HCA | Health Care Authority
School Employees Benefits Board

2025 SEBB Continuation Coverage (COBRA) Election/Change

We must receive this form **no later than 60 days** from the date your SEBB health plan coverage ends or from the postmark date on the *SEBB Continuation Coverage Election Notice* sent to you, whichever is later.

Your first premium payment and applicable premium surcharges are due to the Health Care Authority (HCA) **no later than 45 days** after your 60-day election period ends. We will not enroll you until we receive your first payment. If HCA does not receive your first payment before the end of this 45-day timeframe, you will not be enrolled and you will lose your rights for SEBB Continuation Coverage (COBRA). Premiums and applicable premium surcharges are due from the date your other coverage ended.

This form replaces all *SEBB Continuation Coverage (COBRA) Election/Change* forms previously submitted. You must complete the entire form, including the dependent section for any children you want to continue to cover.

Inaccurate, incomplete, or illegible information may delay coverage. Type or print clearly in black ink and use all capital, block lettering in the spaces provided. Example: J O H N

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

⚠ Remember to read and sign Section 8.

School employee (subscriber) information only

Last name

First name

Social Security number

Date SEBB health plan coverage ended

1 Subscriber

Social Security number

Date of birth

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

[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's website at* **hca.wa.gov/gender-x**.

2025 SEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name

Social Security 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

⚠ You must report your new address to the SEBB Program **no later than 60 days** after you move. You can report it by using this form, sending a written request by mail or secure message (see "Form return" on page 13), or calling 1-800-200-1004 (TRS: 711).

Are you or any eligible dependents enrolled in SEBB insurance coverage under another account?

☐ Yes ☐ No

Continue coverage (Select all that apply.)

☐ Medical ☐ Dental ☐ Vision

Add coverage (Select all that apply.)

☐ Medical ☐ Dental ☐ Vision

Terminate coverage (Select all that apply.)

☐ Medical ☐ Dental ☐ Vision

Termination date:

If terminating coverage, include reason:

⚠ You may choose to continue coverage you were enrolled in on the day your SEBB health plan coverage ended. If you have life insurance and wish to port or convert, call MetLife at 1-833-854-9624.

If you are enrolled in a flexible spending arrangement (FSA) or Limited Purpose FSA and would like to continue it, call Navia Benefit Solutions at 1-800-669-3539. Navia must receive your request **no later than 60 days** from the date your SEBB health plan coverage ended, or from the postmark date on the *Navia COBRA election notice* sent to you, whichever is later.

⚠ If you terminate all coverage, you will not be eligible to enroll again in SEBB Continuation Coverage unless you regain eligibility.

2025 SEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name

Social Security number

Do you receive Social Security Disability?

☐ Yes ☐ No If Yes, effective date

If Yes, attach a copy of your Social Security Disability Award letter. Write your full name and the last four digits of your Social Security number on the copy. You and your enrolled dependents may be eligible for additional months of coverage.

Are you enrolled in Medicare Part A or Part B?

Part A (hospital)

☐ Yes ☐ No If Yes, enter effective dates shown on your Medicare card:

Part B (medical)

☐ Yes ☐ No If Yes, enter effective dates shown on your Medicare card:

Tobacco use premium surcharge

Response required if you are enrolling in medical coverage. The SEBB Program requires a $25-per-account tobacco use premium surcharge in addition to your monthly medical premium if you or a dependent (age 13 or older) enrolled on your SEBB medical plan uses a tobacco product. Tobacco use is defined as any use of tobacco products within the past two months except for religious or ceremonial use. Visit HCA's website at **hca.wa.gov/sebb-continuation** for more information.

Does the tobacco use premium surcharge apply to you?

☐ **Yes**, I am subject to the $25 premium surcharge. I have used tobacco products in the past two months. (If this is a change to a previous attestation, indicate the date your tobacco use changed.)

Date of change:

☐ **No**, I am not subject to the $25 premium surcharge. I have not used tobacco products in the past two months, or I have enrolled in or accessed one of the tobacco cessation resources noted on HCA's website.

