2024 PEBB Retiree Change Form (E)

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Benefits 24/7, the new online enrollment system, will be available January 2024.

Complete this form to make changes to an existing retiree account. If you are newly eligible and applying to enroll in or defer PEBB retiree insurance coverage, or enrolling after deferring, please submit the *PEBB Retiree Election Form* (form A).

This form replaces all retiree enrollment/change forms submitted in the past. You must complete the entire form, including the dependent section for any children you want to continue to cover. All forms and documents mentioned are available at **hca.wa.gov/pebb-retirees** under *Forms & publications*.

Type or print in dark ink using all capital lettering in the spaces provided. Inaccurate, incomplete, or illegible information may delay coverage. Follow example to fill in form: J O H N

If you submit this form and more information is needed, the PEBB Program will contact you. You will not lose your coverage.

⚠ Remember to read and sign Section 10. To enroll or remove children, complete Section 3. If you are terminating or deferring your coverage, you only need to complete Sections 1, 7, and 8. To terminate retiree term life insurance, call MetLife at 1-866-548-7139.

What change are you requesting? (Check all that apply.)

- ☐ Name change
- ☐ Address change

Change in coverage:

- ☐ Medical and/or dental plan change
- ☐ Terminate enrollment medical and dental
- ☐ Terminate dental only
- ☐ Defer (postpone) enrollment

Change in family coverage:

- ☐ **Add a spouse, a state-registered domestic partner, or dependents.** Attach a *PEBB Declaration of Tax Status* for children of a state-registered domestic partner, extended dependents, or other nonqualified tax dependents. If adding an extended dependent, also attach a *PEBB Extended Dependent Certification*.
- ☐ **Remove a spouse, a state-registered domestic partner or dependents.**

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Subscriber's last name

Social Security number

1 Subscriber

Social Security number

Date of birth (mm/dd/yyyy)

Sex assigned at birth[1]

Male Female

Last name

Gender identity[2]

Male Female X

First name

Middle initial

Suffix

Phone number

Alternate phone number

Street address

Address line 2

City

State

ZIP/Postal code

County

Mailing address (if different)

Mailing address line 2

City

State

ZIP/Postal code

County

Are you enrolled in Medicare Part A or Part B?

Part A (hospital) Yes No If Yes, enter effective date from Medicare card:

Part B (medical) Yes No If Yes, enter effective date from Medicare card:

Medicare number

If Yes, proof is required. Attach a copy of your entire entitlement letter or a copy of your Medicare card to this form if we don't already have a copy. If you are eligible for Medicare, you must enroll and stay enrolled in both Part A and Part B to keep PEBB retiree health plan coverage.

I am in the process of enrolling in Medicare Part A and Part B. I will submit proof after I receive my entitlement letter or Medicare card. **You will not be enrolled until your proof of Medicare is received.**

[1] This field is required for health care services.

[2] Gender X means a gender that is not exclusively male or female. This field is optional and will be kept private to the extent allowable by law. To learn more, visit **hca.wa.gov/gender-x**.

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Are you enrolled in Medicare Part D (prescription drug coverage)?

Yes No If Yes, effective date:

If Yes, you may enroll only in Premera Blue Cross Medicare Supplement Plan G. (Plan F enrollees may stay in the plan if already enrolled. If you are adding a newly Medicare eligible spouse or state-registered domestic partner you must enroll in Plan G.) If you want to enroll in any other PEBB medical plan, you must disenroll from your Part D plan.

Are you enrolled in Medicaid with Medicare Part D?

Yes No If Yes, effective date:

The premium surcharges, if applicable, only apply to subscribers who are **not** enrolled in Medicare Part A and Part B.

Tobacco use premium surcharge

If you need to report a change to your previous tobacco surcharge attestation, you can do it online through HCA's online enrollment system or submit the *PEBB Premium Surcharge Attestation Change Form*, available on the HCA website at **hca.wa.gov/pebb-retirees**.

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2 Spouse or state-registered domestic partner (SRDP)

List an eligible spouse or SRDP you wish to cover or remove from coverage. SRDP is defined in WAC 182-12-109. Individuals in state-registered domestic partnerships are treated the same as legal spouses except when in conflict with federal law. A spouse or SRDP cannot be enrolled in two PEBB medical or dental accounts at the same time.

