW Fifth Avenue Portland, OR 97204
1-800-368-2860

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

2020 PEBB Premium Surcharge Attestation Help Sheet

- Use the information below to determine whether the premium surcharges apply to you. Then attest on your 2020 PEBB enrollment form or the *2020 PEBB Premium Surcharge Attestation Change Form*.
- The premium surcharges do not apply to subscribers enrolled in PEBB dental coverage only.

Tobacco use premium surcharge

What are "tobacco products"?

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

Tobacco products do not include:

- E-cigarettes.
- Tobacco cessation aids approved by the FDA, such as:
  1. Over-the-counter nicotine replacement products for adults ages 18 and older and children under age 18 if recommended by a doctor.

Examples of over-the-counter nicotine replacement products include:

- Skin patches—generic (nicotine film), private label, or brand-name (Habitrol or Nicoderm).
- Chewing gum (also called nicotine gum)—generic (nicotine polacrilex or Thrive), private label, or brand-name (Nicorette).
- Lozenges—generic (nicotine polacrilex), private label, or brand-name (Nicorette or Commit).

2. Prescription nicotine replacement products.
   - Nasal spray or oral inhaler—brand name (Nicotrol)
   - Products not containing nicotine, such as pills— generic (buproprion hydrochloride) or brand name (Chantix or Zyban).

What is "tobacco use"?

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

The premium surcharge **will not** apply if you and all enrolled dependents ages 18 and older who use tobacco products are currently enrolled in the free tobacco cessation program through your PEBB medical plan, and any enrolled dependents ages 13 to 17 who use tobacco products have accessed resources at **teen.smokefree.gov**. Enrolled dependents ages 12 and younger are automatically defaulted to NO (non-tobacco users) and you **do not** have to attest for them. 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.**

Does this mean tobacco use within the past two months from today?

Tobacco products used within the two months before the date you submit your attestestation count as "tobacco use."

What if tobacco use changes?

You must change your attestation when:

- **Any** enrolled dependent age 13 and older starts using tobacco products.
- **All** enrolled dependents ages 13 and older have stopped using tobacco products for two months, or have enrolled in or accessed one of the tobacco cessation resources noted above.

You can change your attestation online using PEBB My Account at **hca.wa.gov/my-account** or submit a *2020 PEBB Premium Surcharge Attestation Change Form*. Changes that result in a premium surcharge will begin the first day of the month after the status change (the date you or a dependent started using tobacco products). If that day is the first of the month, the change begins on that day. Changes that result in removing a premium surcharge will begin the first day of the month after receipt of the attestation. If that day is the first of the month, the change to the surcharge begins on that day.

(continued)

Spouse or state-registered domestic partner coverage premium surcharge

If you don't have a spouse or state-registered domestic partner enrolled on your PEBB medical plan, you don't need to attest—this premium surcharge doesn't apply to you. If you have a spouse or state-registered domestic partner enrolled or you will enroll them on your 2020 PEBB medical plan, you must:

1. Answer **YES** or **NO** to the following Questions 2-6.
   AND
2. Check the corresponding box(es) on your 2020 PEBB enrollment form or *2020 PEBB Premium Surcharge Attestation Change Form*.

	Questions	YES	NO
1	Are you covering your spouse or state-registered domestic partner in a Public Employees Benefits Board (PEBB) medical plan in 2020?	✓	
2	Will they be eligible for medical coverage through their employer in 2020? (If they will not be employed in 2020, answer NO.)		
3	Will their employer offer at least one medical plan that serves their county of residence in 2020?		
4	Has your spouse or state-registered domestic partner chosen not to enroll in their employer's medical (including SEBB coverage) in 2020?		
5	Will the coverage offered by your spouse's or state-registered domestic partner's employer in 2020 NOT be through the PEBB Program or TRICARE? • Answer YES if their employer does not offer PEBB coverage or a TRICARE plan. • Answer NO if their employer offers PEBB coverage or a TRICARE plan..		
6	Will their share of the medical premium through their employer be less than $108.31 per month in 2020?		

➢ If you answered **NO** to ANY of these questions, check NO on your 2020 PEBB enrollment form or *2020 PEBB Premium Surcharge Attestation Change Form*, and check which question(s) you answered NO to. You will not be charged the premium surcharge.

➢ If you answered **YES** to ALL of these questions, you must complete steps 1 and 2 below to determine whether you will be charged the premium surcharge.

1. Your spouse or state-registered domestic partner should ask their employer for a *2020 Summary of Benefits and Coverage (SBC)* for **all** medical plans that:
   - Serve the county of residence for your spouse or state-registered domestic partner.
   - Have a monthly premium of less than $108.31 per month for the employee.
2. Use the *SBC* information to answer the questions in the *2020 PEBB Spousal Plan Calculator* online tool at **hca.wa.gov/erb**.
   Or, you can download a paper version and submit it with your 2020 PEBB enrollment form or your *2020 PEBB Premium Surcharge Attestation Change Form*.

If you don't have access to the Internet, you may request a paper version of the *2020 PEBB Spousal Plan Calculator* from your employer (if an employee). All other subscribers may call the PEBB Program at 1-800-200-1004 (TRS: 711) to request one.

If using the online *2020 PEBB Spousal Plan Calculator*:

- Enter all the information requested.
- Click the *Calculate* button.
- You will be provided with the YES or NO response to the question "Does the spouse or state-registered domestic partner coverage surcharge apply to you?" Enter this response on your 2020 PEBB enrollment form or *2020 PEBB Premium Surcharge Attestation Change Form*.

If using a paper version of the *2020 PEBB Spousal Plan Calculator*:

- Provide all the information requested.
- Check "Employer or PEBB Program to determine" on the 2020 PEBB enrollment form or *2020 PEBB Premium Surcharge Attestation Change Form*.
- Include a copy of the *2020 PEBB Spousal Plan Calculator* (not this help sheet) when you submit your form.

Your employer (for employees) or the PEBB Program (for retiree and PEBB Continuation Coverage subscribers) will use these to determine whether your spouse's or state-registered domestic partner's employer-based group medical is comparable to PEBB's UMP Classic, and if the premium surcharge will apply.

Washington State
Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

P.O. Box 42684
Olympia, WA 98504
HCA 50-801 (11/19)

READ NOW

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