Subscriber's last name

Social Security number

2 Spouse or state-registered domestic partner (SRDP)

If enrolling or removing a spouse or SRDP, complete this section. If not, skip to Section 3.

List an eligible spouse or SRDP you wish to cover or remove from coverage. SRDP is defined in WAC 182-31-020. State-registered domestic partnerships include partners of legal unions from another jurisdiction that is substantially equivalent to a domestic partnership in Washington State. Individuals in state-registered domestic partnerships are treated the same as legal spouses except when in conflict with federal law. You must also provide proof of their eligibility within the SEBB 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/sebb-continuation**.

Your spouse or SRDP cannot be enrolled in two SEBB medical, dental, or vision accounts at the same time.

If enrolling an SRDP, attach a *SEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes. A health plan change is not allowed when adding an SRDP due to a special open enrollment event if they are not a tax dependent.

Relationship to subscriber

☐ Spouse: Date of marriage

☐ SRDP (Washington State): Partnership start date

☐ SRDP (non-Washington State): Partnership start date

Social Security number

Date of birth

Sex assigned at birth[1]

☐ Male ☐ Female

Last name

Gender identity[2]

☐ Male ☐ Female ☐ X

First name

Middle initial

Suffix

Street address (if different)

Address line 2

City

State

ZIP/Postal code

County

Continue coverage (Select all that apply.)

☐ Medical ☐ Dental ☐ Vision

Add coverage (Select all that apply.)

☐ Medical ☐ Dental ☐ Vision

Terminate coverage (Select all that apply.)

☐ Medical ☐ Dental ☐ Vision

Termination date:

If terminating 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

⚠ If removing a spouse due to divorce, attach a copy of the divorce decree. If removing an SRDP due to dissolution, attach a copy of the dissolution of state-registered domestic partnership.

Does this person receive Social Security Disability?

Yes No If Yes, effective date

If Yes, attach a copy of their Social Security Disability Award letter. Write your full name and last four digits of your Social Security number on the copy. You and your enrolled dependents may be eligible for additional months of coverage.

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

Part A (hospital)

Yes No If Yes, enter effective dates shown on their Medicare card:

Part B (medical)

Yes No If Yes, enter effective dates shown on their Medicare card:

Tobacco use premium surcharge

Response required if you are enrolling your spouse or SRDP in medical coverage. If you check Yes or do not check any boxes below, you will be charged the $25-per-account tobacco use premium surcharge in addition to your monthly premium.

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

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

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

2025 SEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name

Social Security number

Response required if you are enrolling your spouse or SRDP in medical coverage. The SEBB Program requires a $50 premium surcharge in addition to your monthly medical premium if you are enrolling your spouse or SRDP in SEBB medical and they have chosen not to enroll in another employer-based group medical that is comparable to the Public Employees Benefits Board (PEBB) Program's Uniform Medical Plan (UMP) Classic.

Answer these questions for your spouse or SRDP in 2025:

1	Are you covering your spouse or SRDP in a SEBB medical plan under your account?	Yes	No
2	Will they be eligible for medical coverage through their employer? (If they will not be employed, answer No.)	Yes	No
3	Will their employer offer at least one medical plan that serves their county of residence?	Yes	No
4	Have they chosen not to enroll in their employer's medical (including PEBB) coverage?	Yes	No
5	Will the coverage offered by their employer in 2025 **not** be through the SEBB Program or a TRICARE plan? • Answer Yes if their employer **does not** offer SEBB coverage or a TRICARE plan. • Answer No if their employer **offers** SEBB coverage or a TRICARE plan.	Yes	No
6	Will their share of the medical premium through their employer be less than $126.36 per month?	Yes	No

If you answered No to any of these questions, check No below. You will not be charged the surcharge.

If you answered Yes to all of these questions:

1. 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 $126.36 per month for the employee.
2. Use the SBC information to answer the questions in the *SEBB Spousal Plan Calculator* online tool. You will get a Yes or No response from the calculator. Enter this response below.

