Your PEBB Benefits for 2020

Employee Enrollment Guide

Washington State Health Care Authority

PUBLIC EMPLOYEES BENEFITS BOARD

HCA 50-100 (10/19)

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Now serving

Great coverage. Great care networks. Great price.

The providers in the plans below have committed to:

- Follow evidence-based treatment practices.
- Coordinate care with other providers in your plan's network.
- Meet standards about the quality of care they provide.

What does this mean for you?

- Lower out-of-pocket costs for many plans.
- Providers who communicate with each other to ensure you get the right care at the right time.
- Easy access to providers and scheduling.

Great value menu

	Monthly premiums[1] for: subscriber / subscriber, spouse[2], and child(ren)	Annual medical deductibles for: subscriber / subscriber, spouse[2], and child(ren)
Kaiser Permanente NW[3]		
Classic	$140 / $395	$300 / $900
Consumer-Directed Health Plan (CDHP) with a health savings account	$25/$79	$1,400 / $2,800
Kaiser Permanente WA		
Classic	$176 / $494	$175 / $525
Consumer-Directed Health Plan (CDHP) with a health savings account	$27 / $84	$1,400 / $2,800
SoundChoice	$42 / $126	$125 / $375
Value	$100 / $285	$250 / $750
UMP Plus		
Puget Sound High Value Network	$69 / $200	$125 / $375
UW Medicine Accountable Care Network	$69 / $200	$125 / $375

[1] Employees who work for a city, tribal government, county, educational service district, etc., must contact their personnel, payroll, or benefits office to see their monthly premiums.

[2] or state-registered domestic partner.

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

Before you enroll...

1. Find out which medical plans serve the county you live in (see pages 34 – 35).
2. Contact the plan or check their provider directory to make sure your providers are in the plan's network (see page 2).
3. Ready to pick a plan? Submit your *2020 PEBB Employee Enrollment/Change* form to your personnel, payroll, or benefits office. Your employing agency must receive your form no later than 31 days after the date you become eligible for PEBB benefits. **Note:** UW employees must use Workday.

Contact the plans

Medical Plans	Website addresses	Customer service phone numbers
Kaiser Permanente NW Classic or CDHP*	**my.kp.org/wapebb**	Portland area: 503-813-2000 All other areas: 1-800-813-2000 TTY: 711
Kaiser Permanente WA Classic, CDHP, SoundChoice, or Value	**kp.org/wa/pebb**	1-866-648-1928 TTY: 1-800-833-6388 or 711
Uniform Medical Plan (UMP) Classic or CDHP, administered by Regence BlueShield and Washington State Rx Services (WSRxS)	Medical services: Regence BlueShield **regence.com/pebb/ump** Prescription drugs: WSRxS **regence.com/ump/pebb/benefits/prescriptions**	Medical services: 1-888-849-3681 TRS: 711 Prescription drugs: 1-888-361-1611 TRS: 711
UMP Plus—Puget Sound High Value Network	**pugetsoundhighvaluenetwork.org**	1-855-776-9503 TRS: 711
UMP Plus—UW Medicine Accountable Care Network	**pebb.uwmedicine.org**	1-855-520-9500 TRS: 711

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

Dental Plans	Website addresses	Customer service phone numbers
DeltaCare, administered by Delta Dental of Washington	deltadentalwa.com/pebb	1-800-650-1583 TTY: 1-800-833-6384
Willamette Dental of Washington, Inc.	wapebb.willamettedental.com	1-855-4DENTAL (433-6825) TTY: 711
Uniform Dental Plan, administered by Delta Dental of Washington	deltadentalwa.com/pebb	1-800-537-3406 TTY: 1-800-833-6384

Additional contacts		Website addresses	Customer service phone numbers
Auto and Home Insurance	Liberty Mutual Insurance Company	**hca.wa.gov/employee-retiree-benefits/employees/auto-and-home-insurance**	1-800-706-5525
Health Savings Account Trustee	HealthEquity	**healthequity.com/pebb**	Kaiser Permanente members: 1-877-873-8823 UMP members call: 1-844-351-6853 TRS: 711
Life Insurance	Metropolitan Life (MetLife)	**mybenefits.metlife.com/wapebb**	1-866-548-7139
Long-Term Disability (LTD) Insurance	Standard Insurance Company	**n/a**	1-800-368-2860
Medical Flexible Spending Arrangement (FSA) and Dependent Care Assistance Program (DCAP)	Navia Benefit Solutions	**pebb.naviabenefits.com**	1-800-669-3539
SmartHealth	Limeade	**smarthealth.hca.wa.gov**	1-855-750-8866

Contact the health plans for help with:

- Specific benefit questions.
- Checking if your provider contracts with the plan.
- Checking if your medications are covered by the plan.
- ID cards.
- Claims.

Contact your personnel, payroll, or benefits office for help with:

- Enrollment questions and procedures, and deadlines.
- Eligibility questions and changes to your account (Medicare, divorce, etc.).
- Changing your name, address, and phone number.
- Finding forms. You can also find forms on HCA's website at **hca.wa.gov/pebb-employee** under *Forms & publications*.
- Adding or removing dependents.
- Payroll deduction information.
- Eligibility complaints or appeals.
- Life and LTD insurance eligibility and enrollment questions.
- Premium surcharge questions.

The PEBB Program is saving the green

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

Note: Your personnel, payroll, or benefits office must key your enrollment in PEBB coverage before you can access PEBB My Account.

Exception: University of Washington employees must sign up in Workday.

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Enrollment forms
- *2020 PEBB Employee Enrollment/Change*
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- *MetLife Enrollment/Change Form*
- *Long Term Disability (LTD) Enrollment/Change Form*

2020 PEBB Premium Surcharge Attestation Help Sheet **84**

Own Your Health

Need more help making decisions?
For general information and resources to help make informed health care decisions, visit Own Your Health's website at **ownyourhealthwa.org**.

HCA is committed to providing equal access to our services. If you need an accommodation, or require documents in another format, please contact your personnel, payroll, or benefits office.

You have 31 days to enroll or waive after you become eligible for PEBB benefits.

If your employing agency doesn't receive your required forms by this deadline, you will be enrolled as a single subscriber in Uniform Medical Plan Classic, Uniform Dental Plan, basic life insurance,basic accidental death and dismemberment, and basic LTD insurance.

Note: Meeting a deadline depends on when your personnel, payroll, or benefits office (or applicable vendor) receives your form or information, regardless of when you send it.

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Eligibility summary

Are you a school employee? Starting in 2020, eligible school employees (school districts, represented members of educational service districts, and charter schools) will receive their health insurance and other benefits through the School Employees Benefits Board (SEBB) Program.
Visit **hca.wa.gov/sebb-employee** to learn more.

Who's eligible for PEBB benefits?

This guide provides a general summary of employee eligibility for PEBB benefits. In this booklet, employees are also called "subscribers." Your employer will determine if you are eligible based on your specific employment circumstances, and whether you qualify for the employer contribution (see WAC 182-12-114 and 182-12-131).

Please contact your personnel, payroll, or benefits office to find out when benefits begin once you are eligible. If you disagree with their determination about your eligibility, see "PEBB Appeals" on page 25.

For details on PEBB eligibility and enrollment, refer to Chapters 182-08 and 182-12 Washington Administrative Code (WAC) at **hca.wa.gov/pebb-rules.**

Employees from an employer group under contractual agreement

Employees from an employer group (such as a county, municipality, political subdivision, tribal government, or educational service district) obtaining PEBB benefits through a contractual agreement with the Health Care Authority (HCA), should contact their personnel, payroll, or benefits office for employee eligibility criteria.

Employees

Employees are eligible for PEBB benefits upon employment if the employer anticipates the employee will work an average of at least 80 hours per month and for at least eight hours each month for more than six consecutive months.

If the employer determines the employee is ineligible, and the employee later works an average of at least 80 hours per month and at least eight hours each month for more than six consecutive months, the employee becomes eligible for PEBB benefits the first of the month after the six-month period.

If the employer changes the employee's anticipated work hours or duration of employment, and the change allows the employee to meet the criteria listed above, the employee becomes eligible for PEBB benefits when the change is made.

Employees may also "stack" or combine hours worked in more than one position to establish and keep eligibility, as long as the work is within one state agency in which the employee:

- Works two or more positions at the same time (concurrent stacking);
- Moves from one position to another (consecutive stacking); or
- Combines hours from a seasonal position and a non-seasonal position.

Employees must notify their employer if they believe they are eligible for benefits based on stacking (see WAC182-12-114 (1)(c)). Employees become eligible through stacking when they meet the criteria listed in the first paragraph of this section.

Higher-education faculty

"Faculty" means an academic employee of an institution of higher education whose workload is not defined by work hours but whose appointment, workload, and duties directly serve the institution's academic mission.

A higher-education faculty member is eligible for PEBB benefits upon employment if the employer anticipates they will work half-time or more for the entire instructional year or equivalent nine-month period.

If the employer doesn't anticipate that this will happen, then the faculty member is eligible for PEBB benefits at the beginning of the second consecutive quarter or semester of employment, in which they are anticipated to work (or has actually worked) half-time or more. (Spring and fall are considered consecutive quarters/semesters when first establishing eligibility for faculty members who work less than half-time during the summer quarter/semester.)

A faculty member who receives additional workload after the beginning of the anticipated work period (quarter, semester, or instructional year), and meets the criteria listed above, becomes eligible for PEBB benefits when the revision is made.

A faculty member may become eligible by working as faculty for more than one higher-education institution. When a faculty member works for more than one higher-education institution, they must notify all employing agencies that they may be eligible for PEBB benefits through stacking. A faculty member becomes eligible for PEBB benefits through stacking when the employer anticipates they will work half-time or more for the entire instructional year or equivalent nine-month period.

(continued)

Eligibility summary

Faculty members may continue any combination of medical, dental, life insurance, and AD&D insurance when they are between periods of eligibility by enrolling in and self-paying for PEBB Continuation Coverage (Unpaid Leave). They can only do so for a maximum of 12 months. See WAC 182-12-142 for continuation coverage information. The PEBB Program must receive the faculty's election to self-pay benefits **no later than 60 days** from the date the PEBB health plan coverage ends, or from the postmark date on the election notice sent by the PEBB Program, whichever is later.

Seasonal employees

"Seasonal employee" means a state employee hired to work during a recurring, annual season of three months or more, and who is anticipated to return each season to perform similar work.

A seasonal employee is eligible if they are anticipated to work an average of at least 80 hours per month and are anticipated to work for at least eight hours in each month of at least three consecutive months of the season. (A season means any recurring, annual period of work at a specific time of year that lasts 3 to 11 consecutive months.)

If an employer revises a seasonal employee's anticipated work hours or anticipated duration of employment such that the employee meets the eligibility criteria above, the employee becomes eligible for PEBB benefits when the change is made.

A seasonal employee who is determined ineligible for benefits, but who later works an average of at least 80 hours per month and works for at least eight hours in each month for more than six consecutive months, becomes eligible for PEBB benefits the first of the month following the six-month averaging period.

If a seasonal employee works in more than one position or job within one state agency, the employee may "stack" or combine hours worked to establish and maintain eligibility. See WAC 182-12-114(2) for details on when a seasonal employee becomes eligible. A seasonal employee must notify their employer if they believe they are eligible through stacking. A seasonal employee becomes eligible for PEBB benefits through stacking when the employer anticipates they will work an average of at least 80 hours per month and are anticipated to work for at least eight hours in each month of at least three consecutive months of the season.

A benefits-eligible seasonal employee who works a season of **9 months or more:**

- Is eligible for the employer contribution in any month of the season in which they are in pay status for 8 or more hours during that month, and through the off season after each season worked.
- Eligibility may not exceed a total of twelve consecutive calendar months for the combined season and off season.

A benefits-eligible seasonal employee who works a season of **less than 9 months:**

- Is not eligible for the employer contribution during the off season.
- Is eligible for the employer contribution in any month of the season in which they are in a pay status of 8 or more hours during that month.
- May continue any combination of medical, dental, life insurance, and AD&D insurance when they are in between periods of eligibility by enrolling in and self-paying for PEBB Continuation Coverage (Unpaid Leave) (for a maximum of 12 months). See WAC 182-12-142 for continuation coverage information.

The PEBB Program must receive the seasonal employee's election to self-pay benefits no later than 60 days from the date the PEBB health plan coverage ends or from the postmark date on the election notice sent by the PEBB Program, whichever is later.

Elected and full-time appointed officials

Legislators are eligible for PEBB benefits on the date their term begins. All other elected and full-time appointed officials of the legislative and executive branches of state government are eligible on the date their terms begin or the date they take the oath of office, whichever occurs first.

Justices and judges

A justice of the Supreme Court and judges of the court of appeals and the superior courts become eligible for PEBB benefits on the date they take the oath of office.

Can I cover my dependents?

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

- Your legal spouse.
- Your state-registered domestic partner, as defined in WAC 182-12-109 and RCW 26.60.020(1). This includes substantially equivalent legal unions from other jurisdictions as defined in RCW 26.60.090. Strict requirements apply to these partnerships, including that one partner is age 62 or older and you live in the same residence.
- Your children through the last day of the month in which they turn age 26, except for children with a disability (who may be covered past the age of 26 if they qualify).

