

# Your PEBB Benefits for 2019 Retiree Enrollment Guide



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# Contact Information

Contact the health plans for help with:	Go to <a href="http://hca.wa.gov/pebb-retirees">hca.wa.gov/pebb-retirees</a> for help with:
<ul style="list-style-type: none"> <li>• Specific benefit questions.</li> <li>• Verifying if your doctor or other provider contracts with the plan.</li> <li>• Verifying if your medications are listed in the plan's drug formulary.</li> <li>• Claims.</li> <li>• ID cards.</li> </ul>	<ul style="list-style-type: none"> <li>• Eligibility and enrollment questions or changes (Medicare, divorce, etc.).</li> <li>• Changing your name, address, or phone number.</li> <li>• Adding or removing dependents.</li> <li>• Finding forms.</li> <li>• Premium surcharge questions.</li> <li>• Eligibility complaints or appeals.</li> </ul> <p>You may also call the PEBB Program at 1-800-200-1004 for additional help.</p>

Medical plans	Website addresses	Customer service phone numbers	TTY/TRS customer service phone numbers
Kaiser Permanente NW Classic*, CDHP*, or Senior Advantage	<a href="http://my.kp.org/wapebb">my.kp.org/wapebb</a>	503-813-2000 or 1-800-813-2000 Medicare members: 1-877-221-8221	711
Kaiser Permanente WA Classic, CDHP, Medicare, SoundChoice, or Value	<a href="http://kp.org/wa/pebb">kp.org/wa/pebb</a>	1-866-648-1928 Medicare members: 206-630-4600	711 or 1-800-833-6388
Medicare Supplement Plan F (Group), administered by Premera Blue Cross	<a href="http://premera.com">premera.com</a> (general information, not specific to the PEBB Program)	1-800-817-3049	1-800-842-5357
Uniform Medical Plan (UMP) Classic or UMP CDHP, administered by Regence BlueShield	<a href="http://hca.wa.gov/ump">hca.wa.gov/ump</a>	1-888-849-3681	711
UMP Plus–Puget Sound High Value Network, administered by Regence BlueShield	<a href="http://pugetsoundhighvaluenetwork.org">pugetsoundhighvaluenetwork.org</a> <a href="http://hca.wa.gov/ump/plan-ump-plus">hca.wa.gov/ump/plan-ump-plus</a>	1-855-776-9503	711
UMP Plus–UW Medicine Accountable Care Network, administered by Regence BlueShield	<a href="http://uwmedicine.org/umpplus">uwmedicine.org/umpplus</a> <a href="http://hca.wa.gov/ump/plan-ump-plus">hca.wa.gov/ump/plan-ump-plus</a>	1-855-520-9500	711
UMP (prescription drugs), administered by Washington State Rx Services	<a href="http://hca.wa.gov/ump/find-drugs">hca.wa.gov/ump/find-drugs</a>	1-888-361-1611	711

\*Kaiser Foundation Health Plan of the Northwest, with plans offered in Clark and Cowlitz counties in Washington and select counties in Oregon.

(continued)

# Contact Information

Dental plans	Website addresses	Customer service phone numbers
DeltaCare, administered by Delta Dental of Washington	<a href="http://deltadentalwa.com/group/pebb">deltadentalwa.com/group/pebb</a>	1-800-650-1583
Uniform Dental Plan, administered by Delta Dental of Washington	<a href="http://deltadentalwa.com/group/pebb">deltadentalwa.com/group/pebb</a>	1-800-537-3406
Willamette Dental of Washington, Inc.	<a href="http://willamettedental.com/wapebb">willamettedental.com/wapebb</a>	1-855-433-6825

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

## PEBB Program is saving the green

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





# Introduction

**This booklet contains information you need to know about benefits, monthly premiums, Public Employees Benefits Board (PEBB) rules and timelines, and the plans available to you for 2019. Keep this booklet for future reference.**

Important requirements and deadlines to remember:

- **You have 60 days to enroll in or defer (postpone) enrollment in PEBB retiree insurance coverage** after the date your employer-paid coverage, Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage, or continuation coverage ends. If you are an elected or full-time appointed official as described in Washington Administrative Code (WAC) 182-12-180(1), you have 60 days after the date you leave public office. If the PEBB Program doesn't receive your completed *Retiree Coverage Election Form* (form A) within the required timeframe, you could lose your right to enroll. If you need help with the form, check out our self-help tutorial for Form A at [hca.wa.gov/pebb-retirees](http://hca.wa.gov/pebb-retirees). You may also need to complete and submit other forms in addition to Form A.
- **To enroll dependents, you must provide valid documents to prove their eligibility** within the PEBB

Program's timelines, or they will not be enrolled.

This applies to retirees not entitled to Medicare Part A and Part B (non-Medicare retirees) and any retiree enrolling a state-registered domestic partner.

- **If you and/or your dependent(s) are entitled to Medicare**, you and/or your Medicare-entitled dependent(s) **must enroll and remain enrolled in both Medicare Part A and Part B** to qualify for a PEBB retiree health plan. If you don't, you and/or your dependent(s) will no longer be eligible for enrollment in a PEBB retiree health plan.
- **We must receive your first premium payment and applicable premium surcharges before we will enroll you** (unless you choose to pay through Department of Retirement Systems [DRS] pension deduction). See "Paying for benefits" on page 20 for more information.

## If you want more information about PEBB Program coverage

Visit [hca.wa.gov/pebb-retirees](http://hca.wa.gov/pebb-retirees) for forms, publications, and information updates.

### Call the PEBB Program

Toll-free at 1-800-200-1004

**Monday through Friday, 8 a.m. to 4:30 p.m.** (*Other business activities may result in the phones being unavailable at times.*)

### Fax documents to the PEBB Program

360-725-0771

### Write to the PEBB Program

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

### Visit our office

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

(**Note:** The PEBB Program does not take appointments. We see visitors on a first-come, first-served basis. The last visitor will be accepted at 4:30 p.m.)

### Send a secure online message to

[fuzeqna.com/pebb/consumer/question.asp](http://fuzeqna.com/pebb/consumer/question.asp).

You must set up a secure login to use this feature. This helps protect your privacy and sensitive health information.

## Paying your premiums

### Mail your first premium payment (and applicable premium surcharges) to:

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

### For automatic bank account withdrawals (EDS):

Complete and submit an *Electronic Debit Service Agreement* form, provided in the back of this booklet.

### For Department of Retirement Systems (DRS) pension deduction:

Due to timing issues with DRS, you may receive an invoice for any premiums and applicable premium surcharges not deducted from your pension when you first enrolled. The PEBB Program will send you an invoice if a first payment is needed.

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

# How to “Shop the Guide”

## Use this checklist to help you make informed choices about your health plans:

### Eligibility and enrollment

- Find out if you or your dependents are eligible to enroll in or defer PEBB retiree insurance coverage. *For eligibility, see pages 11–14. To defer, see pages 29–33.*
- If you or your dependents are entitled to Medicare Part A and Part B, find out how Medicare works with your PEBB retiree insurance coverage. *See page 18 and pages 34–39.*

### Medical and dental plans

- Find the medical plans available in your county of residence. *See pages 41–43.*

**Note: PEBB dental plans are not limited by specific service areas.** Before you enroll, check with the dental plans to make sure there are in-network dentists available where you live.

- Compare the medical plan premiums (the amount you pay each month for medical coverage). *See page 8.*
- Compare the medical and dental plan benefits, and your costs when you receive care (out-of-pocket costs).

*For non-Medicare benefits, use the 2019 Medical Benefits Cost Comparison chart beginning on page 45. If you or your dependents are entitled to Medicare Part A and Part B, use the 2019 Medicare Benefits Cost Comparison chart beginning on page 51. For dental, see page 61.*
- Consider choosing a value-based plan, which rewards providers for high-quality care and patient satisfaction. All Kaiser Permanente NW and Kaiser Permanente WA plans (*for Medicare and non-Medicare*), and the UMP Plus plans (*for non-Medicare only*) are value-based plans.

- Once you've narrowed your plan choices, find providers in the plans' networks (or make sure your current providers, are in the plans' networks). Ask the providers if they:
  - Commit to following best practices for treating patients.

- Coordinate care with other providers in your plan's network.
- Are expected to meet certain measures about the quality of care they provide.

Go to [hca.wa.gov/pebb-retirees](http://hca.wa.gov/pebb-retirees) under Find a provider *for links to the plans' online provider directories, or see pages 1-2 for the plans' customer service phone numbers.*

- Compare the medical plans on other features that may be important to you, such as:
  - Whether the plan covers your medications.
  - Access to virtual care or a 24/7 nurse advice line.
  - Online access to your provider and medical records.
  - Extended office hours for providers.

*See pages 1-2 for the plans' websites and contact information.*

**You have 60 days to enroll in or defer (postpone) PEBB retiree insurance coverage after the date your employer-paid coverage, COBRA coverage, or continuation coverage ends.** If you are an elected or full-time appointed official as described in WAC 182-12-180(1), you have 60 days after the date you leave public office. If the PEBB Program doesn't receive your *Retiree Coverage Election Form* (Form A) and any other required documents or forms within the required timeframe, you could lose your right to enroll. For help filling out the form, read the instruction sheet attached to the form or use our online tutorial at [hca.wa.gov/pebb-retirees](http://hca.wa.gov/pebb-retirees).



For general information and resources to help make informed health care decisions, visit Own Your Health's website at [ownyourhealthwa.org](http://ownyourhealthwa.org)

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# 2019 PEBB Retiree Monthly Premiums

Effective January 1, 2019

## Special Requirements

- To qualify for the Medicare premium, at least one covered enrollee must be enrolled in both Part A and Part B of Medicare.
- Medicare enrollees enrolled in a Kaiser Permanente Washington Medicare Advantage plan or Kaiser Permanente Northwest Senior Advantage plan must complete and sign the *Medicare Advantage Plan Election Form* (Form C) to enroll in one of these plans.
- Medicare premiums are reduced by the state-funded contribution, up to the lesser of \$168 or 50 percent of plan rate per retiree per month.

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

<b>Non-Medicare Medical Plan Premiums</b>				
<b>For members not eligible for Medicare (or enrolled in Part A only)</b>	<b>Subscriber Only</b>	<b>Subscriber and Spouse<sup>1</sup></b>	<b>Subscriber and Child(ren)</b>	<b>Subscriber, Spouse<sup>1</sup>, and Child(ren)</b>
Kaiser Permanente NW Classic <sup>2</sup>	\$710.65	\$1,415.33	\$1,239.16	\$1,943.84
Kaiser Permanente NW CDHP <sup>2</sup>	\$604.16	\$1,196.38	\$1,062.91	\$1,596.81
Kaiser Permanente WA Classic	\$733.39	\$1,460.80	\$1,278.95	\$2,006.37
Kaiser Permanente WA CDHP	\$600.44	\$1,189.46	\$1,056.79	\$1,587.47
Kaiser Permanente WA SoundChoice	\$603.21	\$1,200.44	\$1,051.13	\$1,648.37
Kaiser Permanente WA Value	\$656.25	\$1,306.54	\$1,143.96	\$1,794.25
UMP Classic	\$674.85	\$1,343.72	\$1,176.50	\$1,845.38
UMP CDHP	\$600.54	\$1,189.65	\$1,056.96	\$1,587.74
UMP Plus—PSHVN	\$618.07	\$1,230.18	\$1,077.15	\$1,689.25
UMP Plus—UW Medicine ACN	\$618.07	\$1,230.18	\$1,077.15	\$1,689.25

<b>Medicare Medical Plan Premiums</b>								
<b>For members enrolled in Medicare Parts A and B:</b>	<b>Subscriber Only</b>	<b>Subscriber and Spouse<sup>1</sup></b>		<b>Subscriber and Child(ren)</b>		<b>Subscriber, Spouse<sup>1</sup>, and Child(ren)</b>		
	<i>1 Medicare eligible</i>	<i>1 Medicare eligible</i>	<i>2 Medicare eligible</i>	<i>1 Medicare eligible</i>	<i>2 Medicare eligible</i>	<i>1 Medicare eligible</i>	<i>2 Medicare eligible</i>	<i>3 Medicare eligible</i>
Kaiser Permanente NW Senior Advantage	\$169.80	\$874.48††	\$333.63	\$698.31††	\$333.63	\$1,402.99††	\$862.14††	\$497.46
Kaiser Permanente WA Classic	N/A	\$895.33	N/A	\$713.47	N/A†	\$1,440.89	\$875.41	N/A†
Kaiser Permanente WA Medicare Plan	\$167.91	N/A†	\$329.85	N/A†	\$329.85	N/A†	N/A†	\$491.79
Kaiser Permanente WA SoundChoice	N/A	\$765.15	N/A	\$615.84	N/A†	\$1,213.07	\$777.78	N/A†
Kaiser Permanente WA Value	N/A	\$818.19	N/A	\$655.62	N/A†	\$1,305.90	\$817.56	N/A†
UMP Classic	\$313.09	\$981.96	\$620.20	\$814.74	\$620.20	\$1,483.62	\$1,121.86	\$927.32

<sup>1</sup> Or state-registered domestic partner

<sup>2</sup> Kaiser Foundation Health Plan of the Northwest, with plans offered in Clark and Cowlitz counties in Washington and select Oregon counties.