⚠ **If you check Yes below or leave this section blank, you will be charged the $50 premium surcharge.**

Does the spouse or SRDP coverage surcharge apply to you? Check one:

- **Yes**, I am subject to the $50 premium surcharge. I completed the *SEBB Spousal Plan Calculator*.
- **No**, I am not subject to the $50 premium surcharge. If needed, I completed the *SEBB Spousal Plan Calculator*.
- The SEBB Program to help determine if the premium surcharge applies. I am submitting a printed *SEBB Spousal Plan Calculator*. The SEBB Program will use it to help determine whether my spouse's or SRDP's employer-based group medical is comparable to UMP Classic and whether I am subject to this premium surcharge.

⚠ The *SEBB Spousal Plan Calculator* is available at **hca.wa.gov/sebb-continuation** under *Surcharges*.

2025 SEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name

Social Security number

3 Dependents

List eligible dependents you wish to add or remove from coverage. Enrolled children must be eligible under SEBB 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. You must provide proof of their eligibility within the SEBB 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/sebb-continuation**.

Dependents cannot be enrolled in two SEBB medical, dental, or vision accounts at the same time.

If enrolling a state-registered domestic partner's child, an extended dependent, or a nonqualified tax dependent, attach a *SEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes. A health plan change is not allowed when adding an SRDP's child due to a special open enrollment event if they are not a tax dependent.

If enrolling an extended dependent, attach a *SEBB Extended Dependent Certification*.

If enrolling a child with a disability age 26 or older, attach a *SEBB Certification of Child with a Disability*.

Relationship to subscriber

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

If adding more dependents, copy the dependents section and attach to this form.

Social Security number

Date of birth

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

[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**.

2025 SEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name

Social Security number

Continue coverage (Select all that apply.)

☐ Medical ☐ Dental ☐ Vision

Add coverage (Select all that apply.)

☐ Medical ☐ Dental ☐ Vision

Terminate coverage (Select all that apply.)

☐ Medical ☐ Dental ☐ Vision Termination date:

If terminating coverage, include reason:

Does this person receive Social Security Disability?

☐ Yes ☐ No If Yes, effective date

If Yes, attach a copy of their Social Security Disability Award letter. Write your last name and the last four digits of your Social Security number on the copy. You and your enrolled dependents may be eligible for additional months of coverage.

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

Part A (hospital)

☐ Yes ☐ No If Yes, enter effective dates shown on their Medicare card:

Part B (medical)

☐ Yes ☐ No If Yes, enter effective dates shown on their Medicare card:

Tobacco use premium surcharge

Response required for dependents age 13 or older enrolling in medical coverage. If you check Yes or do not check any boxes below, you will be charged the $25-per-account tobacco use premium surcharge in addition to your monthly medical premium.

Does the tobacco use premium surcharge apply to you?

☐ **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.

Subscriber's last name

Social Security number

4 Changes to an existing account

Are you making changes to an existing account?

☐ Yes, If Yes, check all changes that apply in this section.

Date of event/change:

☐ No If No, continue to Section 5.

Changes you can make anytime

☐ Name change

☐ Address change

☐ Terminate medical coverage for you or your enrolled dependents

☐ Terminate dental coverage for you or your enrolled dependents

☐ Terminate vision coverage for you or your enrolled dependents

☐ Remove dependents from coverage. If removal is due to loss of eligibility (divorce, annulment, dissolution, or dependent ceasing to be eligible as a child), the SEBB Program must receive this form **no later than 60 days** after the last day of the month the dependent loses eligibility. Coverage will be terminated the last day of the month of loss of eligibility.

If applicable, provide your former dependent's new address:

Street address (if different from subscriber)

Address line 2

City State ZIP/Postal code

County

Changes you can make during annual open enrollment

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

☐ Add dependents

☐ Remove dependents

☐ Add or change medical plan

☐ Add or change dental plan

☐ Add or change vision plan

2025 SEBB Continuation Coverage (COBRA) Election/Change

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Social Security number

Changes you can make if an event creates a special open enrollment (SOE)

The SEBB Program only allows changes outside of annual open enrollment when an event creates an SOE. The change must be allowed under the Internal Revenue Code and Treasury regulations and correspond to and be consistent with an SOE event for the subscriber, a dependent, or both. The SEBB Program must receive this form and proof of the event **no later than 60 days** after the event occurs.