Relationship to subscriber

☐ Spouse: date of marriage

☐ SRDP: date registered

Social Security number

Date of birth (mm/dd/yyyy)

Sex assigned at birth[1]

☐ Male ☐ Female

Last name

Gender identity[2]

☐ Male ☐ Female ☐ X

First name

Middle initial

Suffix

Phone number

Alternate phone number

Street address (if different from subscriber)

Address line 2

City

State

ZIP/Postal code

County

Coverage for spouse or SRDP

☐ **Cover**

If enrolling a spouse, you must provide proof of their eligibility within the PEBB Program's enrollment timelines, or they will not be enrolled.

If enrolling an SRDP you must attach a *PEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes. You must also provide proof of their eligibility within the PEBB Program's enrollment timelines, or they will not be enrolled. Timelines and a list of documents we will accept to prove eligibility are available on HCA's website at **hca.wa.gov/pebb-retirees**.

☐ **Remove from coverage**

Attach a copy of divorce decree or dissolution of SRDP if removing for this reason. You must also submit *PEBB Medicare Advantage Plan Disenrollment Form* (form D) if your spouse or SRDP is enrolled in a Medicare Advantage plan.

Requested date of termination:

[1] This field is required for health care services.

[2] Gender X means a gender that is not exclusively male or female. This field is optional and will be kept private to the extent allowable by law. To learn more, visit **hca.wa.gov/gender-x**.

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Is this person enrolled in Medicare Part A or Part B?

Part A (hospital)

Yes No If Yes, enter effective date from Medicare card: (mm/dd/yyyy)

Part B (medical)

Yes No If Yes, enter effective date from Medicare card: (mm/dd/yyyy)

Medicare number

If Yes, proof is required. Attach a copy of their entire entitlement letter or a copy of their Medicare card to this form if we don't already have a copy. Write your full name and the last four digits of your Social Security number on the copy. If your dependent is eligible for Medicare, they must enroll and stay enrolled in Part A and Part B to keep PEBB retiree health plan coverage.

They are in the process of enrolling in Medicare Part A and Part B. They will submit proof after they receive their Medicare entitlement letter or Medicare card. **Your dependent will not be enrolled until their proof of Medicare is received**.

Is this person enrolled in Medicare Part D (prescription drug coverage)?

Yes No If Yes, effective date:

If Yes, they may enroll only in Premera Blue Cross Medicare Supplement Plan G. (Plan F enrollees may stay in the plan if already enrolled.) If they want to enroll in any other PEBB medical plan, they must disenroll from the Part D plan.

Is this person enrolled in Medicaid with Medicare Part D?

Yes No If Yes, effective date:

Tobacco use premium surcharge

The premium surcharges do **not** apply if the subscriber is enrolled in Medicare Part A and Part B. Response required if you are enrolling your spouse or SRDP in medical coverage.

Does the tobacco use premium surcharge apply to you? If you check Yes or leave this section blank, you will be charged the $25 premium surcharge. The PEBB Program requires a monthly $25-per-account premium surcharge in addition to your monthly medical premium if you or an eligible dependent (age 13 orolder) enrolled on your PEBB medical uses a tobacco product. Tobacco use is defined as any use of tobacco products within the past two months, except for religious or ceremonial use.

The premium surcharge will not apply if you or any enrolled dependents who use tobacco meet these requirements:

- Age 18 or older – enrolled in the free tobacco cessation program through your PEBB medical plan (visit HCA's website at **hca.wa.gov/tobacco-free-pebb**).
- Age 13–17 – accessed resources aimed at teens at **teens.smokefree.gov**.

Check only one:

No, I am enrolled in Medicare Part A and Part B. The premium surcharge does not apply.

Yes, I am subject to the $25 premium surcharge. This person has used tobacco products in the past two months.

No, I am not subject to the $25 premium surcharge. This person has not used tobacco products in the past two months or has enrolled in or accessed one of the tobacco cessation resources.

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Subscriber's last name

Social Security number

Spouse or state-registered domestic partner (SRDP) coverage premium surcharge

Response required if you are enrolling your spouse or SRDP in medical coverage. The PEBB Program requires a $50 premium surcharge in addition to your monthly medical premium if you are not enrolled in Medicare Part A and Part B, **and** your spouse or SRDP has chosen not to enroll in another employer-based group medical insurance that is comparable to Uniform Medical Plan Classic.