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

†† If a Kaiser Permanente NW enrollee is enrolled in Medicare Part A and Part B and other enrollees are not eligible for Medicare, the non-Medicare enrollees will be enrolled in Kaiser Permanente NW Classic<sup>2</sup>. The subscriber will pay the combined Medicare and non-Medicare premium shown for Kaiser Permanente NW Senior Advantage.



## Medicare Supplement Plan F Premiums (administered by Premera Blue Cross)

	Subscriber Only	Subscriber and Spouse*		Subscriber and Child(ren)	Subscriber, Spouse*, and Child(ren)			
	1 Medicare eligible	1 Medicare eligible**	2 Medicare eligible: 1 retired, 1 disabled	2 Medicare eligible	1 Medicare eligible**	1 Medicare eligible**	2 Medicare eligible: 1 retired, 1 disabled**	2 Medicare eligible**
<b>Plan F</b> Age 65 or older, eligible by age	\$112.16	\$781.04	\$305.19	\$218.35	\$613.82	\$1,282.69	\$807.60	\$720.01
<b>Plan F</b> Under age 65, eligible by disability	\$199.00	\$867.88	\$305.19	\$392.03	\$700.66	\$1,369.53	\$807.60	\$893.69

\*or state-registered domestic partner

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

### Monthly Premium Surcharges (for non-Medicare subscribers only)

The following surcharges may apply to subscribers not enrolled in Medicare Part A and Part B in addition to the monthly medical premium. **These surcharges do not apply if the subscriber is enrolled in Medicare Part A and Part B.**

- A monthly \$25-per-account premium surcharge will apply if the subscriber or any dependent (age 13 and older) enrolled in PEBB medical uses tobacco products.
- A monthly \$50 premium surcharge will apply if a subscriber enrolls a spouse or state-registered domestic partner, and the spouse or state-registered domestic partner elected not to enroll in another employer-based group medical plan that is comparable to Uniform Medical Plan (UMP) Classic.

For more guidance on whether these surcharges apply to you, see the *2019 Premium Surcharge Help Sheet* at [www.hca.wa.gov/erb](http://www.hca.wa.gov/erb).

### Dental Plan Premiums

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

	Subscriber Only	Subscriber and Spouse*	Subscriber and Child(ren)	Subscriber, Spouse*, and Child(ren)
DeltaCare, administered by Delta Dental of Washington	\$39.53	\$79.06	\$79.06	\$118.59
Uniform Dental Plan, administered by Delta Dental of Washington	\$45.87	\$91.74	\$91.74	\$137.61
Willamette Dental of Washington, Inc.	\$44.45	\$88.90	\$88.90	\$133.35

\*or state-registered domestic partner

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

# 2019 PEBB Retiree Monthly Premiums

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

The Legacy Retiree Life Insurance Plan is only available to retirees enrolled as of December 31, 2016, who didn't elect to increase their retiree term life insurance amount during MetLife's open enrollment (November 1–30, 2016).

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

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

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

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

# Eligibility Summary

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## Who is eligible for PEBB retiree insurance coverage?

This guide provides a general summary of retiree eligibility. The PEBB Program will determine your eligibility based on PEBB Program rules and when your election form is received. If you disagree with the determination, see “PEBB Appeals” on page 17.

You may be eligible to enroll in PEBB retiree insurance coverage if you are a retiring employee of a:

- PEBB-participating employer group.
- State agency.
- State higher-education institution.
- Washington State school district, educational service district, or charter school.

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

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

### Procedural requirements include:

- You must submit a *Retiree Coverage Election Form* (form A) to enroll or defer enrollment in PEBB retiree insurance coverage. Other forms and documents may be required as described on Form A. The PEBB Program must receive your form(s) (and any other required documentation) **no later than 60 days** after your employer-paid coverage, COBRA coverage, or continuation coverage ends. For elected or full-time appointed officials described in WAC 182-12-180(1), the PEBB Program must receive the form **no later than 60 days** after the official leaves public office. Your first premium payment and applicable premium surcharges are due to the Health Care Authority (HCA) **no later than 45 days** after your 60-day election period ends.

- If you or a dependent is entitled to Medicare and your retirement date is after July 1, 1991, you must enroll (and maintain enrollment) in Medicare Part A and Part B to qualify and remain eligible for a PEBB retiree health plan.
- If you do not enroll in PEBB retiree insurance coverage at retirement, when eligible and separating from service, or when leaving public office as an eligible official, you are only eligible to enroll at a later date if you defer (postpone) enrollment and maintain continuous enrollment in other qualifying medical coverage as described in WAC 182-12-200 and 182-12-205. **See important information about deferring PEBB retiree insurance coverage on page 29.**

### In general, the eligibility requirements state:

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

### Washington State-sponsored retirement plans include:

- Public Employees' Retirement System (PERS) 1, 2, or 3
- Public Safety Employees' Retirement System (PSERS) 2
- Teachers Retirement System (TRS) 1, 2, or 3
- Washington Higher Education Retirement Plan (for example, TIAA-CREF)
- School Employees' Retirement System (SERS) 2 and 3
- Law Enforcement Officers' and Fire Fighters' Retirement System (LEOFF) 1 or 2
- Washington State Patrol Retirement System (WSPRS) 1 or 2
- State Judges/Judicial Retirement System

(continued)

# Eligibility Summary

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- Civil Service Retirement System and Federal Employees' Retirement System are considered a Washington State-sponsored retirement system for Washington State University Extension employees covered under PEBB insurance at the time of retirement or disability.

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

- If you receive a lump sum payment instead of a monthly retirement plan payment, you are only eligible for PEBB retiree insurance coverage if the Department of Retirement Systems offered you the choice between a lump sum actuarially equivalent payment and an ongoing monthly payment (as allowed by the plan).
- If you are an employee retiring or separating under PERS Plan 3, TRS Plan 3, or SERS Plan 3, and you meet the retirement plan's eligibility criteria, you do not have to receive a retirement plan payment to enroll in PEBB retiree insurance coverage.
- If you are an employee retiring under a Washington State higher education retirement plan (such as TIAA-CREF) and meet your plan's retirement eligibility criteria, or you are at least age 55 with 10 years of state service, you do not have to receive a monthly retirement plan payment.
- If you are an employee retiring from a PEBB-participating employer group and your employer does not participate in a Washington State-sponsored retirement plan, you do not have to receive a monthly retirement plan payment. However, you do have to meet the same age and years of service requirement as if you had been employed as a member of PERS Plan 1 or Plan 2.
- If you are one of the following elected or full-time appointed officials, you do not have to meet the age and years of service requirement or receive a monthly retirement plan payment from a Washington state-sponsored retirement plan:
  - A member of the state Legislature
  - A statewide elected official of the executive branch

- An executive official appointed directly by the governor as the single head of an executive branch agency
- An official appointed directly by a state legislative committee as the single head of a legislative branch agency
- An official appointed to secretary of the Senate or chief clerk of the House of Representatives

## Can I cover my dependents?

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

- Your legal spouse
- Your state-registered domestic partner as defined in RCW 26.60.020(1), and 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 62 or older and you live in the same residence
- Your children through the last day of the month in which they turn age 26, except for children with a disability (who may be covered past the age of 26 if they qualify)

## How are children defined?

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

- Your children
- Children of your spouse
- Children for whom you have assumed a legal obligation for total or partial support 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

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## Eligible extended dependents

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

This does not include foster children unless you, your spouse, or your state-registered domestic partner has assumed a legal obligation for 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 subscriber for support and ongoing care, provided the condition occurred before age 26. You must provide proof of the disability and dependency. The PEBB Program, with input from your medical plan, 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 after the child turns 26. These verifications may require renewed proof from you.

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

## Verifying dependent eligibility

The PEBB Program verifies the eligibility of all dependents of subscribers not entitled to Medicare Part A and Part B, and any retiree subscriber enrolling a state-registered domestic partner, before they are enrolled under your coverage. You must submit proof of a dependent's eligibility within the PEBB Program's timelines. You can find a list of documents you must provide to verify your dependent's eligibility on page 15. Submit the required documents with your election or change form(s).

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

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

<b>If enrolling a:</b>	<b>Complete this form:</b>
Non-qualified tax dependent (state-registered domestic partner)	<i>Declaration of Tax Status</i>
Dependent child with a disability age 26 or older	<i>Certification of a Child With a Disability</i>
Extended (legal) dependent child	<i>Extended Dependent Certification</i>

To find forms and more information, go to [hca.wa.gov/employee-retiree-benefits/retirees/dependent-verification](http://hca.wa.gov/employee-retiree-benefits/retirees/dependent-verification), or call the PEBB Program at 1-800-200-1004 and select menu option 5.

You must notify the PEBB Program in writing when your dependent is no longer eligible. The PEBB Program must receive notice **no later than 60 days** after the date your dependent is no longer eligible. If you do not notify us within this time, you may face consequences as described in WAC 182-12-262.

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# Eligibility Summary

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## If I die, do my surviving dependents remain eligible for benefits?

As an eligible employee or retiree, your surviving dependent may be eligible to enroll or defer enrollment in PEBB retiree insurance coverage as a survivor if they meet both eligibility and procedural requirements outlined in WAC 182-12-180 or 182-12-265. The PEBB Program must receive all required forms to enroll or defer enrollment in PEBB retiree insurance coverage within the following timelines:

- For an eligible **survivor of an employee**, (including elected or full-time appointed officials) **no later than 60 days after** the date of the employee's death, or the date the survivor's PEBB, school district, educational service district, or charter school coverage ends, whichever is later.
- For an eligible **survivor of a retiree**, **no later than 60 days** after the retiree's death.

For more information about how to continue coverage as a surviving dependent, see "How does a surviving dependent pay for coverage?" on page 21 and "What are my options when coverage ends?" on page 27.

## When are dependents of emergency service employees eligible?

If you are a surviving spouse, state-registered domestic partner, or dependent child of an emergency service employee who was killed in the line of duty, you may be eligible to enroll or defer enrollment in PEBB retiree insurance coverage if you meet both the procedural and eligibility requirements outlined in WAC 182-12-250. All required forms for enrolling or deferring enrollment in PEBB retiree insurance coverage must be received by the PEBB Program **no later than 180 days** after the later of:

- The death of the emergency service worker
- The date on the letter from the Department of Retirement Systems or the board for volunteer firefighters and reserve officers that informs the survivor that they are determined to be an eligible survivor
- The last day the surviving spouse, state-registered

domestic partner, or child was covered under any health plan through the emergency service worker's employer

- The last day the surviving spouse, state-registered domestic partner, or child was covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage from the emergency service worker's employer

For more information, contact the PEBB Program at 1-800-200-1004 and select menu option 6.

# Valid Dependent Verification Documents

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Dependent verification helps make sure the PEBB Program covers only people who qualify.

If you want to enroll dependents to your coverage, you must provide documents to verify their eligibility if you (the subscriber) are not enrolled in Medicare Part A and Part B or you are enrolling a state-registered domestic partner. You must 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 list below to determine which valid verification document(s) to submit with your required form(s). You may submit one copy of your tax return if it includes all dependents that require verification, such as your spouse and children. Submit the documents with your enrollment form(s) within PEBB Program enrollment timelines.