To enroll a newborn or child whom you, the subscriber, have adopted or have assumed a legal responsibility for support ahead of adoption, you should notify the SEBB Program by submitting the required forms as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the required forms must be received **no later than 60 days** after the date of the birth or adoption or the date the legal responsibility for support is assumed ahead of adoption.

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.

Note: A health plan change is not allowed when adding an SRDP or their child if they are not a tax dependent.

Check the box next to the applicable special open enrollment events below.

The following events allow a subscriber to add dependents or change medical, dental, or vision plans:

- Subscriber or dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
- Subscriber has a change in employment status that affects the subscriber's eligibility for their employer contribution under their employer-based group health plan.
- Subscriber's dependent has a change in their own employment status that affects the dependent's eligibility or their dependent's eligibility for their employer contribution under their employer-based group health plan.
- A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber.
- Subscriber or dependent enrolls in or loses eligibility for coverage under Medicaid or a state Children's Health Insurance Program (CHIP).
- Subscriber or dependent becomes eligible for a state premium assistance subsidy for SEBB health plan coverage from Medicaid or CHIP.
- Subscriber or dependent enrolls in or loses eligibility for coverage under Medicare.
- Child becomes eligible as an extended dependent through legal custody or legal guardianship. Also complete a *SEBB Extended Dependent Certification* and *SEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes, available at **hca.wa.gov/sebb-continuation**.
- Marriage, registering a state-registered domestic partnership, birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption. You must also submit a *SEBB Declaration of Tax Status* if adding a state-registered domestic partner or their child to indicate whether they qualify as a dependent for tax purposes.

2025 SEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name

Social Security number

The following events allow a subscriber to add dependents:

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

The following events allow a subscriber to change medical, dental, or vision plans:

- Subscriber or dependent has a change in residence that affects health plan availability.
- Subscriber's or dependent's current medical plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account.
- Subscriber or dependent experiences a disruption of care that could function as a reduction in benefits for the subscriber or their dependent for a specific condition or ongoing course of treatment (requires approval by the SEBB Program).
- Subscriber has a change in employment location that affects medical plan availability.

Subscriber's last name

Social Security number

5 Medical plan selection

Contact the plans with questions about benefits and providers. Their contact information at the end of this form.

Choose one medical plan.

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

- ☐ Kaiser Permanente NW 1
- ☐ Kaiser Permanente NW 2
- ☐ Kaiser Permanente NW 3

Kaiser Foundation Health Plan of Washington (Kaiser Permanente WA)

- ☐ Kaiser Permanente WA Core 1
- ☐ Kaiser Permanente WA Core 2
- ☐ Kaiser Permanente WA Core 3
- ☐ Kaiser Permanente WA SoundChoice

Kaiser Foundation Health Plan of Washington Options, Inc. (Kaiser Permanente WA Options)

- ☐ Kaiser Permanente WA Options Summit PPO 1
- ☐ Kaiser Permanente WA Options Summit PPO 2
- ☐ Kaiser Permanente WA Options Summit PPO 3

Premera Blue Cross

- ☐ Premera High PPO
- ☐ Premera HMO
- ☐ Premera Standard PPO

Uniform Medical Plan, administered by Regence BlueShield and ArrayRX

- ☐ UMP Achieve 1
- ☐ UMP Achieve 2
- ☐ UMP High Deductible
- ☐ UMP Plus–Puget Sound High Value Network
- ☐ UMP Plus–UW Medicine Accountable Care Network

⚠ These plans have specific service areas based on your county of residence. See HCA's website **hca.wa.gov/sebb-continuation** for plans available to you.

If you move out of the medical plan's service area, you must change plans. You must notify the SEBB Program **no later than 60 days** after you move or you will be enrolled in a medical plan as designated by the director of HCA or their designee. You can use this form, send a written request by mail or secure message (see "Form return" on page 14), or call 1-800-200-1004 (TRS: 711).

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

Subscriber's last name

Social Security number

6 Dental plan selection

Choose one dental plan. Before you enroll, make sure the provider you want to use accepts the specific plan and group you choose.