Answer these questions:	**Yes**	**No**
1. Are you covering your spouse or SRDP in a PEBB medical plan under your account in 2024?	✓	■
2. Will they be eligible for medical coverage through their employer in 2024? (If they will not be employed in 2024, answer No.)		
3. Will their employer offer at least one medical plan that serves their county of residence in 2024?		
4. Have they chosen not to enroll in their employer's medical (including SEBB) coverage in 2024?		
5. Will the coverage offered by their employer in 2024 not be through the PEBB Program or a TRICARE plan? Answer Yes if their employer does not offer PEBB coverage or a TRICARE plan. Answer No if their employer offers PEBB coverage or a TRICARE plan.		
6. Will their share of the medical premium through their employer be less than $117.81 per month in 2024?		

If you answered **No** to questions 1–6, check No below. You will not be charged the surcharge. If you answered **Yes** to all of these questions:

Ask your spouse or SRDP for the Summary of Benefits and Coverage (SBC) for all medical plans that:

a. Serve their county of residence.

b. Have a monthly premium of less than $117.81 per month for the employee.

c. Use the SBC information to answer the questions in the PEBB Spousal Plan Calculator online tool. You will get a Yes or No response from the calculator. Enter this response below.

⚠ If you check Yes or do not check any boxes below, you will be charged the $50 monthly premium surcharge.

Does the spouse or SRDP coverage premium surcharge apply to you?

☐ **No**, the subscriber is enrolled in Medicare Part A and Part B. The premium surcharge does not apply.

☐ **Yes**, I am subject to the $50 premium surcharge. I completed the *PEBB Spousal Plan Calculator*.

☐ **No**, I am not subject to the $50 premium surcharge. If needed, I completed the *PEBB Spousal Plan Calculator online*. Which questions did you check No? Check all that apply. **Question 1 is not applicable.**

☐ Question 2 ☐ Question 3 ☐ Question 4 ☐ Question 5 ☐ Question 6

☐ The PEBB Program to help determine if the premium surcharge applies. If needed, I am submitting a printed *PEBB Spousal Plan Calculator*.

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3 Dependents

List eligible dependents you wish to enroll or remove from coverage. Enrolled children must be eligible under PEBB Program rules. This includes children through the month of their 26th birthday regardless of marital status, student status, or eligibility for coverage under another plan and children age 26 or older with a disability. Use additional forms for more dependents. Subscribers must provide proof of eligibility for each dependent within the PEBB Program's enrollment timelines or they will not be enrolled. Timelines and a list of documents we will accept to prove dependent eligibility are available on HCA's website at **hca.wa.gov/pebb-retirees**.

- If enrolling a state-registered domestic partner's child, an extended dependent, or a nonqualified tax dependent, also attach a *PEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes.
- If enrolling an extended dependent, also attach a PEBB Extended Dependent Certification.
- If enrolling a child with a disability age 26 or older, submit a *PEBB Certification of a Child with a Disability* as instructed on the form. Visit HCA's website at **hca.wa.gov/pebb-retirees** for eligibility information.

Relationship to subscriber

- Child
- Stepchild (not legally adopted)
- Extended dependent (attach a copy of court order)
- Child with a disability age 26 or older

Social Security number

Date of birth (mm/dd/yyyy)

Sex assigned at birth[1]
Male Female

Last name

Gender identity[2]
Male Female X

First name

Middle initial

Suffix

Street address (if different from subscriber)

Address line 2

City

State

ZIP/Postal code

County

Coverage for dependent

Add to coverage

Effective date:

Remove from coverage

Include reason:

[1] This field is required for health care services.

[2] Gender X means a gender that is not exclusively male or female. This field is optional and will be kept private to the extent allowable by law. To learn more, visit **hca.wa.gov/gender-x**.

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Subscriber's last name

Social Security number

Is this person enrolled in Medicare Part A or Part B?

PPart A (hospital) Yes No If Yes, enter effective date from Medicare card:

Part B (medical) Yes No If Yes, enter effective date from Medicare card:

Medicare number

If Yes, proof is required. Attach a copy of your dependent's entire entitlement letter or a copy of their Medicare card to this form if we don't already have a copy. Write your full name and the last four digits of your Social Security number on the copy. If your dependent is eligible for Medicare, they must enroll and stay enrolled in Part A and Part B to keep PEBB retiree health plan coverage.