To find forms and for more information, go to [hca.wa.gov/employee-retiree-benefits/retirees/dependent-verification](http://hca.wa.gov/employee-retiree-benefits/retirees/dependent-verification), or call the PEBB Program at 1-800-200-1004 and select option 5.

## To enroll a spouse

Provide a copy of (choose one):

- Most recent year's federal tax return that lists the spouse (black out financial information)
- The most recent subscriber's or spouse's federal tax return if filed separately (black out financial information)
- Proof of common residence (example: a utility bill) and marriage certificate\*
- Proof of financial interdependency (example: a shared bank statement) and marriage certificate\*
- Petition for dissolution of marriage (divorce)
- Legal separation notice
- Defense Enrollment Eligibility Reporting System (DEERS) registration
- Valid J-1 or J-2 visa issued by the U.S. government

\*If within two years of marriage, only the marriage certificate is required.

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

Include the *Declaration of Tax Status* form to enroll a non-qualified tax dependent like a state-registered domestic partner or legal union partner.

Provide a copy of (choose one):

- Proof of common residence (example: a utility bill) and certificate/card of state-registered domestic partnership\* or legal union
- Proof of financial interdependency (example: a bank statement) and certificate/card of state-registered domestic partnership\* or legal union (black out financial information)
- Petition for invalidity (annulment) of state-registered domestic partnership or legal union
- Petition for dissolution of state-registered domestic partnership or legal union
- Legal separation notice of state-registered domestic partnership or legal union
- Valid J-1 or J-2 visa issued by the U.S. government

\*If within two years of state-registered domestic partnership or establishment of a legal union, only the certificate/card of state-registered domestic partnership or legal union is required.

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# Valid Dependent Verification Documents

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## To enroll children

Use the *Extended Dependent Certification* form to enroll an extended (legal) dependent child. For all other children, provide a copy of one of the documents listed below with your enrollment form(s).

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

- Most recent federal tax return that includes dependent child(ren)  
**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
- 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/partner in PEBB insurance coverage.

# PEBB Appeals

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

**Mail:** PEBB Appeals Unit  
Health Care Authority  
PO Box 42699  
Olympia, WA 98504-2699

**Fax:** 360-725-0771

You will find guidance on filing an appeal in chapter 182-16 WAC and at [hca.wa.gov/pebb-appeals](http://hca.wa.gov/pebb-appeals).

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

You must provide us with a copy of a valid power of attorney (and a doctor's note, if the PEBB Program requires it) or a completed *Authorization for Release of Information* form naming your representative and authorizing them to access your PEBB account and exercise your rights under the federal HIPAA privacy rule. HIPAA stands for the Health Insurance Portability and Accountability Act of 1996. The form is available at [hca.wa.gov/pebb-appeals](http://hca.wa.gov/pebb-appeals) or by calling the PEBB Program at 1-800-200-1004.

If you are:	And your appeal concerns:	Follow these instructions:
<ul style="list-style-type: none"> <li>• An applicant for PEBB insurance coverage</li> <li>• A retiree</li> <li>• A survivor of a deceased employee or retiree as described in WAC 182-12-265 or 182-12-180</li> <li>• A survivor of emergency service personnel killed in the line of duty as described in WAC 182-12-250</li> <li>• A continuation coverage enrollee</li> <li>• The dependent of one of the above</li> </ul>	<ul style="list-style-type: none"> <li>• A decision from the PEBB Program about:               <ul style="list-style-type: none"> <li>• Eligibility for benefits</li> <li>• Enrollment</li> <li>• Premium payments</li> <li>• Premium surcharges</li> </ul> </li> <li>• Eligibility to participate in SmartHealth or receive a wellness incentive</li> </ul>	<p>Complete all sections of the <i>Retiree/Continuation Coverage Notice of Appeal</i> form and submit it to the PEBB Appeals Unit as instructed above.</p> <p>The PEBB Appeals Unit must receive the form <b>no later than 60 calendar days</b> after the date of the denial notice regarding the decision you are appealing.</p>
<p>Seeking a review of a decision by a <b>PEBB health plan, insurance carrier, or benefit administrator</b></p>	<ul style="list-style-type: none"> <li>• The administration of the health plan or benefit</li> <li>• A benefit or claim</li> <li>• Completion of the SmartHealth requirements or a reasonable alternative request</li> </ul>	<p>Contact the health plan, insurance carrier, or benefit administrator to request information on how to appeal the decision.</p>

# New Enrollment

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The PEBB Program must receive your *Retiree Coverage Election Form* (form A), and any other required documents, indicating your decision to enroll or defer **no later than 60 days** after your employer-paid coverage, COBRA coverage, or continuation coverage ends. If you are an elected or full-time appointed official, as described in WAC 182-12-180(1), the PEBB Program must receive your forms **no later than 60 days** after you leave public office.

If you miss that 60-day election period, you lose all rights to enroll in or defer PEBB retiree insurance coverage unless you regain eligibility in the future. To regain eligibility, you would have to return to work in a PEBB, Washington State school district, educational service district, or charter school benefits-eligible position and, at the time of termination, meet procedural and eligibility requirements.

To enroll, submit your completed *Retiree Coverage Election Form* (Form A) and any other required documents or forms to the PEBB Program as instructed on the form (found in the back of this guide). **You must submit Form A even if you decide to defer (postpone) your enrollment.** See “Deferring Your Coverage” on page 29 for more information.

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

Include any eligible dependents you wish to enroll on the form(s). If you are a retiree or survivor who is not enrolled in Medicare Part A and Part B (non-Medicare retiree), or if you are enrolling a state-registered domestic partner, the PEBB Program must verify your dependent’s eligibility before they can be enrolled under your coverage. This means you must provide valid proof of your dependents’ eligibility within the PEBB Program’s enrollment timelines or the dependents will not be enrolled. Eligibility can be established for state-registered domestic partners through a domestic partner registry or legal union. See page 15 for a list of acceptable documents to verify dependents.

**You must enroll in medical to enroll in dental.** If you select retiree dental coverage for yourself, you and your enrolled dependent(s) must be enrolled in the same dental plan. You must keep dental coverage for at least two years unless you defer or terminate enrollment as allowed under PEBB Program rules. You may change retiree dental plans within those two years during the PEBB Program’s annual open enrollment, November 1 through 30, or due to a special open enrollment event (see page 25). If you terminate your dependent(s) from your dental coverage, they will also be terminated from medical coverage.

## When do I send payment?

Your first premium payment and applicable premium surcharges are due to the Health Care Authority **no later than 45 days** after your 60-day election period ends, unless you choose to have your premiums and applicable premium surcharges deducted from your monthly Department of Retirement Systems (DRS) pension. Due to timing issues with DRS, you may receive an invoice for any premiums and applicable premium surcharges not deducted from your pension when you first enrolled. The PEBB Program will send you an invoice if a first payment is needed for the premiums and applicable premium surcharges that were not deducted from your monthly DRS pension.

If you select Electronic Debit Service (EDS) as your payment method, you still need to submit your first premium payment and applicable premium surcharges to begin your coverage. Following the first premium payment, premiums and applicable premium surcharges must be paid as described in WAC 182-08-180. See “Paying for Benefits” on page 20 for details. You must continue to pay your monthly premiums and applicable premium surcharges as invoiced until you receive a letter from the PEBB Program with your EDS start date.

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



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## Can I enroll retroactively due to a disability?

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

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

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

## Can I enroll on two PEBB accounts?

No. If you and your spouse or state-registered domestic partner are both independently eligible for PEBB insurance coverage, you need to decide which of you will cover yourselves and any eligible children on your PEBB medical or dental plans. An enrolled dependent may be enrolled in only one PEBB medical or dental plan. For example, you could defer (postpone) PEBB retiree insurance coverage for yourself (see “Deferring Your Coverage” on page 29) and enroll as a dependent on your spouse’s or state-registered domestic partner’s PEBB medical.

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

In most cases, your employer’s payroll office will terminate your employee coverage when they process your final paycheck. **We cannot enroll you in retiree insurance coverage until this occurs.** If you chose to defer your coverage, see “Deferring Your Coverage” on page 29.

Here is what will happen after you submit your retiree election form:

1. When the PEBB Program processes your form, we will send you a letter confirming that we received it and notifying you of next steps.
2. The health plan(s) that covered you as an employee will send you a termination letter after your payroll office terminates your employee coverage.
3. Federal rules require us to send you a *PEBB Continuation Coverage Election Notice* booklet. Keep it for future reference.
4. If your election form is incomplete, or if you do not submit your first premium payment and any applicable premium surcharges within the time allowed, we will send you a letter requesting more information and/or payment.
5. Once your payroll office terminates your employee coverage, we receive your completed election form, including all other required documents and first premium payment (with applicable premium surcharges), and we determine you are eligible, we will enroll you in PEBB retiree insurance coverage.
6. After your enrollment begins, your health plan(s) will send you a welcome packet.

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

## When does coverage begin?

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

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

# Paying for Benefits

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## How much will my monthly premiums be?

The cost for your health benefits depends on which medical or dental plan you select. The list of monthly premiums starts on page 8. In addition to your monthly premium and applicable premium surcharges, you must pay for any deductibles, coinsurance, or copayments under the plan you choose. These costs are outlined in the certificate of coverage or summary of benefits and coverage available from each plan.

The Health Care Authority collects premiums and applicable premium surcharges for the full month, and will not prorate them for any reason, including when a member dies or terminates coverage before the end of the month.

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

## What are the premium surcharges?

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

- A monthly **\$25-per-account tobacco use premium surcharge** will apply if you or one of your enrolled dependents (age 13 or older) uses tobacco products. You must attest to the tobacco use premium surcharge for each dependent you want to enroll. If you do not attest within the PEBB Program's timelines, or if your attestation results in you incurring the surcharge, you will be charged the premium surcharge in addition to your monthly premium. If your or your dependent's tobacco use status changes, you must reattest to the surcharge.
- A monthly **\$50 spouse or state-registered domestic partner coverage premium surcharge** will apply if you enroll your spouse or state-registered domestic partner and they have chosen not to enroll in another employer-based group medical insurance that is comparable to Uniform Medical Plan (UMP) Classic. If you enroll a spouse or state-registered domestic partner and do not attest within the PEBB Program's timelines, or if your attestation results in you incurring the premium surcharge, you will be charged the surcharge in addition to your monthly premium.

**These surcharges do not apply if the subscriber is enrolled in Medicare Part A and Part B.** However, if a dependent is enrolled in Medicare Part A and Part B and the subscriber is not, you must attest to the premium surcharges, as applicable.

See the *2019 Premium Surcharge Help Sheet* in the back of this book for more information.

## To report a change (non-Medicare subscribers only)

If your or your enrolled dependent's tobacco use 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 the tobacco cessation resources for teens mentioned in the *2019 Premium Surcharge Help Sheet*.

You may report the change one of two ways:

- Go to *My Account* at [hca.wa.gov/my-account](http://hca.wa.gov/my-account).
- Complete and submit a *2019 Premium Surcharge Change Form* (found at [hca.wa.gov/pebb-retirees](http://hca.wa.gov/pebb-retirees)).

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

## How do I pay for coverage?

**You must send your first premium payment and applicable premium surcharges to the Health Care Authority (HCA) no later than 45 days after your 60-day election period ends** (unless you elect to pay by pension deduction through the Department of Retirement Systems [DRS]); see "DRS pension deduction" on next page for details.

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

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

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

Here are your payment options:

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

## How does a surviving dependent pay for coverage?

HCA collects premiums and applicable premium surcharges for the full month and does not prorate them for any reason, including when a member passes away before the end of the month. When transitioning from a dependent to a subscriber account, you cannot have a

gap in coverage between these accounts. As a result, you may receive two invoices and must pay both:

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

**You must pay both invoices** to keep your account open.

If these charges were deducted from the subscriber's pension through DRS, this will stop. You may be eligible for a survivor's pension from DRS. To find out, call DRS at 1-800-547-6657.

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

## What happens if I miss a payment?

You must pay the monthly premium and applicable premium surcharges for your PEBB retiree health plan coverage when due. They will be considered unpaid if one of the following occurs:

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

If either of the events listed above occur and the payment remains unpaid for 60 days from the original due date, the PEBB Program will terminate your PEBB

*(continued)*

# Paying for Benefits

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retiree health plan coverage back to the last day of the month for which the monthly premium and applicable premium surcharge was paid.