Employees enrolling non-qualified tax dependents (like state-registered domestic partners or their children, or an extended dependent) must submit a *2020 PEBB Declaration of Tax Status* form to indicate whether these individuals qualify as dependents for tax purposes under IRC Section 152, as modified by IRC Section 105(b).

Employees with non-qualified tax dependents will be able to keep making premium payments for their own insurance coverage with pre-tax payroll deductions, but premiums for the dependents must be deducted on a post-tax basis.

How are children defined?

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

- Your children.
- Children of your spouse.
- Children whose total or partial support is your legal obligation in anticipation of adoption.
- Children of your state-registered domestic partner.
- Children specified in a court order or divorce decree for whom you have a legal obligation to provide support or health care coverage.

Eligible extended dependents

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

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

Eligible children with disabilities

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

The PEBB Program, with input from your medical plan (if the child is enrolled in PEBB medical), will verify the disability and dependency of a child with a disability beginning at age 26, but no more frequently than annually after the two-year period following the child's 26th birthday. These verifications may require renewed proof from you. If the PEBB Program does not receive your verification within the time allowed, the child will no longer be covered.

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

You must notify the PEBB Program in writing when your child with a disability is no longer eligible. The PEBB Program must receive notice **within 60 days** of the last day of the month your child loses eligibility for health plan coverage.

Verifying dependent eligibility

When you add a dependent to your PEBB insurance coverage, you must submit proof of their eligibility within the PEBB Program's enrollment timelines. The PEBB Program reserves the right to review a dependent's eligibility at any time.

If a dependent's eligibility cannot be verified, they will not be enrolled. You can find a list of documents you can submit to verify eligibility on page 11. Submit these documents with your enrollment form.

If you are enrolling a dependent described in the table below, you must also submit the listed form(s) with your election or change form. All forms are available at **hca.wa.gov/employee-retiree-benefits/forms-and-publications.**

If enrolling a ...	... then also complete this form
State-registered domestic partner or their child, or other non-qualified tax dependent	*2020 PEBB Declaration of Tax Status*
Dependent child with a disability age 26 or older	*2020 PEBB Certification of a Child With a Disability*
Extended dependent child	*2020 PEBB Extended Dependent Certification* *2020 PEBB Declaration of Tax Status*

(continued)

Eligibility summary

If I die, are my surviving dependents eligible?

If you are an eligible employee, your surviving dependent (a spouse, state-registered domestic partner or dependent child) may be eligible to enroll or defer (postpone) enrollment as a survivor under PEBB retiree insurance coverage. To do so, they must meet both the procedural and eligibility requirements described in WAC 182-12-265.

The PEBB Program must receive all required forms to enroll or defer (postpone) enrollment as a survivor in PEBB retiree insurance coverage **no later than 60 days** after the later of the date of the employee's death or the date the survivor's PEBB insurance coverage ends.

If your surviving spouse, state-registered domestic partner, or dependent child does not meet the eligibility requirements described in WAC 182-12-265, they may be eligible to continue health plan enrollment in PEBB Continuation Coverage (COBRA) as described in WAC 182-12-146. See "What are my options when coverage ends?" on page 23.

Valid dependent verification documents

Dependent verification helps make sure the PEBB Program covers only people who qualify. If you want to enroll dependents, you must provide documents to show they are eligible before they can be enrolled under your account.

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

Use the lists below to determine which verification documents to submit. If you submit a tax return, you may submit just one copy if it includes all dependents that require verification. Submit the document(s) with your enrollment form(s) within the PEBB Program's enrollment timelines.

To find forms and more information, go to **hca.wa.gov/pebb-employee,** or contact your personnel, payroll, or benefits office.

To enroll a spouse

Provide a copy of (choose one):

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

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

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

Provide a copy of (choose one):

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

To enroll children

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

If you are enrolling an extended dependent, submit the *2020 PEBB Extended Dependent Certification* form in addition to the *2020 PEBB Declaration of Tax Status* form.

For all other children, provide a copy of one of the documents listed below with your enrollment form:

- The most recent year's federal tax return that includes dependent child(ren) (black out financial information). **Note:** You can submit one copy of your tax return if it includes all dependents that require verification.
- Birth certificate (or hospital certificate with the child's footprints on it) showing the name of the parent who is the subscriber, the subscriber's spouse, or the subscriber's state-registered domestic partner*
- Certificate or decree of adoption showing the name of the parent who is the subscriber, the subscriber's spouse, or the subscriber's state-registered domestic partner
- Court-ordered parenting plan
- National Medical Support Notice
- Defense Enrollment Eligibility Reporting System (DEERS) registration
- Valid J-2 visa issued by the U.S. government

*If the dependent is the subscriber's stepchild, the subscriber must also verify the spouse or state-registered domestic partner in order to enroll the child, even if not enrolling the spouse or partner in PEBB insurance coverage.

Enrollment summary

Which forms do I use?

You will find forms in the back of this guide. Your personnel, payroll, or benefits office must receive your forms within the required timelines when you become eligible for PEBB benefits. Ask your personnel, payroll, or benefits office when your benefits begin. See "When does coverage begin?" on page 13 for more information. If your employer offers PEBB medical, dental, life, AD&D, and LTD insurance, complete these forms:

- *2020 PEBB Employee Enrollment/Change form* or *2020 PEBB Employee Enrollment/Change for Medical Only Groups:* **No later than 31 days** after you become eligible for PEBB benefits.
- *2020 PEBB Long-Term Disability (LTD) Enrollment/Change* form: **No later than 31 days** after you become eligible for PEBB benefits.
- *2020 PEBB MetLife Enrollment/Change Form:* If you decide to enroll in supplemental life insurance, MetLife must receive the MetLife Enrollment/Change Form **no later than 31 days** after you become eligible for PEBB benefits, otherwise evidence of insurability will be required. If you have questions about enrollment in life insurance, contact MetLife at 1-866-548-7139.

You will be automatically enrolled in the basic life and basic accidental death and dismemberment (AD&D) insurance when your PEBB benefits begin. For more information, see the Group term life and AD&D insurance section on page 45.

If you are requesting to enroll dependents, the PEBB Program must receive proof of your dependent's eligibility **no later than 31 days** after you become eligible for PEBB benefits or the dependents will not be enrolled. A list of documents we will accept as proof is on page 11.

If your personnel, payroll, or benefits office (or applicable contracted vendor) doesn't receive your completed form(s) and dependent verification documents (if applicable) within the 31-day election period, you will be enrolled as a single subscriber in Uniform Medical Plan (UMP) Classic, Uniform Dental Plan (UDP), basic life, basic AD&D insurance, basic long-term disability (LTD) insurance (if your employer offers these coverages). You will pay $104 for your UMP Classic monthly medical premium, and you will be charged a $25 tobacco use premium surcharge.

If you miss your election period and are enrolled as a single subscriber, you will owe medical premiums and the tobacco use premium surcharge back to the date your enrollment was effective. Your dependents (if any) will not be enrolled. You cannot change health plans or enroll your eligible dependents until the next PEBB Program annual open enrollment (November 1 through 30), unless you have a special open enrollment event that allows the change.

For information on enrollment timelines for life insurance, long-term disability insurance, Medical Flexible Spending Arrangement (FSA), Dependent Care Assistance Program (DCAP), SmartHealth, and auto and home insurance, see pages 45-52.

To enroll in other PEBB-sponsored benefits:

- Medical FSA or DCAP (state agency and higher-education employees only) — Visit **pebb.naviabenefits.com. Note:** University of Washington employees must enroll through Workday.
- Auto/home insurance — Visit **hca.wa.gov/pebb-employee** under *Additional benefits* to find a local office or call Liberty Mutual Insurance Company at 1-800-706-5525.

Am I required to enroll in this health coverage?

Employees may waive enrollment in PEBB medical if they are enrolled in other employer-based group medical, a TRICARE plan, or Medicare. You must submit the appropriate *2020 PEBB Employee Enrollment/Change* form to waive PEBB medical. If you waive medical coverage for yourself, you cannot enroll your eligible dependents in it. If your employer offers PEBB dental, basic life, basic AD&D insurance, and basic LTD insurance, you will be enrolled in these coverages for yourself. If you or an eligible dependent are enrolled in PEBB retiree insurance coverage, you or your dependent may not remain enrolled while also enrolled in PEBB benefits as an employee.

See "Waiving Medical Coverage" on page 21 for instructions and timelines for waiving PEBB medical coverage.

Can I enroll in two PEBB medical or dental plans?

No. Enrollment is allowed in only one PEBB medical or dental plan. If you and your spouse or state-registered domestic partner are both eligible for PEBB coverage, you will need to decide which of you will cover yourself and any eligible children on your medical or dental plans.

For example, you could waive medical coverage for yourselves and any eligible children on your medical or dental plans. You could waive medical coverage for yourself and enroll as a dependent on your spouse's, state-registered domestic partner's, or parent's medical coverage. However, you must enroll in dental, basic life, basic AD&D insurance, and basic LTD insurance under your own account. See "Waiving Medical Coverage" on page 21.

When does coverage begin?

When newly eligible, your medical, dental, basic life, basic AD&D insurance, and basic LTD insurance begins on the first day of the month following the date you become eligible for PEBB benefits. If you become eligible on the first working day of the month, PEBB benefits begin on that day. Contact your personnel, payroll, or benefits office with questions about eligibility and when your benefits begin.

For faculty members hired on a quarter/semester to quarter/semester basis, medical, dental, basic life, basic AD&D insurance, and basic LTD insurance begins on the first day of the month following the beginning of the second consecutive quarter/semester of half-time or more employment (or anticipated half-time or more employment). If the first day of the second consecutive quarter/semester is the first working day of the month, PEBB benefits begin on that day.

When making a change after enrollment in PEBB benefits, coverage will begin as noted in the table on the next page.

For the PEBB Program's annual open enrollment (November 1 through 30), your personnel, payroll, or benefits office must receive the required form(s) and proof of your dependent's eligibility no later than November 30 (even if that day is not a business day).

For a special open enrollment, your personnel, payroll, or benefits office must receive the enrollment form(s) and proof of your dependent's eligibility and/or the event **no later than 60 days** after the event.

In many cases, the date you turn in your form affects the date that coverage begins. You may want to turn the form in sooner to avoid a delay in the enrollment or change. When the special open enrollment is for birth or adoption, submit the required forms and proof of your dependent's eligibility and/or the event as soon as possible to ensure timely payment of claims. If adding the child increases the premium, your employer must receive the enrollment form and proof of your dependent's eligibility and/or the event **no later than 60 days** after the date of birth, adoption, or the date you assume legal obligation for support in anticipation of adoption. See "What is a special open enrollment?" on page 18 for more information. See the table on the next page for more about when coverage begins.

ID cards

After you enroll, your health plan(s) will send you an identification (ID) card to show providers when you receive care. If you have questions about your ID card, contact your plan directly.

The Uniform Dental Plan does not mail ID cards, but you may download one from the plan's website.

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Enrollment summary

When making a change after enrollment in PEBB benefits, coverage will begin as noted in the table below.

Annual event	When coverage begins
PEBB Program's annual open enrollment (November 1–30)	January 1 of the following year
Special open enrollment events	**When coverage begins**
Marriage or registering a state-registered domestic partnership	The first of the month after the date of marriage or registration or the date your personnel, payroll, or benefits office receives your completed enrollment form with proof of your dependent's eligibility, whichever is later. If that day is the first of the month, coverage begins on that day.
Birth, adoption, or assumed legal obligation for total or partial support in anticipation of adoption	The date of birth, or the date of placement, or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier (for newly adopted children). If you enroll yourself in order to enroll a newly born or newly adopted child, medical coverage begins the first day of the month in which the birth or adoption occurs. If you enroll your eligible spouse or state-registered domestic partner to your PEBB insurance coverage due to your child's birth or adoption, PEBB benefits begin the first day of the month in which the birth or adoption occurs. **Note:** If the child's date of birth or adoption is before the 16th day of the month, you pay the higher premium for that full month (if adding the child increases the premium). If the child's date of birth or adoption is on or after the 16th day of the month, the higher premium will begin the next month. A newly born child must be at least 14 days old before supplemental dependent life insurance and AD&D insurance coverage purchased by the employee becomes effective.
Child becomes eligible as an extended dependent	The first day of the month following eligibility certification.
Other events that create a special open enrollment (see pages 18-19)	The first of the month after the date of the event or the date your personnel, payroll, or benefits office receives your enrollment form (and proof of the event that created the special open enrollment) with any other required documents, whichever is later. If that day is the first of the month, the enrollment change begins on that day.

What if I'm entitled to Medicare?

Medicare Parts A and B

When you or your covered dependents become entitled to Medicare Part A and Part B, either by age or by disability, the member entitled to Medicare should contact Medicare to ask about the advantages of immediate or deferred enrollment in Medicare Part B when they have coverage through employment. Contact Medicare at 1-800-633-4227 or visit **medicare.gov** for more information.