They are in the process of enrolling in Medicare Part A and Part B. They will submit proof after they receive their entitlement letter or Medicare card. **Your dependent will not be enrolled until their proof of Medicare is received.**

Is this person enrolled in Medicare Part D (prescription drug coverage)?

Yes No If Yes, effective date:

If Yes, they may enroll only in Premera Blue Cross Medicare Supplement Plan G. (Plan F enrollees may stay in the plan.) If they want to enroll in any other PEBB medical plan, they must disenroll from the Part D plan.

Is this person enrolled in Medicaid with Medicare Part D?

Yes No If Yes, effective date:

The premium surcharges, if applicable, only apply to subscribers who are not enrolled in Medicare Part A and Part B.

Tobacco use premium surcharge

Response required if enrolling a dependent age 13 or older in medical coverage. If you check Yes or do not check any boxes below, you will be charged the $25-per-account premium surcharge. See page 5 of this form for instructions on how to respond.

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

No, I am enrolled in Medicare Part A and Part B. The premium surcharge does not apply.

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

No, I am not subject to the $25 premium surcharge. This dependent has not used tobacco products in the past two months or has enrolled in or accessed one of the tobacco cessation resources listed on this form.

Subscriber's last name

Social Security number

4 Special open enrollment (SOE) changes

The PEBB Program only allows changes outside of an annual open enrollment when an event creates a special open enrollment (SOE). The change must be allowable under the Internal Revenue Code and Treasury regulations, and correspond to and be consistent with a special open enrollment event for the subscriber, their dependents, or both. To disenroll from a Medicare Advantage plan or Medicare Advantage Prescription Drug plan, you must also submit the *PEBB Medicare Advantage Plan Disenrollment Form* (Form D). The change must be allowed under 42 C.F.R. Secs. 422.62(b) and 423.38(c).

The PEBB Program must receive Form E and proof of the event that created the special open enrollment **no later than 60 days** after the event occurs. Exceptions apply for new enrollment in a PEBB Medicare Supplement plan or Medicare Advantage plan. In most cases, the enrollment or change will be effective the first day of the month after the event date or the date the form is received, whichever is later. If that day is the first of the month, the change begins on that day.

Note: A subscriber may not change medical or dental plans if the state-registered domestic partner or their state-registered domestic partner's child is not a tax dependent.

Check the box next to the corresponding event below.

The following events allow a subscriber to enroll dependents and change a medical or dental plan:

- Child becoming eligible as an extended dependent through legal custody or legal guardianship. Also complete a *PEBB Extended Dependent Certification* form and *PEBB Declaration of Tax Status* form to indicate whether they qualify as a dependent for tax purposes, available at **hca.wa.gov/pebb-retirees**.
- Subscriber or dependent losing other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
- Subscriber having a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan.
- Subscriber's dependent has a change in their own employment status that affects their eligibility or their dependent's eligibility for the employer contribution under their employer-based group health plan.
- A court order requiring the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber.
- Subscriber or dependent enrolls in or loses eligibility for coverage under Medicaid or a state Children's Health Insurance Program (CHIP).
- Subscriber or dependent becoming eligible for a state premium assistance subsidy for PEBB Program health plan coverage from Medicaid or CHIP.
- Marriage, registering a state-registered domestic partnership (as defined by WAC 182-12-109), birth, adoption, or assuming a legal obligation for support in anticipation of adoption. If enrolling a state-registered domestic partner (SRDP) or their child, you must also submit a *PEBB Declaration of Tax Status* form to indicate whether they qualify as a dependent for tax purposes.

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The following events allow a subscriber to enroll dependents:

- Subscriber or dependent having a change in enrollment under an employer-based group health plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment.
- Subscriber's dependent moving from another country to the United States, or from the United States to another country, and the move resulted in the dependent losing their health insurance.
- Subscriber's dependent loses eligibility for Medicare.