If your PEBB health plan coverage is terminated, coverage for your dependents is also terminated. You cannot enroll again unless you regain eligibility, for example, by returning to employment in a PEBB, Washington State school district, educational service district, or charter school benefits-eligible position.

## Can I use a VEBA account?

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

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

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

expenses incurred while you are or were not re-employed.

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

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

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

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

More information and forms, including the *Automatic Premium Reimbursement* form and *Limited HRA Coverage Election* form, are available at [veba.org](http://veba.org) (after logging in to your account) or by calling the VEBA MEP customer care center at 1-888-828-4953.



# Medicare Enrollment

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

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

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

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

If you are not entitled to Medicare, you must send us a copy of the Medicare denial letter from the Social Security Administration. Write the subscriber's full name and the last four digits of the subscriber's Social Security number on the copy so we can identify your account. Mail or fax to:

**Mail:** Health Care Authority      **Fax:** 360-725-0771  
 PEBB Program  
 PO Box 42684  
 Olympia, WA 98504-2684

We will reduce your premium to the lower Medicare rate, if applicable, and notify your health plan of your Medicare enrollment. If you are paying premium surcharges in addition to your medical premium, the surcharges will end automatically when you (the subscriber) enroll in Medicare Part A and Part B.

Entitlement to Medicare also qualifies as a special open enrollment event, allowing you to change your medical plan. See "What is a special open enrollment?" on page 25.

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

No. If you are enrolled in a consumer-directed health plan (CDHP) with a health savings account (HSA) or a UMP Plus plan when you or your covered dependent(s) become entitled to Medicare Part A and Part B, you must change medical plans. The PEBB Program should receive your change form 30 days before the Medicare enrollment date, but must receive it **no later than 60 days** after the Medicare enrollment date.

After you leave a CDHP, you will still have access to your existing HSA funds, but you can no longer contribute to it.

See more information below about the CDHP and UMP Plus plans. The effective date of the change in the medical plan will be the first of the month following the date the medical plan becomes unavailable or the date the form is received, whichever is later. Since a medical plan change is required and enrollment in Medicare Part A and Part B may lower your premium, we encourage you to submit your change form promptly to avoid any delays.

If the person entitled to Medicare Part A and Part B is:	You must:
You (the subscriber)	Choose a new medical plan that is not a consumer-directed health plan (CDHP) or UMP Plus plan. Your annual deductible and annual out-of-pocket maximum will restart with your new medical plan.
Your covered dependent	<ul style="list-style-type: none"> <li>• Choose a new medical plan that is not a CDHP or UMP Plus plan and keep your Medicare dependent enrolled in PEBB medical coverage. Your annual deductible and annual out-of-pocket maximum will restart with your new medical plan, <b>or</b></li> <li>• To keep your CDHP or UMP Plus plan, remove your dependent from your PEBB health plan coverage before they enroll in Medicare Part A and Part B. The dependent will not qualify for continuation coverage through the PEBB Program.</li> </ul>



# Making Changes in Coverage

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To make changes, such as enrolling a dependent or electing a different health plan, you must complete and submit the required form(s) during the PEBB Program's annual open enrollment or when a special open enrollment event occurs. You must make all changes within the PEBB Program's timelines. You can also make some changes any time throughout the year.

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

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

During the annual open enrollment, you can:

- Change your medical and/or dental plan.
- Add dental coverage. (If you enroll in a dental plan, you must stay enrolled for two years.)
- Enroll an eligible dependent to your PEBB health plan coverage. If you (the subscriber) are not enrolled in Medicare Part A and Part B or you are enrolling a state-registered domestic partner, you must also provide proof of your dependent's eligibility with your enrollment form, or they will not be enrolled. (See "Valid Dependent Verification Documents" on page 15.)
- Terminate or defer (postpone) your PEBB retiree health plan coverage.
- Remove a covered dependent from your PEBB retiree health plan coverage.
- Enroll in a health plan if you previously deferred (postponed) PEBB retiree health plan coverage for other qualifying coverage. You will need to provide proof of continuous coverage through other qualifying insurance.

**Note:** You cannot enroll if there has been a gap in coverage. (See "Deferring Your Coverage" on page 29.)

## What changes can I make any time?

Below are the changes you can make any time during the year without a special open enrollment event. You can use the *Retiree Coverage Change Form* (form E) to report the change unless otherwise noted below.

- Change your or your enrolled dependent's tobacco use premium surcharge attestation. Use the *2019 Premium Surcharge Change Form* or log in to *My Account* at [hca.wa.gov/my-account](http://hca.wa.gov/my-account).
- Change your name or address. To do so, mail the PEBB Program a written request with your new name or address, send a fax to 360-725-0771, or call 1-800-200-1004 and select menu option 5.
- Terminate or defer (postpone) your PEBB retiree health plan coverage. (See "How do I terminate coverage?" on page 27 or "Deferring Your Coverage" beginning on page 29.)
- Remove a covered dependent from your PEBB retiree health plan coverage.
  - The PEBB Program will remove the dependent on the last day of the month in which the written notice is received. If the written notice is received on the first day of the month, coverage will end on the last day of the previous month.
  - If the dependent is enrolled in a Medicare Advantage Plan, coverage will end on the last day of the month when the Medicare Advantage Disenrollment Form (form D) is received.
- Change your life insurance beneficiary information. Use the *MetLife Group Term Life Insurance Beneficiary Designation* form, or contact MetLife at 1-866-548-7139. (See "Life Insurance" on page 64.)
- Apply for, terminate, or change auto or home insurance coverage. (See "Auto and Home Insurance" on page 68.)
- Start, stop, or change your contributions to your health savings account (HSA) (non-Medicare retirees only). To do this, contact HealthEquity toll-free at 1-877-873-8823.
- Change your HSA beneficiary information. Use the *HealthEquity Beneficiary Designation Form* available at [healthequity.com/pebb](http://healthequity.com/pebb).

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## Removing ineligible dependents

You must notify the PEBB Program in writing when your dependent no longer meets the eligibility criteria described in WAC 182-12-260. The PEBB Program must receive your notice within **60 days** of the last day of the month your dependent is no longer eligible. For example, if your dependent turns 26 on March 15, their last day of eligibility is March 31. You must notify the PEBB Program that your dependent is no longer eligible by May 30 (which is 60 days after March 31). If due to divorce or dissolution of a state-registered domestic partnership, a copy of the divorce decree or dissolution document is required.

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

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

## What is a special open enrollment?

The PEBB Program allows changes outside of the PEBB Program's annual open enrollment when certain events create a special open enrollment. The change must be consistent with and correspond to the event that affects eligibility for coverage (see table on page 26). You must provide proof of the event that created the special open enrollment (for example, a marriage certificate or birth certificate).

To make a change, you must submit the *Retiree Coverage Change Form* (form E) and any other required form(s) or documentation. The PEBB Program must receive your completed form(s) and other required document(s) **no later than 60 days** after the event that created the special open enrollment. However, if adding a newborn or newly adopted child, and adding the child increases your premium, the PEBB Program must receive the required form **no later than 12 months** after the birth or adoption.

If you are changing your medical plan to Premera Blue Cross Medicare Supplement Plan (Plan F) due to you or your dependent becoming entitled to Medicare Part A and Part B, the PEBB Program must receive the required forms no later than six months after you or your dependent enroll in Medicare Part B.

In most cases, the change will occur the first day of the month after the date of the event. One exception is Medicare Advantage plans, which start the first of the month after the PEBB Program receives your change form, per federal regulations. Another exception is a special open enrollment due to the birth or adoption of a child (or when you have assumed a legal obligation for total or partial support in anticipation of adoption of a child), in which case health plan coverage will begin or end as follows:

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

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

*(continued)*

# Making Changes in Coverage

If this event happens:	These changes may be allowed:		
	Add dependent	Change medical plan	Change dental plan
Marriage or registering a domestic partnership (as defined by WAC 182-12-260(2))	Yes	Yes	Yes
Birth or adoption, including assuming a legal obligation for total or partial support in anticipation of adoption	Yes	Yes	Yes
Child becoming eligible as an extended dependent through legal custody or legal guardianship	Yes	Yes	Yes
Subscriber or dependent losing eligibility for other coverage under a group health plan or through health insurance, as defined by the Health Insurance Portability and Accountability Act (HIPAA)	Yes	Yes	Yes
Subscriber having a change in employment status that affects the subscriber's eligibility for the employer contribution toward their employer-based group health plan	Yes	Yes	Yes
The subscriber's dependent has a change in their employment status that affects their eligibility for the employer contribution under their employer-based group health plan.	Yes	Yes	Yes
Subscriber or dependent having a change in enrollment under another employer-based group health insurance plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment	Yes	No	No
Subscriber's dependent moving from outside the United States to live within the United States, or from within the United States to outside of the United States	Yes	No	No
Subscriber or dependent having a change in residence that affects health plan availability	No	Yes	Yes
A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent	Yes	Yes	Yes
Subscriber or a subscriber's dependent becoming entitled to coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or losing eligibility for coverage under Medicaid or a state CHIP	Yes	Yes	Yes
Subscriber or a dependent becoming eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP	Yes	Yes	Yes
Subscriber or dependent becoming entitled to Medicare or losing eligibility under Medicare; or enrolling (or terminating enrollment) in a Medicare Part D plan	No	Yes	No
Subscriber's current health plan becoming unavailable because the subscriber or subscriber's dependent is no longer eligible for a health savings account (HSA)	No	Yes	Yes
Subscriber or dependent experiencing a disruption of care 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 PEBB Program)	No	Yes	Yes

For more information about the changes you can make during these events, read Policy 45-2A at [hca.wa.gov/pebb-rules](http://hca.wa.gov/pebb-rules).

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## How do I terminate coverage?

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

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

**Fax** 360-725-0771

**Secure online message to [fuzeqna.com/pebb/consumer/question.asp](https://fuzeqna.com/pebb/consumer/question.asp).** You must register for an account to use this feature. This helps protect your privacy and sensitive health information. To terminate coverage online, you must attach your written request to the secure message. We cannot terminate your coverage in response to a secure message alone.

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

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

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

## When does PEBB coverage end?

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

- When you or a dependent lose eligibility for PEBB retiree insurance coverage, coverage ends on the last day of the month in which eligibility ends.
- Coverage for you and your enrolled dependents ends on the last day of the month for which the monthly premium and applicable premium surcharges were paid. The PEBB Program charges an entire month's premium for each calendar month of coverage. HCA will not prorate a premium if an enrollee dies or requests to terminate their coverage before the end of the month.

## What are my options when coverage ends?

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

If eligible, the PEBB Program must receive the *PEBB Continuation Coverage (COBRA) Election/Change* form **no later than 60 days** from the date your PEBB health plan coverage ended or from the postmark date on the *PEBB Continuation Coverage Election Notice* booklet, whichever is later. If the election form is not received in a timely manner, you will lose all rights to continue PEBB insurance coverage.

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

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# Making Changes in Coverage

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

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

For information about your rights and obligations, go to [hca.wa.gov/erb](http://hca.wa.gov/erb), select *Forms & publications*, and search for *Continuation Coverage Election Notice*.



# Deferring Your Coverage

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Deferring means postponing your PEBB retiree health plan coverage in a way that lets you keep your eligibility to enroll at a later date. You may choose to defer your enrollment in a PEBB retiree health plan at the time you become eligible for PEBB retiree insurance coverage or after you enroll.

## Why would I defer?

You may want to defer if you have other medical coverage available. For example, if you are retiring but your spouse or state-registered domestic partner is still working, you may want to use their employer's health coverage. Later, when your spouse or partner retires or separates from employment, you can apply to enroll yourself and any eligible dependents in PEBB retiree health plan coverage after your deferral. When you apply for enrollment after your deferral, you must provide proof of continuous enrollment in one or more qualifying medical coverages (including start and end dates).

## How do I defer?

To defer your enrollment, you must:

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

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

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

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

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

- If you are enrolled in a PEBB, Washington State school district, educational service district, or charter school-sponsored medical plan as a

dependent, including such coverage under COBRA or continuation coverage.