Be sure you understand the Medicare enrollment timelines, especially if you will be leaving employment within a few months of you or your covered dependent becoming entitled to Medicare. For employees and their enrolled spouses ages 65 and older, PEBB medical plans provide primary coverage, and Medicare coverage is usually secondary. You may choose to waive your enrollment in PEBB medical and have Medicare as your primary coverage. However, you will remain enrolled in PEBB dental, basic life, basic AD&D and basic long-term disability coverage if the employer offers these benefits.

If you waive PEBB medical, you can reenroll during the PEBB Program's annual open enrollment (for coverage effective January 1 of the following year), or if you have a special open enrollment event that allows the change.

If you retire and are eligible for PEBB retiree insurance coverage, you must enroll and stay enrolled in Medicare Part A and Part B, if entitled, to remain enrolled in a PEBB retiree health plan. Medicare will become the primary insurer, and PEBB medical becomes secondary.

In most cases, employees and their spouses covered under a PEBB medical plan can defer Medicare enrollment without a late enrollment penalty. They can sign up for Medicare Part B during a Special Enrollment Period when the employee terminates employment or retires. If you are receiving a monthly Social Security benefit, you cannot defer Medicare Part A. Contact your nearest Social Security office or call 1-800-772-1213 for information on deferring or reinstating Medicare.

If your entitlement is due to a disability, contact a local Social Security office or call 1-800-772-1213 regarding deferred enrollment.

Medicare Part D

Medicare Part D is available to people enrolled in Medicare Part A and/or Part B. It is a voluntary program that offers prescription drug benefits through private plans. These plans provide at least a standard level of coverage set by Medicare.

All PEBB medical plans available to employees provide creditable prescription drug coverage. This means the plans provide prescription drug benefits that are as good as or better than Medicare Part D coverage. After you become entitled to Medicare Part A and/or Part B, you can keep your PEBB insurance coverage and not pay a late enrollment penalty if you decide to enroll in a Medicare Part D plan later. To avoid a premium penalty, you cannot be without creditable prescription drug coverage for more than two full months.

If you do enroll in a Medicare Part D plan, your PEBB medical plan may not coordinate prescription drug benefits with that plan.

If you enroll or terminate enrollment in Medicare Part D, you may need a "notice of creditable coverage" to prove continuous prescription drug coverage. You can call the PEBB Program at 1-800-200-1004 to request one.

For questions about Medicare Part D, call Medicare at 1-800-633-4227 or visit **medicare.gov**.

How much will my monthly premiums be?

For state agency and higher education employees, see the "2020 Monthly Premiums" on page 27. There are no employee premiums for dental, basic life, basic AD&D insurance, and basic LTD insurance.

Employees who work for a city, tribal government, county, port, water district, hospital, educational service district, etc., must contact their personnel, payroll, or benefits office to get their monthly premiums.

In addition to your monthly premium, you must pay for any deductibles, coinsurance, or copayments under the health plans you choose. See each health plan's certificate of coverage for details.

Your premiums pay for an entire calendar month of coverage. Premiums cannot be prorated for any reason, including when a member dies before the end of the month.

You may also be charged one or both of the following premium surcharges in addition to your monthly medical premium:

- A monthly **$25-per-account tobacco use premium surcharge** will apply if you or one of your enrolled dependents (ages 13 and older) uses tobacco products. You must attest for each dependent you want to enroll. If you do not attest within the PEBB Program's timelines, or if your attestation shows the surcharge applies, you will be charged the premium surcharge in addition to your monthly medical premium. If your or an enrolled dependent's tobacco use status changes, you must reattest.
- A monthly **$50 spouse or state-registered domestic partner coverage premium surcharge** will apply if you enroll your spouse or state-registered domestic partner in PEBB medical,

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and they have chosen not to enroll in another employer-based group medical that is comparable to PEBB's Uniform Medical Plan (UMP) Classic. If you enroll a spouse or partner and do not attest within the PEBB Program's timelines, or if your attestation results in you incurring the premium surcharge, you will be charged the premium surcharge in addition to your monthly medical premium.

For more details on whether these surcharges will apply to you, see "Premium Surcharges" on pages 28-29.

How do I pay for coverage?

Eligible state agency and higher education institution employees may pay medical premiums with pretax dollars from their salary under the premium payment plan contained in the Salary Reduction Plan under IRC Section 125. If you are not a state agency or higher-education employee, ask your personnel, payroll, or benefits office if they offer a pre tax deduction benefit under their own Section 125 plan.

Premiums and applicable premium surcharges are automatically deducted from your paychecks before taxes unless you request otherwise.

If you are enrolling a state-registered domestic partner or their child, or other non-qualified tax dependent, you must submit 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). Monthly medical premiums for these dependents will be post-tax deductions from your paycheck. However, you will be able to make premium payments for your own insurance coverage with pretax payroll deductions.

Why should I pay my monthly premiums with pretax dollars?

You take home more money because taxes are calculated after the premium, applicable premium surcharges and/or contributions are deducted. This reduces your taxable income, which lowers your taxes and saves you money.

Do I need to complete a form to have my medical premium payments withheld pretax?

No. If you are a new employee who enrolls in a medical plan, and your employer offers this benefit, your personnel, payroll, or benefits office automatically have the premiums deducted before calculating taxes.

If you do not want to pay your medical premiums with pre tax earnings, your personnel, payroll, or benefits office must receive your completed *2020 PEBB Premium Payment Plan Election/Change Form* to waive (opt out of) participation in the premium payment plan **no later than 31 days** after you become eligible for PEBB benefits (see WAC 182-08-197). The form is available from your personnel, payroll, or benefits office.

Can I change my mind about having my medical premium payments withheld pretax?

You may change your participation under the state's premium payment plan (opt out of, or revoke your election and make a new election) during the PEBB Program's annual open enrollment or if you have an applicable special open enrollment event as described in WAC 182-08-199.

When would it benefit me not to have a pretax deduction?

If you have your premiums deducted pretax, it may also affect the following benefits:

- **Social Security** — If your base salary is under the annual maximum, IRC Section 125 participation reduces your Social Security taxes now. However, your lifetime Social Security benefit would be calculated using the lower salary. You can find the annual maximum by visiting **ssa.gov/OACT/COLA/cbb.html**.
- **Unemployment compensation** — IRC Section 125 also reduces the base salary used to calculate unemployment compensation.

To learn more about IRC Section 125 and its impact on other benefits, talk to a qualified financial planner, tax specialist, or your local Social Security Office.

To make changes to your enrollment or health plan elections, your personnel, payroll, or benefits office must receive the required form(s) during the PEBB Program's annual open enrollment or when a special open enrollment event occurs. All changes must be made within the PEBB Program's timelines noted on pages 17-20. **Note:** UW employees must use Workday.

What changes can I make any time?

You can make some changes during the year outside of the PEBB Program's annual open enrollment and without a special open enrollment event.

- Change your name and/or address. Use the appropriate *2020 PEBB Employee Enrollment/ Change form*.
- Apply for, terminate, or change coverage amounts, and update beneficiary information for supplemental life and accidental death and dismemberment (AD&D) insurance. (See "Group Term Life and AD&D Insurance" on page 49.)
- Apply for, terminate, or change auto or home insurance coverage. (See "Auto and Home Insurance" on page 48.)
- Remove dependent(s) from coverage due to loss of eligibility due to divorce, annulment, dissolution, or a qualifying event of a dependent ceasing to be eligible as a dependent child (required). Your personnel, payroll, or benefits office must receive the appropriate *2020 PEBB Employee Enrollment/Change* form **within 60 days** of the last day of the month the dependent loses eligibility for health plan coverage (WAC 182-12-262). If a dependent child with a disability loses eligibility, the notice must be provided to the PEBB Program, in writing (WAC 182-12-260).
- Enroll in or terminate supplemental long-term disability coverage, or change the waiting period. Use the *Long-Term Disability Enrollment/Change* form.
- Change your or your dependent's tobacco use premium surcharge attestation. Use the *2020 PEBB Premium Surcharge Attestation Change Form* or log in to PEBB My Account at **hca.wa.gov/my-account**.
- Start, stop, or change your contribution to your health savings account (HSA). Use the *2020 PEBB Employee Authorization for Payroll Deduction to Health Savings Account* form at **hca.wa.gov/pebb-employee**.
- Change your HSA beneficiary information. Use the *Health Savings Account Beneficiary Designation* form available at **healthequity.com/pebb**.

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

To make any of the changes described in the table below, your personnel, payroll, or benefits office must receive the required form(s) during the PEBB Program's annual open enrollment (November 1 through 30). You may also make some of these changes online during open enrollment using PEBB My Account at **hca.wa.gov/my-account**.

Exception: UW employees must enroll through Workday.

The enrollment change will become effective January 1 of the following year.

During the annual open enrollment, you can:	By submitting this form:
• Change your medical or dental plans. • Enroll or remove eligible dependents. • Enroll in a medical plan, if you previously waived PEBB medical. • Waive enrollment in PEBB medical if you have other employer-based group medical, a TRICARE plan, or Medicare effective January 1. See "Waiving Medical Coverage" on page 21.	*2020 PEBB Employee Enrollment/Change form (if you have PEBB medical, dental, life, and long-term disability insurance)* **OR** *2020 PEBB Employee Enrollment/Change for Medical Only Groups (if you have PEBB medical only)*
• Enroll or reenroll in a Medical Flexible Spending Arrangement (FSA) (PEBB benefits-eligible state agency and higher-education employees only). • Enroll or reenroll in the Dependent Care Assistance Program (DCAP) (PEBB benefits-eligible state agency and higher-education employees only). **Note:** Your participation in the Medical FSA and DCAP does not automatically continue from plan year to plan year. If you wish to participate, you must enroll in this benefit annually.	*2020 PEBB Medical Flexible Spending Arrangement and Dependent Care Assistance Program Enrollment Form* **OR** Enroll at **pebb.naviabenefits.com.** (Check the enrollment form for submission directions.) If enrolling for the first time you can't enroll online, you must use the enrollment form. **Exception:** UW employees must use Workday.
Enroll or waive your participation under the premium payment plan (see "How do I pay for coverage?" on page 16).	*PEBB Premium Payment Plan Election/Change Form*

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Making changes in coverage

What is a special open enrollment?

A special open enrollment means a time period after specific life events (such as a birth or marriage) when subscribers may make changes outside of the PEBB Program's annual open enrollment.

The change in enrollment must be allowable under the Internal Revenue Code and Treasury Regulations, and correspond to and be consistent with the event that creates the special open enrollment for the employee, the employee's dependents, or both. A special open enrollment event must be an event other than an employee gaining initial eligibility for PEBB benefits.

Depending on the special open enrollment event, subscribers may change health plans, change their spousal attestation, enroll or remove eligible dependents from coverage, or enroll in or waive enrollment in PEBB medical.

Employees eligible to participate in the salary reduction plan may also be able to enroll in or revoke their election (or make a new election) under the Dependent Care Assistance Program, Medical Flexible Spending Arrangement, or the premium payment plan.

You must provide proof of the event that created the special open enrollment (for example, a marriage certificate or birth certificate).

To make a change, your personnel, payroll, or benefits office must receive the appropriate *2020 PEBB Employee Enrollment/ Change* form and proof of the event **no later than 60 days** after the event that created the special open enrollment. In many instances, the date you turn in your form affects the effective date of the change in enrollment. See the table on page 14 for effective dates.

However, if enrolling a newly born child, newly adopted child, or child for whom the employee has assumed a legal obligation for support in anticipation of adoption, and adding the child increases your premium, your employer must receive your form and evidence of your dependent's eligibility **no later than 60 days** after the birth, adoption, or the date the legal obligation is assumed for support in anticipation of adoption.

If this event happens ...	These changes may be permitted as a special open enrollment:				
	Add dependent	Remove dependent	Change PEBB medical and/ or dental plan	Waive PEBB medical	Enroll after waiving PEBB medical
Marriage or registering a state-registered domestic partnership.	Yes[1]	Yes[2]	Yes	Yes	Yes
Birth or adoption, including assuming a legal obligation for support in anticipation of adoption.	Yes	Yes	Yes	Yes	Yes
Child becomes eligible as an extended dependent through legal custody or legal guardianship. Also complete the 2020 *PEBB Extended Dependent Certification* form and *2020 PEBB Declaration of Tax Status* form.	Yes	No	Yes	No	Yes
Employee or a dependent loses other coverage under a group health plan or through health insurance, as defined by the Health Insurance Portability and Accountability Act (HIPAA).	Yes	No	Yes	No	Yes
Employee has a change in employment status that affects their eligibility for their employer contribution toward their employer-based group health plan.	Yes	Yes	Yes	Yes	Yes
Employee'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. **Note:** "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 54.9801-6.	Yes	Yes	Yes	Yes	Yes

If this event happens ...	These changes may be permitted as a special open enrollment:				
	Add dependent	Remove dependent	Change PEBB medical and/ or dental plan	Waive PEBB medical	Enroll after waiving PEBB medical
Employee or a 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.	Yes	Yes	No	Yes	Yes
Employee's dependent moves from outside the United States to live in the United States, or from within the United States to live outside of the United States and that change in residence resulted in the dependent losing their health insurance.	Yes	Yes	No	No	Yes
A court order requires the employee or any other individual to provide a health plan for an eligible child of the employee.	Yes	Yes	Yes	No	Yes
Employee or a dependent has a change in residence that affects health plan availability.	No	No	Yes	No	No
Employee or a dependent becomes entitled to or loses eligibility for Medicaid or a state Children's Health Insurance Program (CHIP).	Yes	Yes	Yes	Yes	Yes
Employee or a dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or a state CHIP.	Yes	No	Yes	No	Yes
Employee or a dependent becomes entitled to and enrolls in or loses eligibility for Medicare, or enrolls in or terminates enrollment in a Medicare Part D plan. **Note:** If waiving PEBB medical, only allowed if enrolling in Medicare. If enrolling after waiving PEBB medical, only allowed if lost eligibility for Medicare.	No	No	Yes	Yes	Yes
Employee's or a dependent's current health plan becomes unavailable because the employee or dependent is no longer eligible for a health savings account (HSA).	No	No	Yes	No	No
Employee or a dependent experiences a disruption of care for active and ongoing treatment that could function as a reduction in benefits for the employee or their dependent (requires approval by the PEBB Program).	No	No	Yes, if approved by PEBB	No	No
Employee or a dependent becomes eligible and enrolls in a TRICARE plan, or loses eligibility for a TRICARE plan.	No	No	No	Yes	Yes

[1] Employee may add only the new spouse, state-registered domestic partner, or child(ren) of the spouse or partner. Existing dependents may not be added.