The following events allow medical and dental plan changes:

- Subscriber or dependent having a change in residence that affects medical plan availability. **Note:** If the subscriber's current dental plan does not have available providers within 50 miles of the subscriber or the dependent's new residence, the subscriber may select a new dental plan.
- Subscriber or dependent experiencing a disruption of care for active and ongoing treatment that could function as a reduction in benefits for the subscriber or their dependent (requires approval by the PEBB Program).
- Subscriber or dependent's current medical plan becoming unavailable because the subscriber or their enrolled dependent is no longer eligible for a health savings account (HSA).

The following event allows a subscriber to change medical plans:

- Subscriber or dependent enrolling in Medicare or losing eligibility under Medicare or enrolling (or terminating enrollment) in a Medicare Advantage Prescription Drug plan or a Medicare Part D plan.

(continued)

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Subscriber's last name

Social Security number

5 Medical plan selection

Contact the plans with questions about benefits and providers. Their contact information is on page 15 If you or a dependent are in a Medicare Advantage plan and are moving to another type of medical plan, then you must also submit a *PEBB Medicare Advantage Plan Disenrollment Form (form D)* with this form.

Kaiser Foundation Health Plan of the Northwest [1] (Kaiser Permanente NW)

- ☐ Kaiser Permanente NW Classic[2]
- ☐ Kaiser Permanente NW Consumer-Directed Health Plan[2, 5]
- ☐ Kaiser Permanente NW Senior Advantage[2] (MA)

Kaiser Foundation Health Plan of Washington[1] (Kaiser Permanente WA)

- ☐ Kaiser Permanente WA Classic[6]
- ☐ Kaiser Permanente WA Consumer-Directed Health Plan[5]
- ☐ Kaiser Permanente WA Medicare Plan[3,4]
- ☐ Kaiser Permanente WA SoundChoice[6]
- ☐ Kaiser Permanente WA Value[6]

Premera Blue Cross

- ☐ Medicare Supplement Plan G[7]

Uniform Medical Plan (UMP), administered by Regence BlueShield

- ☐ UMP Classic
- ☐ UMP Select[5]
- ☐ UMP Consumer-Directed Health Plan[5]
- ☐ UMP Plus–Puget Sound High Value Network[1, 5]
- ☐ UMP Plus–UW Medicine Accountable Care Network[1, 5]

UnitedHealthcare Medicare Advantage Prescription Drug

- ☐ UnitedHealthcare PEBB Balance[8] (MAPD)
- ☐ UnitedHealthcare PEBB Complete[8] (MAPD)

1. These plans have specific service areas. If you move out of the service area and your current medical plan is no longer available, you must select a new plan. If you do not, the PEBB Program will enroll you in a plan. You must notify the PEBB Program **no later than 60 days** after you move.
2. Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon. KFHPNW Medicare plans have a larger service area.
3. These Medicare plans are available only in certain counties. You will be enrolled in either KPWA Original Medicare or KPWA Medicare Advantage (MA) depending on the county you live in. See "Medical plans & benefits" on HCA's website at **hca.wa.gov/pebb-retirees**.
4. If someone on your account is not enrolled in Medicare, also select Kaiser Permanente WA Classic, SoundChoice, or Value for them.
5. These plans are available only if you and your enrolled dependents are not enrolled in Medicare.
6. Only non-Medicare members can enroll in this plan. Members enrolled in Medicare will be enrolled in Kaiser Permanente WA's Medicare Plan.
7. Also submit the *Premera Group Medicare Supplement Enrollment Application* (Form B) to enroll in this plan. It is only available to Medicare members. Any non-Medicare members on the account will be enrolled in UMP Classic.
8. These plans are only available to Medicare members. Any non-Medicare members on the account will be enrolled in UMP Classic.

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6 Dental plan selection

You must enroll in medical coverage to enroll in dental. Before you enroll or change dental plans, call the dental plan to make sure your provider accepts the specific plan and plan group you choose. Their contact information is on page 15 of this form.

☐ I wish to stay enrolled in my current dental plan.

☐ I wish to enroll in or change my dental plan to (select a plan below):

Preferred Provider Organization (PPO)

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

Managed-Care Plans (limited network)

☐ **DeltaCare** (Group #3100), administered by Delta Dental of Washington. You must select a primary care dentist in the DeltaCare network.

☐ **Willamette Dental Group of Washington** (Group WA82), administered by Willamette Dental of Washington, Inc. You will select and receive services from a provider in the Willamette Dental Group network.