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

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

We encourage you to collect proof of coverage annually and keep a file to provide to the PEBB Program in the event you want to return in the future.

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# Deferring Your Coverage

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## Required timelines for retirees to defer

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

- If you are a retiring or eligible separating employee, the PEBB Program must receive the *Retiree Coverage Election Form* (form A) **no later than 60 days** after your employer-paid coverage, COBRA coverage, or continuation coverage ends. The PEBB Program will defer your enrollment the first of the month following the date your employer-paid coverage, COBRA coverage, or continuation coverage ends.
- If you are an employee determined eligible for disability retirement, see “Can I enroll retroactively due to a disability?” on page 19 for more information.
- If you are an eligible elected or full-time appointed official of the legislative or executive branch of state government leaving public office, the PEBB Program must receive the *Retiree Coverage Election Form* (form A) no later than 60 days after you leave public office. The PEBB Program will defer your enrollment the first of the month following the date you leave public office.
- If you are a retiree enrolled in PEBB retiree insurance coverage, the PEBB Program must receive the *Retiree Coverage Change Form* (form E) and any other required forms before you defer coverage. Enrollment will be deferred effective the first of the month following the date the PEBB Program receives your forms.

**Exception:** If the PEBB Program receives the forms on the first day of the month, enrollment will be deferred effective that day. When a member is enrolled in a Medicare Advantage Plan, enrollment in a PEBB retiree health plan will be deferred effective the first of the month following the date the *Medicare Advantage Plan Disenrollment Form* (form D) is received.

- If you enrolled as a dependent in a medical plan sponsored by PEBB, a Washington State school district, educational service district, or charter school,

or such coverage under COBRA or continuation coverage, and then lose coverage, you will have 60 days to enroll in a PEBB retiree health plan. To continue in a deferred status, the retiree must defer enrollment as described in WAC 182-12-205.

- If you met substantive eligibility requirements and your employer-paid coverage, COBRA coverage, or continuation coverage ended between January 1, 2001 and December 31, 2001, you were not required to have submitted a deferral form at that time. However, you must meet all other procedural requirements.

## Life insurance when medical is deferred

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

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

## Deferral rights for survivors of employees or retirees

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

- If a survivor is enrolled in a PEBB, Washington State school district, educational service district, or charter school-sponsored medical plan as a

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dependent, including such coverage under COBRA or continuation coverage.

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

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

We encourage you to collect proof of coverage annually and keep a file to provide to the PEBB Program in the event you want to return in the future.

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

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

- In the event of an employee's death, including elected or full-time appointed officials, the PEBB Program must receive the form **no later than 60 days** after the date of the employee's death or the date the survivor's PEBB Program, school district, educational service district, or charter school coverage ends, whichever is later. Enrollment will be deferred effective the first of the month following the later of the date of the employee's death or the date the survivor's PEBB, school district, educational service district, or charter school coverage ends.
- In the event of a retiree's death, the PEBB Program must receive the form no later than 60 days after the retiree's death. Enrollment will be deferred effective the first of the month following the date of the retiree's death.
- If a survivor enrolls in PEBB retiree insurance coverage and is eligible to defer coverage in the future, the PEBB Program must receive the *Retiree Coverage Change Form* (form E) and any other required form(s) **before** the survivor defers coverage. Enrollment will be deferred effective the first of the month following the date the PEBB Program receives the form(s). If the forms are received on the first day of the month, enrollment will be deferred effective that day. When a member is enrolled in a Medicare Advantage Plan, then PEBB retiree health plan coverage will be deferred effective the first of the month following the date the *Medicare Advantage Disenrollment Form* (form D) is received.

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# Deferring Your Coverage

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## Deferral rights for survivors of emergency service personnel

A surviving spouse, state-registered domestic partner, or dependent child of emergency service personnel killed in the line of duty who is eligible for PEBB retiree insurance coverage under WAC 182-12-250 may defer enrollment under the circumstances listed below. If a survivor defers enrollment in PEBB retiree health plan coverage, they may not enroll in a PEBB dental plan.

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

- Beginning July 17, 2018, survivors who are enrolled in medical coverage as a retiree or a dependent of a retiree in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). These survivors will have a one-time opportunity to enroll in a PEBB retiree health plan.

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

We encourage you to collect proof of coverage annually and keep a file to provide to the PEBB Program in the event you want to return in the future.

To defer enrollment in PEBB retiree health plan coverage, a survivor must submit a *Retiree Coverage Election Form* (form A) to the PEBB Program. The PEBB Program must receive the form **no later than 180 days** after the later of:

- The death of the emergency service worker.
- The date on the eligibility letter from the Washington State Department of Retirement Systems or the board for volunteer firefighters and reserve officers.
- The last day the survivor was covered under any health plan through the emergency service worker's employer.
- The last day the survivor was covered under COBRA coverage from the emergency service worker's employer.

If a survivor enrolls in PEBB retiree insurance coverage and requests to defer coverage in the future, the PEBB Program must receive the *Retiree Coverage Change Form* (form E) and any other required form(s) **before** the survivor defers coverage. Enrollment will be deferred effective the first of the month following the date the PEBB Program receives the form(s). When a member is enrolled in a Medicare Advantage Plan, then PEBB retiree health plan coverage will be deferred effective the first of the month following the date the *Medicare Advantage Disenrollment Form* (form D) is received.

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## How do I enroll after deferring PEBB coverage?

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

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

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

A retiree or survivor has a one-time opportunity to enroll in PEBB medical and dental if they deferred enrollment in PEBB retiree insurance coverage for CHAMPVA, a TRICARE plan, the Federal Employees Health Benefits Program, or coverage through a health benefit exchange established under the Affordable Care Act.



# Selecting a PEBB Medical Plan

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

- **Eligibility.** You must be enrolled in Medicare Part A and Part B to enroll in the Medicare Advantage or Medicare Supplement plans. Also, not everyone qualifies to enroll in a CDHP with a health savings account (HSA) or a UMP Plus plan. See “Can I enroll in a CDHP or UMP Plus plan and Medicare Part A and Part B?” and “What do I need to know about the consumer-directed health plans?” on page 36.
- **Where you live.** In most cases, you must live in the plan’s service area to join the plan. (See “Medical Plans Available by County” beginning on page 41.) Be sure to contact the plan(s) you’re interested in to ask about provider availability in your county. If you move out of your plan’s service area, you may need to change your plan. You must report your new address to the PEBB Program **no later than 60 days** after your move.

## How can I compare the plans?

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

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

- **Premiums.** Premiums vary by plan. A higher premium doesn’t necessarily mean higher quality of care or better benefits; each plan has the same basic level of benefits (except Medicare Supplement Plan F). Generally, the classic plans have higher premiums than the value plans. However, classic plans may have lower annual deductibles, copays, or coinsurance costs.
- **Deductibles.** Most medical plans, except Premera Blue Cross Medicare Supplement Plan F, and Kaiser

Permanente NW and Kaiser Permanente WA’s Medicare Advantage plans, require you to pay an annual deductible before the plan pays for covered services. Kaiser Permanente WA Classic, Value, and SoundChoice; and UMP Classic also have a separate annual deductible for some prescription drugs. Preventive care and certain other services are exempt from the medical plans’ deductibles. This means you do not have to pay your deductible before the plan covers the service.

- **Coinsurance or copays.** Some plans require you to pay a fixed amount when you receive care, called a copay. Other plans require you to pay a percentage of an allowed fee, called a coinsurance.
- **Out-of-pocket limit.** The annual out-of-pocket limit is the most you pay in a calendar year for covered benefits. Kaiser Permanente WA Classic, Value, and SoundChoice; UMP Classic; and UMP Plus plans have separate out-of-pocket limits for prescription drugs. Once you have paid this amount, the plans pay 100 percent of allowed charges for most covered benefits for the rest of the calendar year. Certain charges incurred during the year (such as your annual deductible, copays, and coinsurance) count toward your out-of-pocket limit. There are a few costs that do not apply toward your annual out-of-pocket limit:
  - Monthly premiums and applicable premium surcharges
  - Charges above what the plan pays for a benefit
  - Charges above the plan’s allowed amount paid to a provider
  - Charges for services or treatments the plan doesn’t cover
  - Coinsurance for non-network providers
  - Prescription drug deductible and prescription drug coinsurance (Kaiser Permanente WA Classic, Value, and SoundChoice; UMP Classic; and UMP Plus only)
- **Referral procedures.** Some plans allow you to self-refer to any network provider; others require you to have a referral from your primary care provider. All plans allow self-referral to a participating provider for women’s health care services.

- **Your provider.** If you want to see a particular doctor or health care provider, you should verify whether they are in the plan's network. Contact the plan before you join. Your dependents may choose from any available provider in the plan's network. After you join a plan, you may change your provider, although the rules vary by plan.
- **Paperwork.** In general, PEBB plans don't require you to file claims. However, UMP Classic members may need to file a claim if they receive services from a non-network provider. CDHP members should also keep paperwork received from their provider or from qualified health care expenses to verify eligible payments or reimbursements from their health savings account.
- **Coordination with your other benefits.** If you are also covered through your spouse's or state-registered domestic partner's comprehensive group health coverage, call the medical and/or dental plan(s) directly to ask how they will coordinate benefits.

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

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

You can compare some of the medical plans' benefits in this booklet on pages 45-52 and at [hca.wa.gov/pebb-retirees](http://hca.wa.gov/pebb-retirees).

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

Value-based plans aim to provide high-quality care at a lower price. Providers have committed to follow evidence-based treatment practices, coordinate care with other providers in your plan's network, and meet certain measures about the quality of care they provide. See page 4 for more information.

## What type of plan should I select?

Available plans by county are listed on pages 41-43. In general, the type of plan you choose depends on whether you are eligible for Medicare Parts A and B, and whether you qualify to enroll in a CDHP with an HSA.

The PEBB Program offers three types of medical plans:

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

*(continued)*

# Selecting a PEBB Medical Plan

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## Medicare options

For members enrolled in Medicare Part A and Part B (see pages 51–52). Value-based plans noted in **bold**.

- **Kaiser Permanente NW Senior Advantage**
- **Kaiser Permanente WA Medicare Plan** (Medicare Advantage or Original Medicare coordination plan)
- Medicare Supplement Plan F, administered by Premera Blue Cross
- UMP Classic (Medicare), administered by Regence BlueShield

## Non-Medicare options

For members not eligible for Medicare or enrolled in Part A only (see pages 45–50). Value-based plans noted in **bold**.

## Consumer-directed health plans (CDHPs)

(Not available if any member is enrolled in Medicare)

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

## Managed-care plans

(At least one member on your account must not be enrolled in Medicare)

- **Kaiser Permanente NW Classic\***
- **Kaiser Permanente WA Classic**
- **Kaiser Permanente WA SoundChoice**
- **Kaiser Permanente WA Value**

## Preferred-provider plans

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

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

A consumer-directed health plan (CDHP) is a high-deductible health plan (HDHP) with a health savings account (HSA). When you enroll in a CDHP, you are automatically enrolled in a tax-free HSA that you can use to pay for IRS-qualified out-of-pocket medical expenses (such as deductibles, copays, and coinsurance), including some expenses and services that your health plans may not cover (see IRS *Publication 969 Health Savings Accounts and Other Tax Favored Health Plans* at [irs.gov](https://www.irs.gov) for details).

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

## Who is eligible?

Before you enroll in a CDHP with an HSA, some exclusions apply. You cannot enroll in a CDHP with an HSA if:

- You or your covered dependent(s) are enrolled in Medicare Part A or Part B or Medicaid.
- You are enrolled in another health plan that is not an HDHP—for example, on a spouse's or state-registered domestic partner's plan—unless the health plan coverage is limited coverage like dental, vision, or disability coverage.
- You or your spouse or state-registered domestic partner is enrolled in a health reimbursement arrangement (HRA), such as the Voluntary Employees' Beneficiary Association Medical Expense Plan (VEBA MEP), unless you take action to convert it to limited HRA coverage.
- You have CHAMPVA or a TRICARE plan.

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\*Kaiser Foundation Health Plan of the Northwest, with plans offered in Clark and Cowlitz counties in WA, and the Portland, OR, area.