[2] Employee may remove a dependent from PEBB insurance coverage only if the dependent enrolls in the new spouse's or state-registered domestic partner's plan.

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

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Making changes in coverage

What happens when a dependent loses eligibility?

Your personnel, payroll, or benefits office must receive the appropriate *2020 PEBB Employee Enrollment/Change* form to remove a dependent from your account due to divorce, annulment, dissolution, or qualifying event of a dependent ceasing to be eligible as a dependent child, **within 60 days** of the last day of the month they no longer meet PEBB eligibility criteria. If a dependent child with a disability is no longer eligible, written notice must be provided to the PEBB Program. Your dependent will be removed from coverage on the last day of the month they no longer meet the eligibility criteria.

Consequences for not submitting the form within 60 days are explained in WAC 182-12-262 (2)(a). The consequences may include (but are not limited to):

- The dependent may lose eligibility to continue health plan coverage under one of the continuation options described in WAC 182-12-270 and on page 22.
- You may be billed for claims paid by the health plan for services that were rendered after the dependent lost eligibility.
- You may not be able to recover subscriber-paid insurance premiums for dependents who lost eligibility.
- You may be responsible for premiums paid by the state for a dependent's health plan coverage after the dependent lost eligibility.

What happens when a dependent dies?

If your covered dependent dies, you must submit the appropriate *2020 PEBB Employee Enrollment/Change* form to your personnel, payroll, or benefits office to remove the deceased dependent. By submitting this form, your premium may be reduced to reflect the change in coverage. For example, if the deceased person was the only dependent on your account, then the premium withheld from your paycheck will be lower when they are removed.

HCA collects premiums for the entire calendar month and will not prorate them for any reason, including when a member dies before the end of the month. The deceased dependent's coverage will end the last day of the month in which the dependent dies. Any change to your premium will be effective the first day of the following month.

If you have life insurance coverage for your dependent, or are unsure if you elected supplemental life insurance for the dependent, contact MetLife at 1-866-548-7139. Also consider updating any beneficiary designations for benefits such as your life insurance, Department of Retirement Systems administered pension benefits, or other administered deferred compensation program accounts.

What if a National Medical Support Notice requires me to provide health plan coverage for a dependent?

You may enroll the child and request changes to their health plan coverage as directed by the National Medical Support Notice (NMSN). You must submit the appropriate *2020 PEBB Employee Enrollment/Change* form and a copy of the NMSN to your personnel, payroll, or benefits office.

If you fail to request enrollment or health plan coverage changes as directed by the NMSN, your employer or the PEBB Program may make the changes upon request of the child's other parent or child support enforcement program. The following options are allowed:

- The child will be enrolled under your health plan coverage as directed by the NMSN.
- If you have previously waived PEBB medical coverage, you will be enrolled in medical as directed by the NMSN in order to enroll the child.
- Your selected health plan will be changed if directed by the NMSN.
- If the child is already enrolled under another PEBB subscriber, the child will be removed from the other health plan coverage and enrolled as directed by the NMSN.
- If the subscriber is eligible for and elects COBRA or other continuation coverage, the NMSN will be enforced and the dependent must be covered in accordance with the NMSN.

Changes to health plan coverage or enrollment will begin the first day of the month following the date your employer receives the NMSN. If that day is the first day of the month, the change or enrollment begins on that day. If removing the child is required, the child will be removed the last day of the month in which the NMSN is received. If that day is the first of the month, the change in enrollment will be made the last day of the previous month.

When a NMSN requires a spouse, former spouse, or other individual to provide coverage for a dependent enrolled in PEBB coverage, and that coverage is provided, the dependent may be removed from your PEBB insurance coverage prospectively.

Waiving medical coverage

Employees may waive PEBB medical coverage if they are enrolled in other employer-based group medical, a TRICARE plan, or Medicare. If you waive coverage for yourself, you cannot enroll your eligible dependents in PEBB medical.

If your employer offers PEBB dental, basic life, basic AD&D insurance, and basic long-term disability (LTD) insurance, you will be enrolled in these coverages (if eligible), regardless of whether you waive PEBB medical.

How do I waive enrollment in medical coverage?

To waive enrollment in PEBB medical, your employer must receive the appropriate *2020 PEBB Employee Enrollment/Change* form indicating this choice **no later than 31 days** after the date you become eligible for PEBB benefits, or during an annual or special open enrollment (as described on pages 17-18).

What happens if I waive coverage?

If you waive PEBB medical:

- The premium surcharges will not apply to you. (See "Premium surcharges" on pages 28-29 for more details.)
- You will not be eligible for the $25 Amazon.com gift card (see page 51).
- You will not be eligible to receive the $125 wellness incentive for a reduction in your medical plan deductible or a deposit to your health savings account for the following plan year (see page 51).

What if I'm already enrolled in PEBB health plan coverage?

If you are a newly eligible employee who is already enrolled in health plan coverage as a dependent under your spouse's, state-registered domestic partner's, or parent's account, you may choose one of these two options:

1. **Waive PEBB medical and stay enrolled in medical under your spouse's, state-registered domestic partner's, or parent's PEBB account.** You must still enroll in PEBB dental, basic life, basic AD&D insurance, and LTD insurance (if your employer offers them) under your own account.

   In addition, your spouse, state-registered domestic partner, or parent must also submit the appropriate *2020 PEBB Employee Enrollment/Change* form to remove you from their dental coverage and prevent dual enrollment in PEBB dental.

2. **Enroll in PEBB health plan coverage under your own account.** To do this, complete the appropriate *2020 PEBB Employee Enrollment/Change* form. Your personnel, payroll, or benefits office must receive this form **no later than 31 days** after the date you become eligible for PEBB benefits. In addition, your spouse, state-registered domestic partner, or parent will also need to submit the required enrollment/change form(s) to remove you from their PEBB account and prevent dual enrollment in PEBB health plan coverage.

How do I enroll after waiving coverage?

Once you waive enrollment in PEBB medical coverage, you may enroll during the PEBB Program's annual open enrollment (November 1 through 30) or if you have an event that creates a special open enrollment event. Your personnel, payroll, or benefits office must receive the appropriate *2020 PEBB Employee Enrollment/Change* form before the end of the PEBB Program's annual open enrollment or **no later than 60 days** after the special open enrollment.

In many special open enrollment events, coverage will begin the first day of the month after the date of the event or the date your personnel, payroll, or benefits office receives your enrollment form and required documents, whichever is later. If that day is the first of the month, coverage will begin on that day (see the table on page 14). You may want to submit the form sooner so your benefits will not be delayed.

You must provide proof of eligibility for any dependents you want to enroll (see "Valid Dependent Verification Documents" on page 11) and proof of the event that created the special open enrollment. For more information, see WAC 182-12-128.

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Waiving medical coverage

What happens if I don't waive enrollment in PEBB medical?

If your personnel, payroll, or benefits office does not receive your completed form to enroll or waive enrollment within the required timeframes, you will be defaulted (automatically enrolled) as a single subscriber in the Uniform Medical Plan (UMP) Classic, the Uniform Dental Plan (UDP), basic life, basic AD&D insurance, and basic LTD insurance (if your employer offers these benefits). You will pay $104 for your UMP Classic monthly medical premium and you will be charged a $25 tobacco use premium surcharge. Your dependents will not be enrolled.

If you miss your election period and are enrolled as a single subscriber, you will owe UMP Classic medical premiums and the tobacco use premium surcharge back to your coverage effective date for PEBB benefits. You cannot change health plans or enroll your eligible dependents until the next PEBB Program annual open enrollment (November 1 through 30) unless you have a special open enrollment event that allows the change.

If you are enrolled on your spouse's, state-registered domestic partner's, or your parent's PEBB health plan coverage, you will be removed from that coverage.

What if I am a retiree/rehire enrolled in PEBB retiree insurance coverage?

You cannot waive your enrollment in employee medical to stay enrolled in PEBB retiree insurance coverage, even if you are enrolled in Medicare. PEBB retiree insurance coverage will be deferred if you become newly eligible for PEBB benefits as an employee.

When coverage ends

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

- When you or a dependent loses eligibility for PEBB benefits, coverage ends on the last day of the month in which eligibility ends. To remove a dependent, your personnel, payroll, or benefits office must receive the appropriate *2020 PEBB Employee Enrollment/Change form* **within 60 days** of the last day of the month your dependent is no longer eligible.
- When you or a dependent misses a required enrollment deadline to continue PEBB benefits, or chooses not to continue enrollment in a PEBB health plan, then coverage ends on the last day of the month in which you or your dependent lost eligibility under PEBB Program rules.
- When your employment relationship is terminated, coverage ends on the last day of the month the employment relationship is terminated. The employment relationship is considered terminated:
  - On the date specified in your letter of resignation; or
  - On the date specified in any contract or hire letter, or on the effective date of an employer-initiated termination notice.

What are my options when coverage ends?

You, your dependents, or both may be able to temporarily continue your PEBB insurance coverage by enrolling in PEBB Continuation Coverage and self-paying the premiums and applicable premium surcharges after your eligibility for employer-paid coverage ends. Your employer will make no contribution toward the premiums. If applicable, you may be eligible to enroll on your spouse's or state-registered domestic partner's PEBB insurance coverage as a dependent.

Options for continuing coverage vary based on the reason eligibility is lost. When your employer-paid coverage ends, the PEBB Program will mail a *PEBB Continuation Coverage Election Notice* to you or your dependent at the address we have on file. This notice explains the coverage options and includes enrollment forms to apply for continuation coverage.

You or your eligible dependents must submit the appropriate form to the PEBB Program **no later than 60 days** from the date PEBB health plan coverage ended, or from the postmark date on the *PEBB Continuation Coverage Election Notice,* whichever is later. **If the PEBB Program does not receive the election notice by the deadline, you will lose all rights to continue PEBB insurance coverage.**

There are three continuation coverage options you and your dependents may qualify for:

1. PEBB Continuation Coverage (COBRA)
2. PEBB Continuation Coverage (Unpaid Leave)
3. PEBB retiree insurance coverage

The first two options temporarily extend PEBB health plan coverage when the employee or dependent's PEBB health plan coverage ends due to a qualifying event.

PEBB Continuation Coverage (COBRA) includes eligibility and administrative requirements under federal law and also includes coverage for some members who are not qualified beneficiaries under federal COBRA continuation coverage. COBRA eligibility is defined in federal law and governed by federal rules.

PEBB Continuation Coverage (Unpaid Leave) is an alternative created by the PEBB Program with wider eligibility criteria and qualifying event types.

These events may include a layoff, approved leave of absence, educational leave, or when called to active duty in the uniformed services. This option allows you to continue life insurance and, in some instances, LTD insurance.

Members who qualify for both PEBB Continuation Coverage (COBRA and Unpaid Leave) may choose to enroll in only one.

PEBB retiree insurance coverage is available only to:

- Individuals who meet eligibility and procedural requirements (see WAC 182-12-171, 182-12-180, and 182-12-211).
- Surviving dependent(s) of a PEBB benefits-eligible employee or retiree (see WAC 182-12-180 and 182-12-265).
- The surviving dependent(s) of an emergency service worker who was killed in the line of duty (see WAC 182-12-250).

The PEBB Program administers all continuation coverage options. For information about your rights and responsibilities under PEBB Program rules and federal law, refer to these documents:

- Your *PEBB Initial Notice of COBRA and Continuation Coverage Rights* booklet (mailed to you after you enroll in PEBB insurance coverage).
- The *PEBB Continuation Coverage Election Notice*.
- The *PEBB Retiree Enrollment Guide*.

You can also call the PEBB Program at 1-800-200-1004.

(continued)

When coverage ends

What happens to my Medical Flexible Spending Arrangement (FSA) or Dependent Care Assistance Program (DCAP) funds when coverage ends?