7 Terminate or defer coverage

If you are terminating or deferring your coverage, you only need to complete Sections 1, 7, and 8. To terminate retiree term life insurance, call MetLife at 1-866-548-7139.

If we receive your termination request on the first day of the month, the termination is effective the last day of the previous month otherwise the termination is effective on the last day of the month that the PEBB Program receives this form and any other required forms or a future date if you request it.

Terminate

☐ **Terminate medical and dental coverage (if enrolled in both) for myself and any enrolled dependents.**
I understand I am forfeiting all further rights to enroll again unless I regain eligibility. I understand I must also submit a *PEBB Medicare Advantage Plan Disenrollment Form* (form D) if I or an enrolled dependent is in a Medicare Advantage plan.

Termination date: (mm/dd/yyyy)

☐ **Terminate dental coverage for myself and any enrolled dependents.**

Termination date: (mm/dd/yyyy)

Defer

☐ **Defer (postpone) my coverage.**
If we receive this form on the first of the month, the deferral is effective that day. If you or an enrolled dependent are in a Medicare Advantage plan, you must also submit a *PEBB Medicare Advantage Plan Disenrollment Form* (form D) with this form. The deferral is effective on the first of the month after the date the PEBB Program receives both Form D and Form E. Except as stated below, this defers coverage for all enrolled dependents.

Termination date: (mm/dd/yyyy)

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To remain eligible to enroll after deferring, you must provide proof of continuous enrollment in one or more qualifying coverages listed below since your date of deferral. A gap in coverage of 31 days or less is allowed between the date PEBB retiree insurance coverage is deferred and the start date of a qualifying coverage, and between each enrollment in qualifying coverages during the deferral period.

Deferral reason:

- Enrolled as a dependent in a health plan sponsored by the PEBB Program, a Washington State educational service district, or the School Employees Benefits Board (SEBB) Program. This includes coverage under COBRA or continuation coverage.
- Enrolled in employer-based group medical as an employee or employee's dependent, including medical insurance continued under COBRA or continuation coverage. **This does not include an employer's retiree coverage**.
- Enrolled in medical coverage as a retiree or dependent of a retiree in a TRICARE plan or the Federal Employees Health Benefits Program. You have a one-time opportunity to enroll in a PEBB retiree health plan.
- Enrolled in a Medicaid program that provides creditable coverage and in Medicare Part A and Part B. You may continue to cover eligible dependents who are not eligible for creditable coverage under Medicaid.
- Enrolled in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). You have a one-time opportunity to enroll in a PEBB retiree health plan.
- Non-Medicare subscribers only: Enrolled in a qualified health plan coverage through a health benefit exchange established under the Affordable Care Act. This does not include Medicaid (called Apple Health in Washington State). You have a one-time opportunity to enroll or reenroll in a PEBB retiree health plan.

8 Payment

How would you like to pay your premiums and applicable premium surcharges?

- I wish to continue my current payment method.

I wish to change my payment method to:

- **Electronic debit service (EDS):** I will pay my monthly medical and dental premiums (if elected) and applicable premium surcharges by EDS. I will submit the *PEBB Electronic Debit Service Agreement* available at **hca.wa.gov/pebb-retirees**. I understand I must pay by check until I am notified of my EDS effective date.

- **Pension deduction:** I authorize the Department of Retirement Systems to deduct medical and dental premiums (if elected), and applicable premium surcharges I am required to pay from my retirement pension. I understand deductions are taken at the end of the month that you receive coverage. For example, if your coverage starts September 1, the deduction will be taken at the end of September.
- **Invoicing:** I will pay my medical and dental premiums (if elected) and applicable premium surcharges monthly by check.

Subscriber's last name

Social Security number

9 Subscriber agreement

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

If I send payment, this does not mean my change request will be approved. The PEBB Program will verify special open enrollment eligibility for me and my dependents. If we do not qualify, I will receive a refund of premium payments.

I understand I am responsible for paying the applicable tobacco use premium surcharge and spouse or state-registered domestic partner coverage premium surcharge in addition to my monthly medical premium (if I am not enrolled in Medicare Part A and Part B).

I understand if I enroll in PEBB retiree dental, it is my responsibility to call the plan (not my provider) to verify my dentist is covered by the dental plan network I selected.