- You enrolled in a Medical Flexible Spending Arrangement (FSA). This also applies if your spouse has a Medical FSA, even if you are not covering your spouse on your CDHP. This does not apply if the Medical FSA or HSA is a limited purpose account, or for a post-deductible Medical FSA.
- You are claimed as a dependent on someone else's tax return.

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

### PEBB Program contributions

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

- \$58.34 each month for an individual subscriber, up to \$700.08 for the 2019 calendar year; or
- \$116.67 each month for a subscriber with one or more enrolled dependents, up to \$1,400.04 for the 2019 calendar year.
- \$125 if you qualified for the SmartHealth wellness incentive in 2018.

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

### Subscriber contributions

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

The IRS has an annual limit for contributions from all sources into an HSA. In 2019, the annual HSA contribution limit is \$3,500 (subscriber only) and

\$7,000 (you and one or more dependents). If you are age 55 or older, you may contribute up to \$1,000 more per year in addition to these limits.

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

### Other features of the CDHP/HSA

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

### CDHP and Medicare do not mix

If you enroll in a CDHP and you or a covered dependent becomes eligible for Medicare Part A or Part B during the year, you must change to another PEBB medical plan that is not a CDHP, or remove the Medicare-eligible dependent from your PEBB coverage. The removed dependent will not qualify for continuation coverage through the PEBB Program. If you change your medical plan midyear, any payments you have made toward your annual deductible and out-of-pocket maximum may not apply to your new plan. See "Can I enroll in a CDHP or UMP Plus plan and Medicare Part A and Part B?" on page 23.

*(continued)*

\*Kaiser Foundation Health Plan of the Northwest, with plans offered in Clark and Cowlitz counties in WA, and the Portland, OR, area.



# Selecting a PEBB Medical Plan

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

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

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

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

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

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

Medicare Advantage plans are available from Kaiser Permanente NW and Kaiser Permanente WA but are not available in every county (see pages 41–43). If you or a covered dependent are enrolled in Medicare Part A and Part B and you choose Kaiser Permanente NW or Kaiser Permanente WA, you must enroll in the Medicare Advantage plan if they offer it in your county.

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

Kaiser Permanente WA also offers an Original Medicare plan for Medicare retirees who live in a county not served by the Kaiser Permanente WA Medicare Advantage plan. See “Medical plans by county” on pages 41–43.

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

**Medicare Supplement Plan F, administered by Premera Blue Cross**, allows the use of any Medicare-contracted physician or hospital nationwide. The plan is designed to supplement your Medicare coverage by reducing your out-of-pocket expenses and providing additional benefits. It pays some Medicare deductibles and coinsurances, but primarily supplements only those services covered by Medicare.

The PEBB Program does not offer the high-deductible Plan F shown in the *Outline of Medicare Supplement Coverage* that begins on page 53.

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

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

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

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

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

- These plans, on average for all plan members, meet at least what the standard Medicare Part D prescription drug coverage will pay.



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

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

# How to Find the Summaries of Benefits and Coverage

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

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

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

<b>If you want to request an SBC from your current PEBB medical plan</b>	<b>If you want to request an SBC from another PEBB medical plan</b>
<p>You can either:</p> <ul style="list-style-type: none"><li>• Go to your plan's website or visit <a href="http://hca.wa.gov/employee-retiree-benefits/retirees/benefits-and-coverage-plan">hca.wa.gov/employee-retiree-benefits/retirees/benefits-and-coverage-plan</a> to view it online; OR</li><li>• Call your plan to request a paper copy at no charge.</li></ul>	<p>You can either:</p> <ul style="list-style-type: none"><li>• Go to the plan's website or visit <a href="http://hca.wa.gov/employee-retiree-benefits/retirees/benefits-and-coverage-plan">hca.wa.gov/employee-retiree-benefits/retirees/benefits-and-coverage-plan</a> to view it online; OR</li><li>• Call the PEBB Program at 1-800-200-1004 to request a paper copy at no charge.</li></ul>

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

# 2019 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 plan(s) you are interested in to ask about provider availability in your county.

Washington			
<b>Kaiser Permanente NW Classic*</b> <b>Kaiser Permanente NW Consumer-Directed Health Plan (CDHP)*</b> <i>These plans are not available to Medicare members</i>	<ul style="list-style-type: none"> <li>• Clark</li> <li>• Cowlitz</li> </ul>		
<b>Kaiser Permanente NW Senior Advantage</b>	<ul style="list-style-type: none"> <li>• Clark</li> <li>• Cowlitz</li> </ul>	<ul style="list-style-type: none"> <li>• Skamania</li> </ul>	<ul style="list-style-type: none"> <li>• Wahkiakum (ZIP Codes 98612 and 98647)</li> </ul>
<b>Kaiser Permanente WA Classic</b> <b>Kaiser Permanente WA Consumer-Directed Health Plan (CDHP)</b> <b>Kaiser Permanente WA Value</b> <i>These plans are not available to Medicare members</i>	<ul style="list-style-type: none"> <li>• Benton</li> <li>• Columbia</li> <li>• Franklin</li> <li>• Grays Harbor (ZIP Codes 98541, 98557, 98559, and 98568)</li> <li>• Island</li> <li>• King</li> <li>• Kitsap</li> <li>• Kittitas</li> <li>• Lewis</li> </ul>	<ul style="list-style-type: none"> <li>• Lincoln (ZIP Codes 99008, 99029, 99032, and 99122)</li> <li>• Mason</li> <li>• Pend Oreille (ZIP Code 99180)</li> <li>• Pierce</li> <li>• San Juan</li> <li>• Skagit</li> <li>• Snohomish</li> <li>• Spokane</li> </ul>	<ul style="list-style-type: none"> <li>• Stevens (ZIP Codes 99013, 99034, 99040, 99110, 99148, and 99173)</li> <li>• Thurston</li> <li>• Walla Walla</li> <li>• Whatcom</li> <li>• Whitman</li> <li>• Yakima</li> </ul>
<b>Kaiser Permanente WA Medicare Advantage</b>	<ul style="list-style-type: none"> <li>• Grays Harbor (ZIP Codes 98541, 98557, 98559, and 98568)</li> <li>• Island</li> <li>• King</li> <li>• Kitsap</li> </ul>	<ul style="list-style-type: none"> <li>• Lewis</li> <li>• Mason (ZIP Codes 98524, 98528, 98546, 98548, 98555, 98584, 98588, and 98592)</li> <li>• Pierce</li> </ul>	<ul style="list-style-type: none"> <li>• San Juan</li> <li>• Skagit</li> <li>• Snohomish</li> <li>• Spokane</li> <li>• Thurston</li> <li>• Whatcom</li> </ul>
<b>Kaiser Permanente WA Original Medicare</b>	<ul style="list-style-type: none"> <li>• Benton</li> <li>• Columbia</li> <li>• Franklin</li> <li>• Kittitas</li> <li>• Lincoln (ZIP Codes 99008, 99029, 99032, and 99122)</li> </ul>	<ul style="list-style-type: none"> <li>• Mason (ZIP Code 98560)</li> <li>• Pend Oreille (ZIP Code 99180)</li> <li>• Stevens (ZIP Codes 99013, 99034, 99040, 99110, 99148, and 99173)</li> </ul>	<ul style="list-style-type: none"> <li>• Walla Walla</li> <li>• Whitman</li> <li>• Yakima</li> </ul>
<b>Kaiser Permanente WA SoundChoice</b> <i>This plan is not available to Medicare members</i>	<ul style="list-style-type: none"> <li>• King</li> <li>• Kitsap</li> <li>• Pierce</li> </ul>	<ul style="list-style-type: none"> <li>• Snohomish</li> <li>• Spokane**</li> <li>• Thurston</li> </ul>	
<p>**Not all contracted providers in Spokane County are in the SoundChoice network. Please make sure your provider is in-network before your visit.</p>			

\*Kaiser Foundation Health Plan of the Northwest, with plans offered in Clark and Cowlitz counties in Washington and select counties in Oregon.

If you move out of your plan's service area, you may need to change plans. You must report your new address to the PEBB Program **no later than 60 days** after your move. See how to report an address change at [www.hca.wa.gov/employee-retiree-benefits/contact-pebb-program](http://www.hca.wa.gov/employee-retiree-benefits/contact-pebb-program).

(continued)

# 2019 Medical Plans Available by County

Washington (continued)	
<b>Medicare Supplement Plan F, administered by Premera Blue Cross</b>	Available in all Washington counties and nationwide.
<b>UMP Classic</b>	Available in all Washington counties and worldwide.
<b>UMP Consumer-Directed Health Plan (CDHP)</b> <i>This plan is not available to Medicare members</i>	Available in all Washington counties and worldwide.
<b>UMP Plus—Puget Sound High Value Network</b> <i>This plan is not available to Medicare members</i>	<ul style="list-style-type: none"> <li>• King</li> <li>• Kitsap</li> <li>• Pierce</li> <li>• Snohomish</li> <li>• Spokane</li> <li>• Thurston</li> <li>• Yakima</li> </ul>
<b>UMP Plus—UW Medicine Accountable Care Network</b> <i>This plan is not available to Medicare members</i>	<ul style="list-style-type: none"> <li>• King</li> <li>• Kitsap</li> <li>• Pierce</li> <li>• Skagit</li> <li>• Snohomish</li> <li>• Thurston</li> </ul>

Oregon	
<b>Kaiser Permanente NW Classic*</b> <b>Kaiser Permanente NW Consumer-Directed Health Plan (CDHP)*</b> <i>These plans are not available to Medicare members</i>	<ul style="list-style-type: none"> <li>• Benton (ZIP Codes 97330, 97331, 97333, 97339, 97370, and 97456)</li> <li>• Clackamas (all ZIP Codes available except 97028)</li> <li>• Columbia</li> <li>• Hood River (ZIP Code 97014)</li> <li>• 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)</li> <li>• Linn</li> <li>• Marion (all ZIP Codes available except 97350)</li> <li>• Multnomah</li> <li>• Polk</li> <li>• Washington</li> <li>• Yamhill</li> </ul>
<b>Kaiser Permanente NW Senior Advantage</b>	<ul style="list-style-type: none"> <li>• Benton (ZIP Codes 97330, 97331, 97333, 97339, and 97370)</li> <li>• Clackamas</li> <li>• Columbia</li> <li>• Hood River</li> <li>• Linn (ZIP Codes 97321, 97322, 97335, 97355, 97358, 97360, 97374, and 97389)</li> <li>• Marion</li> <li>• Multnomah</li> <li>• Polk</li> <li>• Washington</li> <li>• Yamhill</li> </ul>
<b>Kaiser Permanente WA Classic</b> <b>Kaiser Permanente WA Consumer-Directed Health Plan (CDHP)</b> <b>Kaiser Permanente WA Value</b> <i>These plans are not available to Medicare members</i>	<ul style="list-style-type: none"> <li>• Umatilla (ZIP Codes 97810, 97813, 97835, 97862, 97882, and 97886)</li> </ul>

\*Kaiser Foundation Health Plan of the Northwest, with plans offered in Clark and Cowlitz counties in Washington and select counties in Oregon.

<b>Oregon (continued)</b>	
<b>Kaiser Permanente WA Original Medicare</b>	<ul style="list-style-type: none"> <li>• Umatilla (ZIP Codes 97810, 97813, 97835, 97862, 97882, and 97886)</li> </ul>
<b>Medicare Supplement Plan F, administered by Premera Blue Cross</b>	Available in all Oregon counties and nationwide.
<b>UMP Classic</b>	Available in all Oregon counties and worldwide.
<b>UMP Consumer-Directed Health Plan (CDHP)</b> <i>This plan is not available to Medicare members</i>	Available in all Oregon counties and worldwide

<b>Idaho</b>	
<b>Kaiser Permanente WA Classic</b> <b>Kaiser Permanente WA Consumer-Directed Health Plan (CDHP)</b> <b>Kaiser Permanente WA Value</b> <i>These plans are not available to Medicare members</i>	<ul style="list-style-type: none"> <li>• Kootenai</li> <li>• Latah</li> </ul>
<b>Kaiser Permanente WA Original Medicare</b>	<ul style="list-style-type: none"> <li>• Kootenai</li> <li>• Latah</li> </ul>
<b>Medicare Supplement Plan F, administered by Premera Blue Cross</b>	Available in all Idaho counties and nationwide.
<b>UMP Classic</b>	Available in all Idaho counties and worldwide.
<b>UMP Consumer-Directed Health Plan (CDHP)</b> <i>This plan is not available to Medicare members</i>	Available in all Idaho counties and worldwide.