When your PEBB insurance coverage ends or you go on unpaid leave that is not approved under the Family and Medical Leave Act (FMLA), the Washington Paid Family and Medical Leave program, or military leave, you are no longer eligible to contribute to your Medical FSA. Eligibility ends on the last day of the month of loss of coverage or unapproved leave. You will only be able to claim expenses incurred while employed (up to your available funds), unless you are eligible to continue your Medical FSA through Navia Benefit Solutions.

If you terminate employment and have unspent DCAP funds, you may continue to submit claims for eligible expenses as long as the expenses allow you to attend school full-time, look for work, or work full-time. Claims may be submitted up to your account balance and must be submitted to Navia Benefit Solutions by March 31 of the following plan year. You cannot incur expenses after December 31 of the plan year. There are no continuation coverage rights for the DCAP.

For more information on when coverage ends, see the *2020 PEBB Medical FSA Enrollment Guide* or *2020 PEBB DCAP Enrollment Guide* at **pebb.naviabenefits.com.** You can also contact Navia Benefit Solutions at 1-800-669-3539 or send an email to **customerservice@naviabenefits.com.**

What happens to my consumer-directed health plan (CDHP) with a health savings account (HSA) when coverage ends?

If you enroll in a CDHP with an HSA, then later decide to switch to another type of plan, leave employment, or retire, any unspent funds in your HSA will remain unless you close your account. HealthEquity, the HSA administrator, charges a fee for account balances below $2,500. These fees only apply to members who are no longer active employees.

You can use your HSA funds on qualified medical expenses, or you can leave them for the future. However, you, your employer, the PEBB Program, and others may no longer contribute to your HSA.

Contact HealthEquity with questions on how your HSA works when you switch plans, enroll in continuation coverage, or retire. If you set up automatic payroll deductions to your HSA, contact your payroll office to stop them. If you set up direct deposits to your HSA, contact HealthEquity to stop them.

See "Selecting a PEBB Medical Plan" starting on page 30 to learn more about the CDHP/HSA options.

What happens to my life insurance when coverage ends?

If your PEBB employee life insurance ends, you may have an opportunity to continue all or part of your coverage through a portability or conversion option. If you are eligible for these options, MetLife will send you information and an application. For more information, see "Group Term Life and AD&D insurance" on page 45–46 or contact MetLife at 1-866-548-7139.

PEBB appeals

If you or your dependent disagrees with a specific decision or denial, you or your dependent may file an appeal. You can find guidance on filing an appeal in chapter 182-16 WAC and at **hca.wa.gov/pebb-appeals.**

If you are...	And you...	Follow these instructions and submission deadlines:
A current or former **state agency** or **higher education employee** (or their dependent)	Disagree with a decision **made by your employer** about your: • Premium surcharges • Eligibility for or enrollment in: ◦ Medical ◦ Dental ◦ Life and AD&D insurance ◦ Long-term disability insurance ◦ Medical Flexible Spending Arrangement (FSA) ◦ Dependent Care Assistance Program (DCAP) **And are requesting your employer's review.**	Complete Sections 1–4 of the *2020 PEBB Employee Request for Review/Notice of Appeal* form and **submit it to your personnel, payroll, or benefits office.** Your employer must receive the form **no later than 30 calendar days** after the date of the initial denial notice or decision you are appealing.
	Disagree with a review decision **made by your employer or agree that an error occurred** and are now requesting the Public Employees Benefits Board (PEBB) Program's review of your employer's decision.	Complete Section 8 of the *2020 PEBB Employee Request for Review/Notice of Appeal* form and submit it to the PEBB Appeals Unit. The PEBB Appeals Unit must receive this form **no later than 30 calendar days** after your employer's review decision date in Section 7 of the form.
	Disagree with a decision **from the PEBB Program** about: • Eligibility and enrollment in: ◦ Premium payment plan ◦ Medical FSA ◦ DCAP ◦ Life and AD&D insurance • Eligibility to participate in SmartHealth or receive a wellness incentive • Eligibility and enrollment for a dependent, an extended dependent, or dependent child with a disability • Premium surcharges • Premium payments	Complete Sections 1–4 of the *2020 Employee Request for Review/Notice of Appeal* form. Check with your employer to see if they need to review the form before you submit it to the PEBB Appeals Unit (see Section 8 of the form). The PEBB Appeals Unit must receive the form **no later than 30 calendar days** after the date of the initial denial notice or decision you are appealing.

(continued)

PEBB appeals

If you are ...	And you ...	Follow these instructions and submission deadlines:

A current or former employer group employee (or their dependent) of:
• A county
• A municipality
• A political subdivision of the state
• A tribal government
• An educational service district
• The Washington Health Benefit Exchange
• An employee organization representing state civil service employees
	Disagree with a decision **made by your employer** about:
	• Premium surcharges
	• Eligibility for or enrollment in:
	  ◦ Medical
	  ◦ Dental
		Contact your employer for information on how to appeal the decision or action.

	Disagree with a decision **made by your employer, a PEBB insurance carrier, or the PEBB Program** about:
	• Eligibility for or enrollment in:
	  ◦ Life and AD&D insurance
	  ◦ Long-term disability insurance
	• Eligibility to participate in SmartHealth or receive a wellness incentive
		Complete Sections 1–4 of the *2020 PEBB Employee Request for Review/Notice of Appeal* form.
		The PEBB Appeals Unit must receive this form **no later than 30 calendar days** after the date of the initial denial notice or decision you are appealing.

A current or former **state agency or higher education employee** (or their dependent), or **employer group employee** (or their dependent)	Are seeking a review of a decision **made by a PEBB health plan, insurance carrier, or benefit administrator** regarding the administration of: • A benefit or claim • Completion of SmartHealth requirements or a request for a reasonable alternative to a SmartHealth requirement • Life insurance premium payments	Contact the health plan, insurance carrier, or benefit administrator to request information on how to appeal the decision.

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

You must provide us with an *Authorization for Release of Information* form naming your representative or a copy of a valid power of attorney authorizing access to your medical records and/or PEBB Program account information, and exercise your rights under the federal HIPAA privacy rule. HIPAA stands for the Health Insurance Portability and Accountability Act of 1996. The form is available at **hca.wa.gov/pebb-appeals.**

2020 monthly premiums

There are no employee premiums for dental, basic life and accidental death and dismemberment, and basic long-term disability insurance benefits. Employees who work for an educational service district, city, tribal government, county, port, water district, hospital, etc., must contact their personnel, payroll, or benefits office to get their monthly premiums.

PEBB medical plans	Employee	Employee & spouse[1]	Employee & child(ren)	Employee, spouse[1], & child(ren)
Kaiser Permanente NW[2] Classic	$140	$290	$245	$395
Kaiser Permanente NW[2] CDHP	$25	$60	$44	$79
Kaiser Permanente WA Classic	$176	$362	$308	$494
Kaiser Permanente WA CDHP	$27	$64	$47	$84
Kaiser Permanente WA SoundChoice	$42	$94	$74	$126
Kaiser Permanente WA Value	$100	$210	$175	$285
UMP Classic	$104	$218	$182	$296
UMP CDHP	$25	$60	$44	$79
UMP Plus—PSHVN	$69	$148	$121	$200
UMP Plus—UW Medicine ACN	$69	$148	$121	$200

[1] *Or state-registered domestic partner*

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

Premium surcharges

In 2013, the Legislature established two premium surcharges:

- Tobacco use premium surcharge
- Spouse or state-registered domestic partner coverage premium surcharge

You must attest to these premium surcharges if you are enrolled in a PEBB medical plan. When you enroll a dependent on your PEBB medical coverage, you must attest on your enrollment form to whether the surcharges apply. See the *2020 PEBB Premium Surcharge Attestation Help Sheet* on page 84 for more details.

Premium surcharges

Tobacco use premium surcharge

You will be charged 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 has used a tobacco product in the past two months (whether this dependent lives with you or not), or if you do not attest to this premium surcharge for each enrolled dependent.

To determine whether this surcharge applies to your account, use the *2020 PEBB Premium Surcharge Attestation Help Sheet* (found on page 84) and attest by completing and submitting the *PEBB 2020 Employee Enrollment/ Change* form or *Employee Enrollment/ Change for Medical Only Groups*.

To report a change

If you or your enrolled dependent's tobacco use status changes, or:

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

You may report the change one of two ways:

- Go to PEBB My Account at **hca.wa.gov/my-account. Exception:** University of Washington employees must use Workday.
- Submit a *2020 PEBB Premium Surcharge Attestation Change Form* (found at **hca.wa.gov/pebb-employee**) to your personnel, payroll, or benefits office.

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.**

Spouse or state-registered domestic partner coverage premium surcharge

If you do not enroll a spouse or state-registered domestic partner, this premium surcharge does not apply to you.

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

- Your spouse or state-registered domestic partner chose not to enroll in another employer-based group medical insurance that is comparable to PEBB's Uniform Medical Plan (UMP) Classic.
- You do not attest for the spouse or state-registered domestic partner you wish to enroll.

Use the *2020 PEBB Premium Surcharge Attestation Help Sheet* (found on page 84) to determine whether this premium surcharge applies to your account. Then attest by submitting the *2020 PEBB Employee Enrollment/ Change* form or *2020 PEBB Employee Enrollment/Change for Medical Only Groups* with your attestation.

Do I need to attest during the PEBB Program's annual open enrollment?

During November 1 through 30, you must attest (or re-attest) to the spouse or state-registered domestic partner coverage 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 the spouse's or state-registered domestic partner's share of the medical premium through their employer-based group medical was not comparable to PEBB's UMP Classic.
- Not incurring the surcharge because the benefits provided through the spouse's or state-registered domestic partner's employer-based group medical were not comparable to PEBB's UMP Classic.

If required, you must update your attestation by either submitting the *2020 PEBB Premium Surcharge Attestation Change Form* to your personnel, payroll, or benefits office, or logging in to PEBB My Account at **hca.wa.gov/my-account** and following the instructions. **Exception:** University of Washington employees must use Workday.

If your personnel, payroll, or benefits office does not receive your attestation within the open enrollment timeframe, or if the response results in incurring the premium surcharge, you will be charged the $50 premium surcharge in addition to your monthly medical premium starting January 1 of the next plan year. You will be charged the premium surcharge for the whole plan year unless there is a change in your spouse's or state-registered domestic partner's employer-based group medical that meets the requirements as described in WAC 182-08-185.

To report a change

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

- When you regain eligibility for the employer contribution for PEBB benefits.
- When you submit the appropriate *2020 PEBB Employee Enrollment/ Change* form to add a spouse or state-registered domestic partner to your PEBB medical.
- When you submit the *2020 PEBB Premium Surcharge Attestation Change* form when there is a change in your spouse's or state-registered domestic partner's employer-based group medical plan.
- When you submit the appropriate *2020 PEBB Employee Enrollment/ Change* form to enroll in a PEBB medical plan after waiving your employer coverage, and you enroll your spouse or state-registered domestic partner.

You may report the change by submitting ***the required*** form to your personnel, payroll, or benefits office. In some cases, you must provide proof of the qualifying event.

When changes take effect

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 the receipt of your attestation. If that day is the first day of the month, then the change begins on that day.

For more information on the premium surcharges, visit **hca.wa.gov/pebb-employee** and select *Surcharges*.

Selecting a PEBB medical plan

When selecting a PEBB medical plan, your options are limited based on eligibility and where you live. You must consider which medical plans are available in your county. Remember, if you cover dependents, everyone must enroll in the same medical and dental plans.

- **Eligibility.** Not everyone qualifies to enroll in a consumer-directed health plan (CDHP) with a health savings account (HSA) or a UMP Plus plan. See "Can I enroll in a CDHP and Medicare Part A or Part B?" on page 31 and "What do I need to know about the CDHP with a health savings account (HSA)?" on page 32.
- **Where you live.** In most cases, you must live in the medical plan's service area to join the plan. See the "2020 Medical Plans Available by County" on pages 34-35. Be sure to contact the medical plan(s) you're interested in to ask about provider availability in your county. If you move out of your medical plan's service area, you may need to change your plan, otherwise there will be limited accessibility to network providers and covered services. You must report your new address to your personnel, payroll, or benefits office **no later than 60 days** after your move.

How can I compare the medical plans?

All medical plans cover the same basic health care services, but they vary in other ways such as provider networks, premiums, your out-of-pocket costs, and drug formularies. See a side-by-side comparison of the medical plans' benefits and costs on pages 37-42.

Medical plan differences to consider

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

Premiums. Premiums vary by medical plan. A higher premium doesn't necessarily mean higher quality of care or better benefits; each plan has the same basic level of benefits. See premiums for all PEBB medical plans on page 27. If you are employed by an educational service district, city, county, tribal government, port, water district, hospital, or another employer group, contact your personnel, payroll, or benefits office to find your monthly premium. Generally, plans with higher premiums may have lower annual deductibles, copays, or coinsurance costs while plans with lower premiums may have higher deductibles, coinsurance, copays, and more limited networks.

Deductibles. All medical plans require you to pay an annual deductible before the plan pays for covered services. Kaiser Permanente WA Classic, SoundChoice, and Value, and UMP Classic also have a separate annual deductible for some prescription drugs. Covered preventive care and certain other services are exempt from the medical plans' deductibles. This means you do not have to pay your deductible before the plan pays for the service.