I understand if I or any enrolled dependent is eligible for Medicare Part A and Part B, we must enroll and stay enrolled in Part A and Part B.

If I choose to defer medical/dental, I understand I can enroll or reenroll no later than 60 days after losing other qualifying medical coverage or during the PEBB Program's annual open enrollment as long as I maintain and provide proof of continuous enrollment in one or more qualifying coverages. A gap in coverage of 31 days or less is allowed between the date PEBB retiree insurance coverage is deferred and the start date of a qualifying coverage, as well as between each enrollment in qualifying coverages during the deferral period. The PEBB Program must receive my enrollment form no later than 60 days after other qualifying medical coverage ends, or no later than the last day of the PEBB Program's annual open enrollment period. If I defer enrollment for myself, I cannot enroll my eligible dependents except as allowed under PEBB Program rules. I understand in most cases, enrollment will be deferred effective the first of the month following the date this form is received by the PEBB Program unless a future date is provided.

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

If I die, my eligible surviving dependents must complete the *PEBB Retiree Election Form* (form A) to enroll or defer enrollment in PEBB retiree insurance coverage. The PEBB Program must receive the form no later than 60 days after my death.

If I am electing to enroll in a Kaiser Medicare Advantage (MA) or UnitedHealthcare Medicare Advantage-Prescription Drug (MAPD) plan, I certify that I have read and understand the Statement of Understanding at the end of this form. I know that I must refer to the plan's certificate of coverage for rules I must follow to receive coverage under a PEBB Medicare Advantage contract. I understand that enrollment in a Kaiser MA or UnitedHealthcare MAPD plan may not be retroactive. If I elect to enroll in a Kaiser MA plan, and the required forms are received by the PEBB Program after the date PEBB retiree insurance coverage is to begin, my enrolled dependents and I will be enrolled in another Kaiser plan during the gap month(s) prior to when Kaiser MA coverage begins. If I elect to enroll in a UnitedHealthcare MAPD plan, and the required forms are received by the PEBB Program after the date PEBB retiree insurance coverage is to begin, my enrolled dependents and I will be enrolled in UMP Classic during the gap month(s) prior to when the UnitedHealthcare MAPD plan begins. This form cannot be signed more than 90 days before the effective date of this coverage. (See Statement of Understanding at the end of this form for coverage effective date.)

This form replaces all enrollment or change forms previously submitted to the PEBB Program. If I am a retiree or survivor receiving benefits from the Department of Retirement Systems (DRS), the PEBB Program may share my information with DRS to better serve me.

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

(Continue to Section 10 Signature, on next page)

2024 PEBB Retiree Change form

Subscriber's last name

Social Security number

10 Signature

Please sign, date, and keep a copy for your records.

Subscriber signature

Date

Spouse or SRDP signature (only if enrolling in a Medicare Advantage or Medicare Advantage Prescription Drug health plan)

Date

Dependent signature

Date

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

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

Fax form to: 360-725-0771

HCA is committed to providing equal access to our services. If you need an accommodation, please call the PEBB Program at 1-800-200-1004 (TRS: 711).

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

PEBB Program contractors ⚠ Do not send forms to addresses below. They are only for your reference.

Medical

Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah St., Suite 100
Portland, OR 97232-5398
1-800-813-2000 (TRS: 711)
Medicare members: 1-877-221-8221 (TRS: 711)

Kaiser Foundation Health Plan of Washington
1300 SW 27th Street
Renton, WA 98057
1-866-648-1928
TTY: 1-800-833-6388
Medicare Advantage: 1-888-901-4600

Premera Blue Cross
PO Box 327, MS 295
Seattle, WA 98111
1-800-817-3049
TTY: 1-800-842-5357

Uniform Medical Plan, administered by Regence BlueShield (for medical benefit questions)
PO Box 1106
Lewiston, ID 83501-1106
1-888-849-3681 (TRS: 711)

Uniform Medical Plan, administered by Washington State Rx Services (for prescription drug questions)
PO Box 40168
Portland, OR 97240
1-888-361-1611 (TRS: 711)

UnitedHealthcare
Customer Service Department
185 Asylum Ave
Hartford, CT 06103
1-855-873-3268