If you move out of your plan's service area, you may need to change plans. You must report your new address to the PEBB Program **no later than 60 days** after your move. See how to report an address change at [www.hca.wa.gov/employee-retiree-benefits/contact-pebb-program](http://www.hca.wa.gov/employee-retiree-benefits/contact-pebb-program).



# 2019 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.

<b>Annual Costs</b> (You pay)	<b>Medical deductible</b> Applies to medical out-of-pocket limit	<b>Medical out-of-pocket limit<sup>1</sup></b> (See separate prescription drug out-of-pocket limit for some plans.)	<b>Prescription drug deductible</b>	<b>Prescription drug out-of-pocket limit<sup>1</sup></b>
<b>Kaiser Foundation Health Plan of the Northwest</b>				
<b>Kaiser Permanente NW Classic<sup>2</sup></b>	\$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.
<b>Kaiser Permanente NW CDHP<sup>2</sup></b>	\$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.	
<b>Kaiser Foundation Health Plan of Washington</b>				
<b>Kaiser Permanente WA Classic</b>	\$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 Your prescription drug deductible and coinsurance for all covered prescription drugs apply.
<b>Kaiser Permanente WA CDHP Individual</b>	\$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.
<b>Kaiser Permanente WA CDHP Family</b>	\$2,800/person \$2,800/family*	\$5,100/person • \$10,200/family Your deductible and coinsurance for all covered services apply.		
<b>Kaiser Permanente WA SoundChoice</b>	\$125/person \$375/family	\$2,000/person • \$4,000/family Your deductible, copays, and coinsurance for all covered services apply.	\$100/person \$300/family	\$2,000/person Your prescription drug deductible and coinsurance for all covered prescription drugs apply.
<b>Kaiser Permanente WA Value</b>	\$250/person \$750/family	\$3,000/person • \$6,000/family Your deductible, copays, and coinsurance for all covered services apply.	Does not apply to value and Tier 1 drugs	
<b>Uniform Medical Plan (UMP)<sup>3</sup></b>				
<b>UMP Classic</b>	\$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 and 3 drugs only)	\$2,000/person Your prescription drug deductible and coinsurance for all covered prescription drugs apply.
<b>UMP CDHP</b>	\$1,400/person \$2,800/family*	\$4,200/person • \$8,400/family (\$6,850 per person in a family) 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.
<b>UMP Plus– PSHVN</b>	\$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 Your coinsurance for all covered prescription drugs applies.
<b>UMP Plus– UW Medicine ACN</b>				

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

(continued)

# 2019 Medical Benefits Cost Comparison

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

<sup>1</sup> 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)<sup>3</sup>, 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.

<sup>2</sup> Kaiser Foundation Health Plan of the Northwest, with plans offered in Clark and Cowlitz counties in Washington and select counties in Oregon.

<sup>3</sup> 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.

Benefits (You pay)	Hospital services		Office visit					
	Inpatient	Outpatient	Primary care	Urgent care	Specialist	Mental health	Chemo-therapy	Radiation
<b>Kaiser Foundation Health Plan of the Northwest</b>								
Kaiser Permanente NW Classic <sup>2</sup>	15%	15%	\$25	\$45	\$35	\$25	\$0	\$0
Kaiser Permanente NW CDHP <sup>2</sup>	15%	15%	\$20	\$40	\$30	\$20	\$0	\$0
<b>Kaiser Foundation Health Plan of Washington</b>								
Kaiser Permanente WA Classic	\$150/day up to \$750 maximum/admission	\$150	\$15	\$15	\$30	\$15	\$30	\$30
Kaiser Permanente WA CDHP	10%	10%	10%	10%	10%	10%	10%	10%
Kaiser Permanente WA SoundChoice	\$500/admission	15%	\$0	15%	15%	15%	15%	15%
Kaiser Permanente WA Value	\$250/day up to \$1,250 maximum/admission	\$200	\$30	\$30	\$50	\$30	\$50	\$50
<b>Uniform Medical Plan (UMP)<sup>3</sup></b>								
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)

# 2019 Medical Benefits Cost Comparison

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

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

Benefits (You pay)	Prescription drugs				
	Mail order (up to a 90-day supply unless otherwise noted)				
	Value tier	Tier 1	Tier 2	Tier 3	Tier 4
<b>Kaiser Foundation Health Plan of the Northwest</b>					
Kaiser Permanente NW Classic <sup>2</sup>	—	\$30	\$80	\$150	50% up to \$150
Kaiser Permanente NW CDHP <sup>2</sup>	—	\$30	\$80	\$150	50% up to \$150
<b>Kaiser Foundation Health Plan of Washington</b>					
Kaiser Permanente WA Classic	\$10	\$40	\$80	50% up to \$750	—
Kaiser Permanente WA CDHP	\$10	\$40	\$80	50% up to \$750	—
Kaiser Permanente WA SoundChoice	\$10	\$30	\$120	50%	—
Kaiser Permanente WA Value	\$10	\$50	\$100	50%	—
<b>Uniform Medical Plan (UMP)<sup>3</sup></b>					
UMP Classic	5% up to \$30	10% up to \$75	30% up to \$225	50% (Specialty drugs: up to \$150 [up to a 30-day supply only]; Non-specialty drugs: no cost-limit)	—
UMP CDHP	15%	15%	15%	15% (Specialty drugs: up to a 30-day supply only)	—
UMP Plus–PSHVN	5% up to \$30	10% up to \$75	30% up to \$225	50% (Specialty drugs: up to \$150 [up to a 30-day supply only]; Non-specialty drugs: no cost-limit)	—
UMP Plus–UW Medicine ACN	5% up to \$30	10% up to \$75	30% up to \$225	50% (Specialty drugs: up to \$150 [up to a 30-day supply only]; Non-specialty drugs: no cost-limit)	—

(continued)



Benefits (You pay)	Preventive care See certificate of coverage or check with plan for full list of services.	Spinal manipulations	Vision care <sup>5</sup>	
			Exam (annual)	Glasses and contact lenses
<b>Kaiser Foundation Health Plan of the Northwest</b>				
Kaiser Permanente NW Classic <sup>2</sup>	\$0	\$35 Maximum 12 visits/year	\$25	You pay any amount over \$150 every 24 months for frames, lenses, and contacts combined.
Kaiser Permanente NW CDHP <sup>2</sup>	\$0	\$30 Maximum 12 visits/year	\$20	
<b>Kaiser Foundation Health Plan of Washington</b>				
Kaiser Permanente WA Classic	\$0	\$15 Maximum 10 visits/year	\$15	You pay any amount over \$150 every 24 months for frames, lenses, and contacts combined.
Kaiser Permanente WA CDHP	\$0	10% Maximum 10 visits/year	10%	
Kaiser Permanente WA SoundChoice	\$0	\$0 Maximum 10 visits/year	15%	
Kaiser Permanente WA Value	\$0	\$30 Maximum 10 visits/year	\$30	
<b>Uniform Medical Plan (UMP)<sup>3</sup></b>				
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		

<sup>5</sup> Contact your plan about costs for children's vision care.

# 2019 Medicare Benefits Cost Comparison

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

Annual Costs	Kaiser Permanente NW Senior Advantage	Kaiser Permanente WA Medicare Plan		UMP Classic
		Medicare Advantage	Original Medicare (coordinates with Medicare)	Medicare
	You pay	You pay		You pay
<b>Medical deductible</b>	\$0	\$0	\$250/person \$750/family	\$250/person \$750/family
<b>Medical out-of-pocket limit<sup>1</sup></b> (See separate prescription drug out-of-pocket limit for UMP Classic)	\$1,500/person Your copays and coinsurance for most covered services apply (except prescription drug costs).	\$2,500/person Your copays and coinsurance for most covered services apply (except prescription drug costs).	\$2,000/person \$4,000/family Your medical deductible, copays, and coinsurance for all covered services apply.	\$2,500/person \$5,000/family Your medical deductible, copays, and coinsurance for most covered services apply.
<b>Prescription drug deductible</b>	None	None	None	\$100/person \$300/family (Tier 2 and 3 drugs only)
<b>Prescription drug out-of-pocket limit<sup>1</sup></b>	None	None	Prescription copays and coinsurance apply to the medical out-of-pocket limit.	\$2,000/person Your prescription drug deductible and coinsurance for all covered prescription drugs apply.

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

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

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

(continued)

Benefits	Kaiser Permanente NW Senior Advantage	Kaiser Permanente WA Medicare Plan		UMP Classic
		Medicare Advantage	Original Medicare (coordinates with Medicare)	Medicare
	You pay	You pay		You pay
<b>Hospital services</b> Inpatient	\$500/admission	\$200/day for the first 5 days, up to \$1,000 maximum/admission	\$150/day, up to \$750 maximum/admission	\$200/day, up to \$600 maximum/admission + 15% professional fees
Outpatient	\$50	\$200	\$150	15%
<b>Office visit</b> Primary care	\$30	\$20	\$15	15%
Urgent care	\$35	\$20	\$15	15%
Specialist	\$30	\$20	\$30	15%
Mental health	\$30	\$20	\$15	15%
Chemotherapy	\$0	\$0	\$30	15%
Radiation	\$0	\$0	\$30	15%
<b>Physical, occupational, and speech therapy</b>	\$30	\$20	\$30 (Per-visit cost for 60 visits/year combined)	15%
<b>Prescription drugs</b> Retail pharmacy (up to a 30-day supply) — includes Medicare-approved diabetic disposable supplies	—			
Value tier		—	\$5	5% up to \$10
Tier 1	\$20	\$20	\$20	10% up to \$25
Tier 2	\$40	\$40	\$40	30% up to \$75
Tier 3	—	50% up to \$250	50% up to \$250	50%
Tier 4 (preventive)	—	\$0	\$0	\$0
Mail order (up to a 90-day supply)	—			
Value tier		—	\$10	5% up to \$30
Tier 1	\$40	\$40	\$40	10% up to \$75
Tier 2	\$80	\$80	\$80	30% up to \$225
Tier 3	—	50% up to \$750	50% up to \$750	50% (up to \$150 for specialty drugs; no per-prescription cost-limit for non-specialty drugs)
<b>Preventive care</b>	\$0	\$0	\$0	\$0
	See certificate of coverage or check with plan for full list of services.			
<b>Spinal manipulations</b>	\$20	\$20	\$15	15%
<b>Vision care<sup>2</sup></b> Exam (annual)	\$30	\$20	\$15	\$0 You pay any amount over \$65 for contact lens fitting fees.
Glasses and contact lenses		You pay any amount over \$150 every 24 months (or two calendar years for UMP) for frames, lenses, and contacts combined.		

<sup>2</sup> Contact your plan about copays and limits for children's vision care.

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

**Basic Benefits included in all plans:**

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

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

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

**Washington State Health Care Authority**  
**SUBSCRIPTION CHARGES AND PAYMENT INFORMATION**  
(Rates effective January 1, 2019)

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

<b>PEBB Retiree</b> Plan F    \$112.16	<b>PEBB Retiree &amp; Spouse</b> Plan F    \$218.35	<b>State Resident</b> Plan F    \$212.38	<b>State Resident &amp; Spouse</b> Plan F    \$424.76
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**Eligible By Reason Of Disability Subscription Charges - Per Month**

<b>PEBB Retiree</b> Plan F    \$199.00	<b>PEBB Retiree &amp; Spouse</b> Plan F    \$392.03	<b>State Resident</b> Plan F    \$361.03	<b>State Resident &amp; Spouse</b> Plan F    \$722.06
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Please Note: The subscription charge amount charged is the same for all plan subscribers with certificates like yours. However, the actual amount a plan subscriber pays can vary depending on if and how much the group contributes toward a particular class of subscribers' subscription charges.