Note: If you enroll in a CDHP, keep in mind:

- If you cover one or more dependents, you must pay the entire family deductible before the plan begins paying benefits.
- Although the CDHPs don't have a separate prescription drug deductible, your prescription drug costs are subject to the CDHP annual deductible.

Coinsurance or copays. Some medical plans require you to pay a fixed amount, called a copay. Other medical plans require you to pay a percentage of an allowed fee (called a coinsurance) when you receive care.

Out-of-pocket limit. The annual out-of-pocket limit is the most you pay in a calendar year for covered benefits. Kaiser Permanente WA Classic, SoundChoice, and Value, and UMP Classic and UMP Plus have a separate out-of-pocket limit for prescription drugs. Once you have paid this amount, the plans pay 100 percent of allowed charges for most covered benefits for the rest of the calendar year. Certain charges incurred during the year (such as your annual deductible, copays, and coinsurance) count toward your out-of-pocket limit. See the plan's certificate of coverage for details. There are a few costs that do not apply toward your out-of-pocket limit:

- Monthly premiums and applicable premium surcharges.
- Charges above what the plan pays for a benefit.
- Charges above the plan's allowed amount paid to a provider.
- Charges for services or treatments the plan doesn't cover.
- Coinsurance for non-network providers.
- Prescription drug deductible and prescription drug coinsurance (Kaiser Permanente WA Classic, SoundChoice, and Value, and UMP Classic and UMP Plus).

Referral procedures. Some medical plans allow you to self-refer to most network providers for specialty care. Others require you to have a referral from your primary care provider. All plans allow self-referral to a participating provider for women's health care services.

Your provider. If you have a long-term relationship with your doctor or health care provider, you should check whether they are in the plan's network. Contact the plan before you join. Your dependents may choose the same provider, but it's not required. Each dependent may select from any available provider in the plan's network. After you join a medical plan, you may change your provider, although the rules vary by plan.

Network adequacy. All health carriers in Washington State are required to maintain provider networks that provide enrollees reasonable access to covered services. Check the plans' provider directories to see how many providers are accepting new patients and what the average wait time is for an appointment. Beginning in 2020, for mental health and substance abuse treatment, carriers must also provide additional information on their websites to consumers on the ability to ensure timely access to care. For more information, see Engrossed Substitute House Bill 1099 (Brennen's Law) at **leg.wa.gov**.

Paperwork. In general, PEBB medical plans don't require you to file claims. However, UMP members may need to file a claim if they receive services from an out-of-network provider. CDHP members also should keep paperwork received from their provider or for qualified health care expenses to verify eligible payments or reimbursements from their health savings account.

Coordination with your other benefits. If you are also covered through your spouse's or state-registered domestic partner's comprehensive group health coverage, call the medical plan(s) directly to ask how they will coordinate benefits.

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

Note: If you have other comprehensive health coverage, you may not enroll in a CDHP with an HSA. Call HealthEquity at 1-877-873-8823 to ask about certain exceptions. In addition, if you enroll in a CDHP with an HSA, you cannot also enroll in a Medical FSA in the same plan year. Employees who elect both will only be enrolled in the CDHP with a HSA.

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

Value-based plans aim to provide high quality care at a lower cost. Providers have committed to follow evidence-based treatment practices, coordinate care with other providers in your network, and meet certain measures about the quality of care they provide. See the first page of this guide for more information. Value-based plans are listed in **bold**, below.

The PEBB Program offers three type of medical plans

- **Consumer-directed health plans (CDHP).** A CDHP lets you use a health savings account (HSA) to help pay for out-of-pocket medical expenses tax free, have a lower monthly premium than most plans, and a higher deductible and a higher out-of-pocket limit. Also see "What do I need to know about the CDHP with a health savings account (HSA)?" on page 32 to find out if you qualify to enroll.
  - **Kaiser Permanente NW* CDHP**
  - **Kaiser Permanente WA CDHP**
  - UMP CDHP
- **Managed-care plans.** Managed-care plans may require you to select a primary care provider within its network to fulfill or coordinate all of your health care needs. You can change providers at any time, for any reason within the contracted network. The plan may not pay benefits if you see a non-contracted provider.
  - **Kaiser Permanente NW* Classic**
  - **Kaiser Permanente WA SoundChoice**
  - **Kaiser Permanente WA Value**
- **Preferred provider organization (PPO) plans.** PPOs allow you to self-refer to any approved provider type in most cases, but usually provide a higher level of coverage if the provider contracts with the plan.
  - UMP Classic
  - **UMP Plus–Puget Sound High Value Network**
  - **UMP Plus–UW Medicine Accountable Care Network**

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

If you enroll in Medicare Part A or Part B and are enrolled in a consumer-directed health plan (CDHP) with a health savings account (HSA), you should change medical plans, or you could be subject to IRS tax penalties.

The PEBB Program should receive your medical plan change request 30 days before the Medicare enrollment date, but must receive your request to change plans **no later than 60 days** after the Medicare enrollment date. See additional information on the next page about the CDHP.

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

What do I need to know about the CDHP with an HSA?

A consumer-directed health plan (CDHP) is a high-deductible health plan (HDHP) with a health savings account (HSA). When you enroll in a CDHP you are automatically enrolled in a tax-free HSA that you can use to pay for IRS-qualified out-of-pocket medical expenses (such as deductibles, copays, and coinsurance), including some expenses and services that your health plans may not cover. The HSA is set up by your health plan with HealthEquity, Inc. (the HSA administrator) to pay for or reimburse your costs for qualified medical expenses.

See IRS *Publication 969 Health Savings Accounts and Other Tax Favored Health Plans* at **irs.gov** for details.

Who is eligible?

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

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

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

Employer contributions

If you are eligible, your employer will contribute the following amounts to your HSA:

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

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

Subscriber contributions

You can also choose to contribute to your HSA, either through pre-tax payroll deductions (if available from your employer) or direct deposits to HealthEquity. You may be able to deduct your HSA contributions from your federal income taxes.

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

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

Other features of the CDHP/HSA

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

What happens to my HSA when I leave the CDHP?

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

- You won't forfeit any unspent funds in your HSA after enrolling in a different plan. You can spend your HSA funds on qualified medical expenses in the future. However, you, your employer, the PEBB Program, and other individuals can no longer contribute to your HSA.
- If you leave employment or retire, HealthEquity will charge you a monthly fee if you have less than $2,500 in your HSA after December 31. You can avoid this charge by either ensuring you have at least $2,500 in your HSA or by spending all of your HSA funds by December 31. Other fees may apply. Contact HealthEquity for details.

You must contact HealthEquity to stop automatic direct deposits to your HSA if you previously set this up.

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

Yes. Enrolling in a CDHP and opening an HSA mid-year may limit the amount of contributions you (or your employer) can make in the first year.

If you have any questions about this, talk to your tax advisor.

How do I find Summaries of Benefits and Coverage?

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

- What is not included in the plan's out-of-pocket limit?
- Do I need a referral to see a specialist?
- Are there services this plan doesn't cover?

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

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

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

You can find the medical plan websites and customer service phone numbers on page 2.

2020 Medical plans available by county

In most cases, you must live in the medical plan's service area to join the plan. Be sure to call the medical plan(s) you are interested in to ask about provider availability in your county. If you move out of your medical plan's service area, you may need to change plans. You must report your new address to your personnel, payroll, or benefits office **no later than 60 days** after your move.

Washington			
Kaiser Permanente NW Classic* **Kaiser Permanente NW Consumer-Directed Health Plan (CDHP)***	• Clark • Cowlitz		
Kaiser Permanente WA Classic **Kaiser Permanente WA Consumer-Directed Health Plan (CDHP)** **Kaiser Permanente WA Value**	• Benton • Columbia • Franklin • Island • King • Kitsap • Kittitas	• Lewis • Mason • Pierce • Skagit	• Snohomish • Spokane • Thurston • Walla Walla • Whatcom • Whitman • Yakima
Kaiser Permanente WA SoundChoice	• King • Kitsap **Note:** Not all contracted providers in Spokane County are in the SoundChoice network. Please make sure your provider is in-network before your visit.	• Pierce • Snohomish	• Spokane • Thurston
Uniform Medical Plan (UMP) Classic **UMP Consumer-Directed Health Plan (CDHP)**	Available in all Washington counties and worldwide.		
UMP Plus—Puget Sound High Value Network	• King • Kitsap	• Pierce • Snohomish	• Thurston • Yakima
UMP Plus—UW Medicine Accountable Care Network	• King • Kitsap	• Pierce • Skagit	• Snohomish • Spokane

Oregon			
Kaiser Permanente NW Classic* **Kaiser Permanente NW Consumer-Directed Health Plan (CDHP)***	• Benton (ZIP Codes: 97330, 97331, 97333, 97339, and 97370, 97456) • Clackamas • Columbia • Hood River (ZIP Code: 97014)	• Lane (ZIP Codes: 97401, 97402, 97403, 97404, 97405, 97408, 97409, 97419, 97424, 97426, 97431, 97437, 97438, 97440, 97448, 97451, 97452, 97454, 97455, 97461, 97475, 97477, 97478, 97487, and 97489)	• Linn (ZIP Codes: 97321, 97322, 97335, 97348, 97355, 97358, 97360, 97374, 97377, 97389, and 97446) • Marion • Multnomah • Polk • Washington • Yamhill
Uniform Medical Plan (UMP) Classic **UMP Consumer-Directed Health Plan (CDHP)**	Available in all Oregon counties and worldwide.		

Idaho	
UMP Classic **UMP Consumer-Directed Health Plan (CDHP)**	Available in all Idaho counties and worldwide.

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

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2020 PEBB Medical Benefits Cost Comparison

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

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

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

(continued)

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

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

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

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

2020 Medical benefits comparison

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

(continued)

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

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

2020 Medical benefits comparison

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

(continued)

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

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

Selecting a PEBB dental plan

You and any enrolled dependents must be enrolled in the same PEBB dental plan.

Dental Plan Options

Make sure you confirm with your dentist that they accept the **specific plan network** and **plan group**.

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

How do the DeltaCare and Willamette Dental Group plans work?

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

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

DeltaCare and Willamette Dental Group are managed-care plans. You must select and receive care from a primary care dental provider in that plan's network. If you choose one of these plans and seek services from a dentist not in the plan's network, the plan will not pay your dental claims. Before enrolling, call the plan to make sure your dentist is in the plan's network. Do not rely solely on information from your dentist's office.

Neither plan has an annual deductible. You don't need to track how much you have paid out of pocket before the plan begins covering benefits. You pay a set amount (copay) when you receive dental services. Neither plan has an annual maximum that they pay for covered benefits (some specific exceptions apply).

Referrals are required from your primary care dental provider to see a specialist. You may change providers in your plan's network at any time.

How does the Uniform Dental Plan (UDP) work?

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

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

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

Under UDP, you pay a percentage of the plan's allowed amount (coinsurance) for dental services after you have met the annual deductible.

UDP pays up to an annual maximum of $1,750 for covered benefits for each enrolled dependent, including preventive visits.

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

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

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

Check with the plan to see if your dentist is in the plan's network. Make sure you correctly identify your dental plan's network and group number (see table above). You can call the dental plan's customer service (listed in the front of this booklet), or use the dental plan network's online directory. Carefully review the selection you made before submitting your enrollment form.

Dental benefits comparison

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

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

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

Group term life and AD&D insurance

Your life insurance benefits allow you to cover yourself, your spouse or state-registered domestic partner, and your children. As an employee, your basic and supplemental life insurance covers you and pays your designated beneficiaries in the event of your death.

The PEBB Program also offers basic and supplemental accidental death and dismemberment (AD&D) insurance, which provides extra benefits for certain injuries or death resulting from a covered accident.

Life and AD&D insurance are available to PEBB benefits-eligible state and higher-education employees, as well as employees who work for an educational service district, a tribal government, or an employer group that offers both PEBB medical and dental coverage.

The PEBB Program offers life insurance through Metropolitan Life Insurance Company (Plan number 164995).

This is a summary of benefits only. To see the certificate of coverage, either:

- Go to **hca.wa.gov/pebb-employee** under Forms and publications.
- Contact your personnel, payroll, or benefits office.
- Go to **metlife.com/wshca** under Documents.

What are my PEBB life and AD&D insurance options?

The PEBB Program offers $35,000 of basic life insurance and $5,000 basic AD&D insurance (called Basic Life and AD&D Insurance for Employees) as part of your benefits package, at no cost to you.