Preferred Provider Organization (PPO)

☐ **Uniform Dental Plan** (Group #09600), administered by Delta Dental of Washington. You can choose any dental provider and change providers at any time. Your out-of-pocket costs will be lower if you use a preferred provider.

Managed-care plans (limited network)

☐ **DeltaCare** (Group #09601), administered by Delta Dental of Washington. You must select a primary care dentist in the DeltaCare network.

☐ **Willamette Dental of Washington** (Group WA 733), administered by Willamette Dental of Washington, Inc. You must select and receive care from a primary care dental provider in the Willamette Dental Group network.

7 Vision plan selection

Choose one vision plan. Before you enroll, make sure the provider you want to use accepts the specific plan you choose.

☐ **Davis Vision by MetLife,** underwritten by Metropolitan Life Insurance Company ("MetLife")

☐ **EyeMed Vision Care**, underwritten by Fidelity Security Life Insurance Company

☐ **MetLife Vision**, underwritten by Metropolitan Life Insurance Company ("MetLife")

⚠ Plan contact information is at the end of this form.

Subscriber's last name

Social Security number

8 Signature

I have received and read the *SEBB Continuation Coverage Election Notice*, including any appendices. By submitting this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not update this information within the timeline in the SEBB Program rules, to the extent permitted by federal and state laws, I must repay any claims paid by my health plans or premiums paid on my behalf. My dependents and I may also lose SEBB benefits as of the last day of the month we were eligible. To the extent permitted by law, the SEBB Program may retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility or do not 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 SEBB insurance benefits.

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

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

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

I understand that my enrollment and my dependents' enrollment are subject to me abiding by all applicable deadlines and SEBB Program rules and policies. Failure to comply with applicable deadlines and SEBB Program rules and policies may result in my benefits selection being rejected.

This form replaces all *SEBB Continuation Coverage (COBRA) Election/Change* forms previously submitted to the SEBB Program.

Sign, date, and keep a copy for your records.

Subscriber's signature

Date

Form return

Submit form and documentation using one of the methods below:

Mail to:

Washington State Health Care Authority
PO Box 42720
Olympia, WA 98504-2720

Fax to:

360-725-0771

If payment is enclosed, make check payable to Health Care Authority and mail to:

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

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.

HCA is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-200-1004 (TRS: 711) or visit **hca.wa.gov/about-hca/nondiscrimination-statement**.

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

2025 SEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name

Social Security number

SEBB Program contractors

⚠ Do not send forms to the addresses below. This information is 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)

Kaiser Foundation Health Plan of Washington
2715 Naches Ave. SW
Renton, WA 98057
1-888-901-4636
TTY: 1-800-833-6388

Kaiser Foundation Health Plan of Washington Options, Inc.
2715 Naches Ave. SW
Renton, WA 98057
1-888-901-4636
TTY: 1-800-833-6388

Premera Blue Cross
High PPO and Standard PPO
7001 220th St. SW
Mountlake Terrace, WA 98043
1-800-807-7310 (TRS: 711)

Premera Blue Cross HMO
7001 220th St. SW
Mountlake Terrace, WA 98043
1-800-807-7310 (TRS: 711)

Uniform Medical Plan, administered by Regence BlueShield (for medical benefits)
PO Box 1106
Lewiston, ID 83501-1106
1-800-628-3481 (TRS: 711)

Uniform Medical Plan, administered by ArrayRx (for prescription drug questions)
PO Box 40168
Portland, OR 97240-0168
1-888-361-1611 (TRS: 711)

Dental

DeltaCare, administered by Delta Dental of Washington
400 Fairview Ave. 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 Ave. 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)

Vision

Davis Vision by MetLife, underwritten by Metropolitan Life Insurance ("MetLife")
200 Park Ave.
New York, NY 10166
1-877-377-9353
TTY: 1-800-523-2847

EyeMed Vision Care, underwritten by Fidelity Security Life Insurance Company
1209 Orange St.
Wilmington, DE 19801
1-800-699-0993
TTY: 1-844-230-6498

Metropolitan Life Insurance Company (Vision Plan)
200 Park Ave.
New York, NY 10166
1-833-854-9624
TTY: 1-800-428-4833