Dental

DeltaCare, administered by Delta Dental of Washington
400 Fairview N, Suite 800
Seattle, WA 98109-5371
1-800-650-1583
TTY: 1-800-833-6384

Uniform Dental Plan, administered by Delta Dental of Washington
400 Fairview N, Suite 800
Seattle, WA 98109-5371
1-800-537-3406
TTY: 1-800-833-6384

Willamette Dental of Washington, Inc.
6950 NE Campus Way
Hillsboro, OR 97124-5611
1-855-433-6825 (TRS: 711)

11 Medicare Advantage and Medicare Advantage Prescription Drug agreement

This section applies only to subscribers enrolling in a Medicare Advantage (MA) or Medicare Advantage Prescription Drug (MAPD) plan. We offer four MA or MAPD plans: Kaiser Permanente of the Northwest Senior Advantage, Kaiser Permanente of Washington Medicare Advantage Plan, UnitedHealthcare PEBB Balance, and UnitedHealthcare PEBB Complete. If you are not enrolling in one of these plans, skip this section.

Statement of Understanding

I understand that beginning on my effective date with the Medicare Advantage plan I have selected in Section 5 of this form, as long as this form is signed prior to the effective date, all medical services, with the exception of emergency or out -of -area urgently needed services, must be provided or arranged for by the plan. Services rendered without prior authorization from my Medicare Advantage plan when required will not be reimbursed by the plan or Medicare, except for emergency services anywhere in the world or urgently needed services outside the plan's service area (or services provided under unusual and extraordinary circumstances when I am in the service area but my contracting medical group is temporarily unavailable or inaccessible).

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

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

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

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

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

I understand that I may disenroll from this Medicare Advantage plan by sending a written request to the PEBB Program with Form D. Until confirmation of the effective date of disenrollment, I must continue to receive health care from the Medicare Advantage plan providers.

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

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

I understand that upon confirmation from CMS, the PEBB Program will send me written notice of my effective date of enrollment. I understand that when my coverage begins I must get all of my medical (and prescription drug, if applicable) benefits from the plan. **Note:** Until you have received written notification of your effective date, you should not drop any supplemental insurance you have in effect now.

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

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

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

2024 PEBB Retiree Change form

Subscriber's last name

Social Security number

Medicare Advantage plan enrollment supplemental demographic information

Providing this demographic information is **optional** and will not affect your enrollment in a Medicare Advantage plan.

Preferred language other than English

- Spanish
- Other (please indicate) :
- No selected preference

Preferred accessible format

- Braille
- Large print
- Audio CD
- No selected preference

Subscriber

Are you of Hispanic, Latino/a, or Spanish origin? Select all that apply.

- Not of Hispanic, Latino/a, or Spanish origin
- Puerto Rican
- Another Hispanic, Latino/a, or Spanish origin
- Mexican, Mexican American, Chicano/a
- Cuban
- I choose not to answer

Which of the following best describes you? Select all that apply.

- White
- Black or African American
- American Indian or Alaska Native
- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian
- Native Hawaiian
- Samoan
- Guamanian or Chamorro
- Other Pacific Islander
- A race/ethnicity not listed
- I choose not to answer

Spouse or SRDP

Are you of Hispanic, Latino/a, or Spanish origin? Select all that apply.

- Not of Hispanic, Latino/a, or Spanish origin
- Puerto Rican
- Another Hispanic, Latino/a, or Spanish origin
- Mexican, Mexican American, Chicano/a
- Cuban
- I choose not to answer

Which of the following best describes you? Select all that apply.

- White
- Black or African American
- American Indian or Alaska Native
- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian
- Native Hawaiian
- Samoan
- Guamanian or Chamorro
- Other Pacific Islander
- A race/ethnicity not listed
- I choose not to answer

Dependent

Are you of Hispanic, Latino/a, or Spanish origin? Select all that apply.

- Not of Hispanic, Latino/a, or Spanish origin
- Puerto Rican
- Another Hispanic, Latino/a, or Spanish origin
- Mexican, Mexican American, Chicano/a
- Cuban
- I choose not to answer

Which of the following best describes you? Select all that apply.

- White
- Black or African American
- American Indian or Alaska Native
- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian
- Native Hawaiian
- Samoan
- Guamanian or Chamorro
- Other Pacific Islander
- A race/ethnicity not listed
- I choose not to answer