The PEBB Program also offers Supplemental Life and Supplemental AD&D insurance for you to purchase:

- **Supplemental life insurance for employees:** Increments of $10,000 up to $500,000 with no Medical Evidence of Insurability (if elected **no later than 31 days** after becoming eligible for PEBB benefits), to a maximum of $1,000,000 with Medical Evidence of Insurability.
- **Supplemental life insurance for a spouse or state-registered domestic partner:** If you are enrolled in Supplemental Life Insurance for Employees, you may apply for amounts of supplemental life Insurance for your spouse or state-registered domestic partner in increments of $5,000 up to $500,000 with $100,000 of guaranteed issue, not to exceed one-half the amount of the Supplemental Life Insurance for Employees that you get for yourself).
- **Supplemental life insurance for children:** If you enroll in supplemental life insurance for yourself, you may apply for child coverage in $5,000 increments up to $20,000. The amount you select applies to all children enrolled. Children are no longer eligible for this coverage when they turn 26.
- **Supplemental AD&D insurance for employees:** You may enroll in supplemental AD&D coverage in increments of $10,000 up to $250,000. Supplemental AD&D insurance does not cover death and dismemberment from nonaccidental causes. Supplemental AD&D insurance never requires evidence of insurability.
- **Supplemental AD&D insurance for a spouse or state-registered domestic partner:** You can choose to cover your spouse or state-registered domestic partner with AD&D coverage. You may enroll in supplemental AD&D coverage in increments of $10,000 up to $250,000.
- **Supplemental AD&D insurance for children:** For your children, supplemental AD&D coverage is available in $5,000 increments up to $25,000. Children are no longer eligible for this coverage when they turn 26. Contact MetLife about this coverage if your child is approaching age 26.

When can I enroll?

You may enroll for up to the guaranteed issue amounts of supplemental life insurance without submitting evidence of insurability to MetLife no later than:

- **31 days** after the date you become eligible for PEBB benefits.
- **60 days** after the date of marriage or registering a state-registered domestic partnership.
- **60 days** after the birth or adoption of a child, once the child is 14 days old. Once you have enrolled one child in Child Dependent Life Insurance, each succeeding child will automatically be covered for the same amount on the date that child becomes eligible as defined in Metropolitan Life Insurance's (MetLife) certificate of coverage.

Supplemental AD&D insurance never requires evidence of insurability. You must provide evidence of insurability to MetLife if you:

- Apply for any amount of supplemental life insurance, spouse/state-registered domestic partner life insurance, or dependent child life insurance after 31 days from becoming eligible for PEBB benefits.
- Request more than $500,000 in supplemental employee life insurance for yourself.
- Request more than $100,000 in supplemental life insurance for your spouse or state-registered domestic partner.

MetLife must approve your request for additional levels of coverage.

How do I enroll?

Complete your enrollment directly with MetLife at **mybenefts.metlife.com/wapebb** or using the ***2020 PEBB MetLife Enrollment/Change Form*** in the back of this book and submit to MetLife via the instructions on the form. **Note:** It can take up to 30 days to process the MetLife enrollment/change form. If you have any questions about enrollment, please contact MetLife at 1-866-548-7139.

If I leave employment, can I continue life insurance coverage?

If you're eligible for Portability or Conversion due to termination or other reasons, MetLife will send you information and an application. Complete and mail to the address on the application. When Porting or Converting your employee life insurance coverage, your coverage will become an individual policy that is not tied to the PEBB Program.

Portability Provision

Under the Portability Provision, you can apply to continue your active employee basic and supplemental life insurance until age 100 if certain conditions are met.

You must be actively enrolled in coverage to have the opportunity to continue all or part of your coverage through portability.

You may also apply to continue your dependent child basic life insurance and your spouse or state-registered domestic partner supplemental life insurance at the same time you apply to continue your own life insurance. You may continue life insurance for your dependents even if you choose not to continue your life insurance.

To continue life insurance under the Portability Provision, you must apply to MetLife **no later than 60 days** after the date your PEBB Program life insurance ends. Any amount of life insurance not ported may be converted.To continue life insurance under the Portability Provision, you must apply to MetLife within 60 days after the date your PEBB employee life insurance ends, including when you move to PEBB retiree term life insurance.

Conversion of Life Insurance Provision

You may convert your basic life, supplemental life, spouse/state-registered domestic partner, or dependent child life insurance to an individual policy.

The amount of the individual policy will be equal to (or if you choose, less than) the amount of life insurance you or your insured dependents had on the termination date of the policy you are converting.

You must apply to continue your coverage under the Conversion of Life Insurance Provision. You have **60 days** to apply for conversion coverage after your employee life insurance ends. Contact MetLife directly at 1-866-548-7139 with any questions.

Monthly rates

Rates are based on your age as of December 31 of the prior year.

Supplemental life insurance for employees and spouse or state-registered domestic partner, and child(ren)		
Age	Monthly cost per $1,000	
	Non-tobacco user	tobacco user
Less than 25	$0.028	$0.037
25–29	$0.031	$0.043
30–34	$0.034	$0.057
35–39	$0.043	$0.066
40–44	$0.064	$0.073
45–49	$0.092	$0.111
50–54	$0.143	$0.170
55–59	$0.268	$0.317
60–64	$0.411	$0.482
65–69	$0.758	$0.929
70+	$1.131	$1.510
Cost for your child(ren)	$0.124	$0.124
Rates are based on your age as of December 31 of the prior year.		

Supplemental accidental death and dismemberment (AD&D) insurance	
	Monthly cost per $1,000
Employee	$0.019
Dependent Spouse or State-Registered Domestic Partner	$0.019
Dependent Child(ren)	$0.016

Long-term disability insurance

Long-term disability (LTD) insurance is designed to help protect you from the financial risk of lost earnings due to serious injury or illness. When you enroll in LTD coverage, it pays a percentage of your monthly earnings to you if you become disabled as defined below.

The PEBB Program offers long-term disability (LTD) insurance through Standard Insurance Company. This is a summary. To see details of this benefit, read the LTD plan booklet, or to get forms:

- Visit **hca.wa.gov/pebb-employee.**
- Contact your employer's personnel, payroll, or benefits office.

LTD insurance is available to PEBB benefits-eligible state and higher-education employees, employees of an educational service district, tribal government, or employer group that offers both PEBB medical and dental coverage. **Exceptions:** Supplemental LTD insurance is not available to seasonal employees who work a season that is less than nine months, or port commissioners.

What are my PEBB long-term disability insurance options?

LTD coverage has two parts:

1. The PEBB Program offers a maximum $240 monthly basic LTD benefit as part of your benefits package, at no cost to you.
2. The PEBB Program also offers supplemental LTD insurance for you to purchase.

LTD benefit amounts

The monthly LTD benefit is a percentage of your insured monthly predisability earnings, reduced by deductible income (such as work earnings, workers' compensation, sick pay, Social Security, etc.).

The LTD benefit for each plan is shown below:

	Basic LTD	Supplemental LTD
% of monthly predisability earnings the plan pays	60% of the first $400	60% of the first $10,000
Minimum monthly LTD benefit	$50	$50
Maximum monthly LTD benefit	$240	$6,000

Waiting period before benefits become payable

Basic LTD Plan. The longer of:

- 90 days
- The period of sick leave (excluding shared leave) for which you are eligible under the employer's sick leave plan, and/or
- The period of Washington Paid Family and Medical Leave for which you are receiving benefits

Supplemental LTD Plan. The longer of:

- 90, 120, 180, 240, 300, or 360 days (depending on your election)
- The period of sick leave (excluding shared leave) for which you are eligible under the employer's sick leave plan, and/or
- The period of Washington Paid Family and Medical Leave for which you are receiving benefits

What is considered a disability?

Being unable to perform with reasonable continuity the duties of your own occupation as a result of sickness, injury, or pregnancy during the benefit waiting period and the first 24 months for which LTD benefits are payable.

During this period, you are considered partially disabled if you are working but unable to earn more than 80 percent of your indexed pre-disability earnings.

After that, as a result of sickness, injury, or pregnancy, being unable to perform with reasonable continuity the material duties of any gainful occupation for which you are reasonably able through education, training, or experience.

During this period, you are considered partially disabled if you are working, but unable to earn more than 60 percent of your indexed pre-disability earnings in that occupation and in all other occupations for which you are reasonably suited.

Maximum benefit period

For both basic and supplemental LTD coverage, the benefit duration is based on your age when the disability begins.

Age	Maximum benefit period
61 or younger	To age 65, or to SSNRA* or 42 months, whichever is longer
62	To SSNRA* or 42 months, whichever is longer
63	To SSNRA* or 36 months, whichever is longer
64	To SSNRA* or 30 months, whichever is longer
65	24 months
66	21 months
67	18 months
68	15 months
69 or older	12 months

*SSNRA is Social Security Normal Retirement Age, your normal retirement age under the Federal Social Security Act as amended.

How much does supplemental LTD insurance cost?

Payroll deduction is a percentage of your pre-disability earnings. Multiply your monthly base pay (up to $10,000) by the percentage shown in the table below for the desired benefit waiting period to calculate your supplemental LTD monthly premium.

Benefit waiting period	Higher-education retirement plan employees	TRS, PERS, and other retirement plan employees
90 days	0.72%	0.60%
120 days	0.42%	0.36%
180 days	0.32%	0.28%
240 days	0.30%	0.27%
300 days	0.28%	0.25%
360 days	0.27%	0.24%

When can I enroll?

You may enroll in supplemental LTD coverage **no later than 31 days** after becoming eligible for PEBB benefits (generally your first day of employment) without providing evidence of insurability.

If you apply for supplemental LTD coverage after 31 days, or decrease the waiting period for supplemental LTD coverage, you must provide evidence of insurability and your *PEBB Long Term Disability (LTD) Evidence of Insurability Form* must be approved by Standard Insurance Company before your insurance becomes effective.

How do I enroll?

If applying **no later than 31 days** after you become eligible for PEBB benefits, complete and submit the *PEBB Long Term Disability (LTD) Enrollment/ Change Form* (found in the back of this booklet) to your personnel, payroll, or benefits office.

If applying after 31 days, or decreasing the waiting period for supplemental LTD coverage, you must also complete the *PEBB Long Term Disability (LTD) Evidence of Insurability Form* (foundin the back of this book or online at **hca.wa.gov/pebb-employee**) and submit it to Standard Insurance Company.

For questions about enrollment, contact your personnel, payroll, or benefits office. If you have a specific question about a claim, contact Standard Insurance Company at 1-800-368-2860.

The PEBB Program offers long-term disability (LTD) insurance through Standard Insurance Company. **This is a summary.** To see the LTD plan booklet or to get forms:

- Go to **hca.wa.gov/pebb-employee**.
- Contact your employer's personnel, payroll, or benefits office.

Below are some examples to help you calculate the cost of supplemental LTD insurance.

Example #1

If you are a higher-education retirement plan employee with monthly earnings of $1,000, the 90-day benefit waiting period would cost $7.20 per month.

Earnings: $ 1,000 per month
90-day benefit waiting period: x 0.0072 (0.72% converts to 0.0072 when multiplying)
Monthly cost: **$ 7.20**

Example #2

If you are a TRS, PERS, or other retirement plan employee with monthly earnings of $1,000, the 90-day benefit waiting period would cost $6.00 per month.

Earnings: $ 1,000 per month
90-day benefit waiting period: x 0.006 (0.6% converts to 0.006 when multiplying)
Monthly cost: **$ 6.00**

Medical Flexible Spending Arrangement (FSA) and Dependent Care Assistance Program (DCAP)

Both the Medical FSA and DCAP are available to public employees eligible for PEBB benefits who work at state agencies, higher-education institutions, and community and technical colleges, as described in Washington Administrative Code (WAC) 182-12-114. See **hca.wa.gov/pebb-employee** under *Additional benefits* to learn more.

Navia Benefit Solutions, Inc. administers the Medical FSA and DCAP for the PEBB Program. For details and forms, visit **pebb.naviabenefts.com** or call 1-800-669-3539. Email questions to **customerservice@naviabenefits.com**.

What is a Medical Flexible Spending Arrangement (FSA)?

A Medical FSA allows you to set aside money from your paycheck on a pre-tax basis to pay for qualifying out-of-pocket health care costs for you and your qualified dependents. You can set aside as little as $240 or as much as $2,700 per calendar year. The full amount you elect to set aside for your Medical FSA is available on the first day your benefits become effective.

Note: You cannot enroll in both a Medical FSA and a PEBB consumer-directed health plan (CDHP) with a health savings account (HSA) because both are tax-preferred benefits. If you elect to enroll in both, you will only be enrolled in the CDHP with a HSA.

How does the Medical FSA work?

- Your Medical FSA helps you pay for deductibles, copays, coinsurance, dental, vision, and many other expenses. You can use your Medical FSA for you, your spouse's, or qualified dependent's health care expenses, even if they are not enrolled in your PEBB medical or dental plan.
- To figure out how much you should contribute, estimate your out-of-pocket medical expenses for the calendar year and enroll in a Medical FSA for that amount. The more accurate you are in estimating your expenses, the better this benefit will work for you.
- Your election amount is deducted from your pay, divided by the number of paychecks you will receive in the calendar year. Your election amount will be deducted from your paychecks pre-tax (which reduces your taxable income), so you don't pay Federal Insurance Contributions Act (FICA) or federal income taxes on your elected dollars.

$250 Medical FSA contribution for represented employees

The collective bargaining agreement negotiated in September 2018 states that represented employees who make $50,004 or less per year as of November 1 will receive a Medical FSA contribution of $250 in January 2020. This money is an employer-paid benefit; it will **not** come out of your paycheck. If you have questions, please contact your collective bargaining agreement or your personnel, payroll, or benefits office.

How do I get this benefit?

If you are eligible for this contribution as of November 1, 2019, you will receive it automatically from your employer. No action is required on your part.

- If you do **not** enroll in a Medical FSA for 2020, Navia Benefit Solutions will open an account in your name and send you a welcome letter with a debit card loaded with $250. Use the debit card for eligible health care expenses by March 15, 2021. If you do not want the funds, you do not have to spend them. They will be forfeited.
- If you enroll in a Medical FSA for the 2020 plan year, the $250 contribution will be added to your account with Navia Benefit Solutions in January 2020.

You will not receive this benefit if you enroll in a CDHP with an HSA for 2020. This limitation is an Internal Revenue Service rule. You will also forfeit this benefit if you waive PEBB medical coverage for 2020, unless you waive to enroll as a dependent on someone else's PEBB medical plan (that is not a CDHP). If you cannot receive the $250 for one of these reasons, the collective bargaining agreement does not allow the $250 to be distributed or used in any other way. You will forfeit this benefit.

What is the Dependent Care Assistance Program (DCAP)?

Child or elder care can be one of the largest expenses for a family. The DCAP allows you to set aside money from your paycheck on a pre-tax basis to help pay for qualifying child care or elder care expenses while you and your spouse attend school full-time, work, or look for work.

A qualifying dependent must live with you and must be 12 years old or younger. A dependent age 13 or older qualifies only if they are physically or mentally incapable of self-care and regularly spends at least eight hours each day in your household. The care must be provided during the hours the parent(s) work, look for work, or attend school.

(continued)

You can set aside as much as $5,000 annually (single person or married couple fling joint income tax return) or $2,500 annually (married fling separate income tax return). The total amount of your contribution cannot be more than either your earned income or your spouse's earned income, whichever is less. Earned income means wages, salaries, tips, and other employee compensation, plus net earnings from self-employment.

How does the DCAP work?

- The DCAP helps you pay for eligible expenses including elder day care, babysitting, day care, preschool, and registration fees.
- Estimate your child or elder care expenses for the calendar year and enroll in the DCAP for that amount.
- Your election amount is deducted from your pay, and divided by the number of paychecks you will receive in the calendar year. Your election amount will be deducted from your paychecks pre-tax (which reduces your taxable income).

When can I enroll?

You may enroll in the Medical FSA and the DCAP at the following times:

- No later than 31 days after the date you become eligible for PEBB benefits (usually on your first day of employment; see WAC 182-08-197 for details).
- During the PEBB Program's annual open enrollment (November 1 through 30).
- **No later than 60 days** after you or an eligible dependent experiences a qualifying event that creates a special open enrollment during the year.

Before you enroll, make sure to review the PEBB Medical FSA or DCAP Enrollment guides at **pebb.naviabenefts.com.** You can also call Navia Benefit Solutions at 1-800-669-3539 if you have questions.

How can I enroll?

You can download and print enrollment form at **pebb.naviabenefts.com**.

To enroll as a first time subscriber in these optional benefits, you must return the form to your personnel, payroll or benefits office **no later than 31 days** after you become eligible for PEBB benefits. **Exception:** University of Washington employees must enroll through Workday.

Employees who enroll in a consumer-directed health plan (CDHP) with a health savings account (HSA) cannot also enroll in a Medical FSA in the same plan year.

When can I change my Medical FSA or DCAP election?

Once you enroll in a Medical FSA or DCAP, you can change your election only if you have a qualifying life event that creates a special open enrollment. The requested change must correspond to and be consistent with the qualifying event. For example, you cannot reduce your annual election if you get married; you can only increase it.

If you have a qualifying event and want to change your elections, your personnel, payroll, or benefits office must receive your Navia Benefit Solutions *PEBB Change of Status* form and proof of the event that created the special open enrollment **no later than 60 days** after the date of the event. **Note:** University of Washington employees must submit the change through Workday.

For more information, see the *Medical FSA Enrollment Guide or DCAP Enrollment Guide* at **pebb.naviabenefits.com.**

To learn more about special open enrollments, find PEBB Program Administrative Policy 45-2 and Addendum 45-2A Special Open Enrollment Matrix at **hca.wa.gov/pebb-rules.**

SmartHealth

SmartHealth is included in your benefits and is Washington State's voluntary wellness program that supports you on your journey toward living well.

The secure website offers fun activities to help you reach your wellness goals, such as sleeping better, eating healthier, and planning for retirement. As you progress on your wellness journey, you can qualify for SmartHealth wellness incentives.

Who is eligible for SmartHealth?

Generally, 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 wellness incentives.

> **Note:** If you waive PEBB medical coverage, you will have access to SmartHealth, but will not receive the wellness incentive unless you are enrolled in a medical plan in 2021.

What are the wellness incentives?

Eligible subscribers can qualify for both SmartHealth wellness incentives:

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

How do I qualify for the wellness incentives?

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

- Not be enrolled in Medicare Part A and Part B as their primary insurance.
- Complete the SmartHealth Well-being Assessment and claim the $25 Amazon.com gift card* by December 31, 2020.

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

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

To receive the $125 wellness incentive in 2021, the subscriber must still be enrolled in a PEBB medical plan in 2021.

The PEBB Program 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 the wellness incentive or waive the requirement.

If a subscriber qualifies for the $125 wellness incentive in 2020, then becomes a retiree, or continuation coverage subscriber enrolled in Medicare Part A and Part B as their primary coverage and while enrolled in a PEBB medical plan after January 1, 2021, they will still receive the SmartHealth incentive in 2021.

How do I get started?

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

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

What are the deadlines?

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

The deadline to meet the requirements for the $125 wellness incentive is as follows:

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

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

Auto and home insurance

What does Liberty Mutual offer?

PEBB Program members may receive a discount of up to 12 percent off Liberty Mutual's auto insurance rates and up to 5 percent off Liberty Mutual's home insurance rates.

In addition to the discounts, Liberty Mutual also offers:

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

When can I enroll?

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

How do I enroll?

To request a quote for auto or home insurance, you can contact Liberty Mutual one of three ways (have your current policy handy):

- Look for auto/home insurance on the PEBB Program's website at **hca.wa.gov/employee-retiree-benefits/public-employees/auto-and-home-insurance**.
- Call Liberty Mutual at 1-800-706-5525. Be sure to mention that you are a State of Washington PEBB Program member (client #8246).
- Call or visit one of the local offices (see box).

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

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

Contact a local Liberty Mutual office (mention client #8246):

Portland, OR 1-800-248-8320
4949 SW Meadows Rd., Suite 650,
Lake Oswego, OR 97035

Bellevue 1-800-253-5602
11711 SE 8th St. Suite 220,
Bellevue, WA 98005

Spokane 1-800-208-3044
24041 E Mission Ave
Liberty Lake, WA 99019

Tukwila 1-800-922-7013
14900 Interurban Ave., Suite 142
Tukwila, WA 98168

Olympia 1-360-705-0600
400 Union Ave SE, Suite 253
Olympia, WA 98501

Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

PEBB Program Nondiscrimination Notice and Language Access Services

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

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

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

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

If you believe this organization has failed to provide language access services or discriminated in another way…	You can file a grievance with:
PEBB Program	Health Care Authority Enterprise Risk Management Office 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**

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If you believe this organization has failed to provide language access services or discriminated in another way…	You can file a grievance with:
Regence BlueShield (for discrimination concerns about UMP Classic, UMP 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)

Washington State Health Care Authority

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

[Amharic] የደምጽ እገዛ አገልግሎት፣ ተርጓሚዎችን እና የተተረጎሙ የታተሙ ጽሁፎችን ጨምሮ፣ በነጻ አዚህ 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 Authority ን 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 ပံ့ပိုးထားသည် စာရွက်စာတမ်းများကို ဘာသာပြန်ပေးမှုများ အပါအဝင် ဘာသာစကား အထောက်အကူပြု ဝန်ဆောင်မှုများကို အခမဲ့ ဖိတ်ခေါ်ထားပေးပါသည်။ ဝန်ထမ်းများ:သည် မိမိတို့ ဝန်ထမ်း၊ လစာထုတ်ပေး:သည် ဝို: သိမ်းဟုတ် အကျိုး:ခံစား:ခွင့်များ: စီစဉ်ပေး:သည်နဲ့တကွ ကိုသွယ်ပါ။ အငြိမ်စား:ယူထား:သူများ: အစိုး:ရ ဝန်ထမ်း:များ: အကျိုး:ခံစား:ခွင့် ဘုတ်အဖွဲ့ (PEBB) နှင့် ကျောင်း:ဝန်ထမ်း:များ: အကျိုး:ခံစား:ခွင့် ဘုတ်အဖွဲ့ (SEBB) အဖမ်း ကိုလက်မှတ်စား:ရေး: အဖွဲ့ဝင်များ: Health Care Authority ထံ 1-800-200-1004 (TRS: 711) တွင် ကိုသွယ်ပါ။

[Cambodian] សេវាជំនួយផ្នែកភាសា រួមទាំងអ្នកបកប្រែ និងការបកប្រែឯកសារបោះពុម្ព មានផ្តល់ជូនដោយឥតគិតថ្លៃ។ និយោជិត៖ ទាក់ទងបុគ្គលិក បញ្ជីបើកប្រាក់ខែ ឬការិយាល័យផលប្រយោជន៍របស់អ្នក។ និវត្តជន សមាជិកកម្មវិធីបន្ត្រូវគ្នាក្រោមកិច្ចការពារសន្តិសុខសង្គមរបស់ PEBB និងក្រុមប្រឹក្សាកិច្ចការសន្តិសុខសង្គមរបស់ SEBB: ហៅ 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) 繼保會員：請致電 1-800-200-1004 (TRS: 711) 聯絡 Health Care Authority。

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

[Laotian] ບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ , ລວມທັງ: ການແປ ແລະການແປ ເອກະສານ, ແມ່ນມີໃຫ້ບໍລິການ ຟຣີ. ພະນັກງານ: ຂໍໄດ້ຮັບຄຳແນະນຳຫຍຸດຕະລາການ, ບັນຊີເງິນເດືອນ, ຫຼືເຈົ້າຫນ້າທີ່ຜົນປະໂຫຍດຕ່າງໆ . ບຳນານ, ສະມາຊິກຜູ້ບັນເນດ ອງຄໍເພື່ອຂະຫຍາຍການຄຸ້ມຄອງການ ແລະ ສະມາຊິກ PEBB ແລະ SEBB: ໂທຫາ Health Care Authority ທີ່ 1-800-200-1004 (TRS: 711).

[Oromo] Tajaajila deeggarsa afaanii, afaan hiikuu fi waraqawwan afaan barbaachiseti hiikuu, kafaltii kamiyu malee. Mindeffamtonnic Nama isin to'atu, galmee kaffaltii, yookiin biiroo fayyadamtan quunnama. Soroomaa, 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, ਜਿਹਨਾਂ ਵਿੱਚ ਦੁਭਾਸ਼ਿਏ ਅਤੇ ਪ੍ਰਿੰਟ ਕੀਤੀ ਹੋ ਸਾਮੱਗਰੀ ਦਾ ਅਨੁਵਾਦ ਕਰਨਾ ਸ਼ਾਮਲ ਹੈ, ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। ਕਰਮਚਾਰੀ: ਆਪਣੇ ਅਮਲੇ, ਤਨਖ਼ਾਹ ਜਾਂ ਫ਼ਾਇਦੇਆਂ ਦੇ ਦਫ਼ਤਰ ਨਾਲ ਸੰਪਰਕ ਕਰੋ। ਰਿਟਾਇਰ ਹੋ ਚੁੱਕੇ, PEBB ਅਤੇ SEBB ਜਾਰੀ ਕੰਵਰ ਦਾਖ਼ੇ ਕਵਰੇਜ ਮਮੰਦ: 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 interpreți 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 bixi 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 ወተርጓሚትን ሓዲስ ብዘይ ምንም ክፍሊት ንህብ እና። ቅጥረኛታት፡ ምስ ናይ ሰራሕተኛ ጕዳያት ኣሰሪምዚ ቢሮ ምስ ቢሮ ከፍሊት ወነፃ ወይ ከፍ ምስ ቢሮ ጥቅማ ጥቅሚ ተራኸቡ። ጡረተኛታት፡ ናይ ህዝቢ ሰራሕተኛታት ጥቅሚ ቦርድ (PEBB)ን ናይ ትምህርቲ ትካላት ሰራሕተኛታት ጥቅሚ ቦርድ (SEBB) ኣባላት ዝኾኑ፡ ናብ Health Care Authority ስ 1-800-200-1004 (TRS: 711) ቁፅሪ ኣዝ 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).

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Enrollment Forms

The following forms are available online:

2020 Employee Enrollment/Change

hca.wa.gov/assets/pebb/50-400-pebb-employee-enrollment-change-form-2020.pdf

2020 Employee Enrollment/Change for Medical Only Groups

hca.wa.gov/assets/pebb/52-030-pebb-employee-enrollment-form-medical-only-2020.pdf

2020 Enrollment/Change MetLife

hca.wa.gov/assets/pebb/metlife-pebb-employee-enrollment-change-form-2020.pdf

Long Term Disability (LTD) Enrollment/Change Form

standard.com/eforms/7533_377661.pdf

2020 Premium Surcharge Help Sheet

hca.wa.gov/assets/pebb/50-226-pebb-premium-surcharge-attestation-help-sheet-2020.pdf