**SUBSCRIPTION CHARGE INFORMATION**

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

**DISCLOSURES**

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

**READ YOUR CERTIFICATE VERY CAREFULLY**

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

**RIGHT TO RETURN CERTIFICATE**

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

**CERTIFICATE REPLACEMENT**

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

**NOTICE**

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

**COMPLETE ANSWERS ARE VERY IMPORTANT**

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

**F****PLAN F:  
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD**

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

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

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



**PLAN F (continued):**

**MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

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

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

## Discrimination is Against the Law

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

Premera:

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

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

If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator — Complaints and Appeals  
PO Box 91102, Seattle, WA 98111  
Toll free 855-332-4535, Fax 425-918-5592,  
TTY 800-842-5357  
Email AppealsDepartmentInquiries@Premera.com

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

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

## Getting Help in Other Languages

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

### አማርኛ (Amharic):

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

### العربية (Arabic):

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

### 中文 (Chinese):

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

**Oromoo (Cushite):****Beeksisni kun odeeffannoo barbaachisaa qaba.**

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

**Français (French):**

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

**Kreyòl ayisyen (Creole):**

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

**Deutsche (German):**

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

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

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

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

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



**한국어 (Korean):**

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

**ລາວ (Lao):**

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

**ភាសាខ្មែរ (Khmer):**

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

**ਪੰਜਾਬੀ (Punjabi):**

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

**فارسی (Farsi):**

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

**Polskie (Polish):**

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

**Português (Portuguese):**

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

**Română (Romanian):****Prezenta notificare conține informații importante.**

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

**Русский (Russian):****Настоящее уведомление содержит важную**

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

**Fa'asamoa (Samoan):**

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

**Español (Spanish):**

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

**Tagalog (Tagalog):****Ang Paunawa na ito ay naglalaman ng mahalagang**

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

**ไทย (Thai):**

ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้อาจมีข้อมูลที่สำคัญเกี่ยวกับการสมัครหรือขอขอบเขตประกันสุขภาพของคุณผ่าน Premera Blue Cross และอาจมีกำหนดการในประกาศนี้ คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 800-722-1471 (TTY: 800-842-5357)

**Український (Ukrainian):****Це повідомлення містить важливу інформацію.**

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

**Tiếng Việt (Vietnamese):****Thông báo này cung cấp thông tin quan trọng.**

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

# Selecting a PEBB Dental Plan

You must enroll in medical to enroll in dental. You and any dependents must enroll in the same PEBB dental plan. Once enrolled, you must keep dental coverage for at least two years unless you defer or terminate enrollment in a PEBB retiree health plan as allowed under PEBB Program rules. If you terminate dental coverage for your dependents, they will also lose medical coverage. You may change retiree dental plans within those two years during the PEBB Program's annual open enrollment (November 1 through 30) or due to a special open enrollment event.

<b>Dental Plan Options</b>				
Make sure you contact the dental plan to confirm that your dentist is part of the specific plan network and plan group.				
Plan Name	Plan Type	Plan Administrator	Plan Network	Plan Group
DeltaCare Plan	Managed-care plan	Delta Dental of Washington	DeltaCare	Group 3100
Willamette Dental Group Plan	Managed-care plan	Willamette Dental of Washington, Inc.	Willamette Dental Group, P.C.	WA82
Uniform Dental Plan (UDP)	Preferred-provider plan	Delta Dental of Washington	Delta Dental PPO	Group 3000

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

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

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

DeltaCare and Willamette Dental Group are managed care plans. You must select and receive care from a primary care dental provider in that plan's network. 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. Before enrolling, call the plan to make sure your dentist is in the plan's network. **If you choose DeltaCare or Willamette Dental and seek services from a dentist not in the plan's network, the plan will not pay your dental claims.**

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

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

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

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

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

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

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

*(continued)*



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

**DeltaCare and Willamette Dental Group are managed-care plans.** You must choose a primary dental provider within their networks. If you do not 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. Before you enroll in one of these plans, be sure to check whether they have providers near you.

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

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

Confirm the selection you've made before you submit your *Retiree Coverage Election Form* (form A) or *Retiree Coverage Change Form* (form E).

# 2019 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)
	<b>You pay after deductible:</b>	<b>You pay:</b>	
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	<b>DeltaCare:</b> 30% of costs, then any amount after plan has paid \$1,000 per year, then any amount over \$5,000 in member's lifetime <b>Willamette Dental Group:</b> 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 erupted teeth	
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 crowns	50% PPO and out of state; 60% non-PPO	\$100 to \$175	

# Life Insurance

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## Can I purchase life insurance when I retire?

The PEBB Program provides life insurance to eligible members through Metropolitan Life Insurance Company (MetLife). As a PEBB retiree, you may be eligible to purchase retiree term life insurance on a self-pay basis or continue your employee life insurance coverage under the Portability or Conversion provisions.

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

If your PEBB employee life insurance ends due to retirement, you may have an opportunity to continue all or part of your coverage through Portability or Conversion. This must happen before your retirement. When Porting or Converting, your coverage will become an individual policy that is not tied to the PEBB Program. If you are eligible for these options, MetLife will send you information and an application. For more information, please contact MetLife at 1-877-275-6387.

## Who qualifies for PEBB retiree term life insurance?

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

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

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

## What amount of insurance can I buy?

Eligible PEBB retirees have the option to buy \$5,000, \$10,000, \$15,000, or \$20,000 of coverage.

## How do I enroll?

Complete the 2019 *Retiree Coverage Election Form* (form A) and the *MetLife Enrollment/Change Form for Retiree Plan* to elect PEBB retiree term life insurance. The PEBB Program must receive these forms **no later than 60 days** after your PEBB employee life insurance ends.

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

## Who can I name as my beneficiary?

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

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

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

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

# Life Insurance

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## **How do my survivors file a claim?**

If you die, your beneficiary should call MetLife at 1-866-548-7139. Your beneficiary should also notify the PEBB Program of your death. We may share this information with the Department of Retirement Systems to better serve your survivors.

## **Where can I get the insurance certificate?**

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

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

You have the option to convert if your life insurance:

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

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

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

# SmartHealth (for non-Medicare subscribers only)

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SmartHealth is Washington State's voluntary wellness program designed to help you improve your health by participating in fun and engaging SmartHealth activities. The secure website offers tips, tools, and fun activities designed to improve nutrition, sleep, exercise, and more. As you progress on your wellness journey, you can qualify for SmartHealth wellness incentives.

## Who is eligible to participate?

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

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

Subscribers enrolled in Medicare Part A and Part B are not eligible to participate in SmartHealth or qualify for its rewards. If you are a non-Medicare subscriber who becomes eligible for Medicare Part A and Part B, you will no longer be able to access the SmartHealth website to earn points toward the wellness incentives.

## What are the financial wellness incentives?

Eligible non-Medicare subscribers who participate in SmartHealth activities can qualify for two financial wellness incentives:

1. A \$25 Amazon.com gift card\*
2. Either a \$125 reduction in the subscriber's 2020 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 2020)

## How do I qualify for the financial wellness incentives?

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

- Not be enrolled in Medicare Part A and Part B
- Complete the SmartHealth Well-being Assessment and claim the gift card by December 31, 2019

To qualify for the \$125 financial wellness incentive, you must do the following:

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

To receive the incentive in 2020, the subscriber must still be enrolled in a PEBB medical plan in 2020.

If you qualify for the \$125 wellness incentive in 2019, and enroll in Medicare Part A and Part B while enrolled in a PEBB medical plan after January 1, 2020, you will still receive the incentive in 2020.

## 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](http://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 financial wellness incentives). After completing the Well-being Assessment, you earn the \$25 gift card wellness incentive.  
  
**Note:** If you don't have internet access, call SmartHealth Customer Service toll-free at 1-855-750-8866 (Monday through Friday, 7 a.m. to 7 p.m. Pacific Time) to complete the Well-being Assessment by phone. You do not earn SmartHealth points for completing your PEBB medical plan's health assessment.
3. Complete other activities on SmartHealth's website to earn 2,000 total points by the applicable deadline to qualify for the \$125 wellness incentive.

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



# SmartHealth (for non-Medicare subscribers only)

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## Deadline requirements

The deadline to qualify for and claim the \$25 Amazon.com gift card wellness incentive is **December 31, 2019**.

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

- If you are continuing enrollment in PEBB medical or are a new subscriber with a PEBB medical effective date in January through June, your deadline to qualify for the financial incentive is **September 30, 2019**.
- If your PEBB medical effective date is in July or August, your deadline is **120 days** from your PEBB medical effective date.

***Example:** Sam is enrolling in PEBB retiree insurance coverage after deferral and his PEBB medical effective date is July 1, 2019. Sam's deadline to complete his SmartHealth activities and earn his financial wellness incentive is October 29, 2019.*

- If your PEBB medical effective date is in September through December, your deadline is **December 31, 2019**.

# Auto and Home Insurance

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

## What does Liberty Mutual offer?

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

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

## When can I enroll?

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

## How do I enroll?

You can request a quote for auto or home insurance from Liberty Mutual one of three ways (be sure to have your current policy handy):

- Look for auto/home insurance under *Additional benefits* at [hca.wa.gov/pebb-retirees](http://hca.wa.gov/pebb-retirees).
- Call Liberty Mutual at 1-800-706-5525. Be sure to mention that you are a State of Washington PEBB Program member (client #8250).
- Call or visit one of the local offices (see table at right).

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

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

### Contact a local Liberty Mutual office (mention client #8250):

<b>Bellevue</b>	<b>1-800-253-5602</b> 11711 SE 8th St., Suite 220 Bellevue, WA 98005
<b>Spokane</b>	<b>1-800-208-3044</b> 24041 E Mission Ave. Liberty Lake, WA 99019
<b>Tukwila</b>	<b>1-800-922-7013</b> 14900 Interurban Ave., Suite 142 Tukwila, WA 98168
<b>Olympia</b>	<b>1-360-705-0600</b> 400 Union Ave. SE, Suite 253 Olympia, WA 98501
<b>Portland, OR</b>	<b>1-800-248-8320</b> 4949 SW Meadows Rd., Suite 650 Lake Oswego, OR 97035
<b>Outside Washington</b>	<b>1-800-706-5525</b>

## 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:
<p><b>PEBB Program</b>  <i>You can file a grievance in person, by mail, fax, or email, or online at <a href="http://hca.wa.gov/about-hca/nondiscrimination-statement">hca.wa.gov/about-hca/nondiscrimination-statement</a>. If you need help filing a grievance, the HCA ADA/Nondiscrimination Coordinator is available to help.</i></p>	<p>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  <b><a href="mailto:compliance@hca.wa.gov">compliance@hca.wa.gov</a></b></p>
<b>PEBB MEDICAL PLANS</b>	
<p><b>Kaiser Foundation Health Plan of the Northwest</b></p>	<p>Kaiser Foundation Health Plan of the Northwest            Attn: Member Relations – Kaiser Civil Rights Coordinator            500 NE Multnomah, Suite 100            Portland, OR 97232            1-800-813-2000 or 503-813-2000 (TRS: 711)</p>
<p><b>Kaiser Foundation Health Plan of Washington</b></p>	<p>Kaiser Foundation Health Plan of Washington            Civil Rights Coordinator            Quality GNE-D1E-07            PO Box 9812            Renton, WA 98057            1-866-648-1928 or 206-630-4636 (TRS: 711)   Fax 206-901-6205  <b><a href="http://kp.org/wa/feedback">kp.org/wa/feedback</a></b></p>
<p><b>Washington State Rx Services</b>            (for discrimination concerns about prescription-drug benefits for Uniform Medical Plan [UMP])</p>	<p>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  <b><a href="mailto:compliance@modahealth.com">compliance@modahealth.com</a></b></p>
<p><b>Premera Blue Cross</b>            (for discrimination concerns about Medicare Supplement Plan F and the Centers of Excellence Program for UMP Classic and UMP CDHP members)</p>	<p>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  <b><a href="mailto:AppealsDepartmentInquiries@Premera.com">AppealsDepartmentInquiries@Premera.com</a></b></p>

If you believe this organization has failed to provide language access services or discriminated in another way...	You can file a grievance with:
<b>Regence BlueShield</b> (for discrimination concerns about UMP Classic, UMP Consumer-Directed Health Plan [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) <b>CS@regence.com</b>
<b>Regence BlueShield</b> (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 <b>medicareappeals@regence.com</b>
<b>PEBB DENTAL PLANS</b>	
<b>Delta Dental</b> (for discrimination concerns about DeltaCare and the Uniform Dental Plan)	Delta Dental Attn: Elizabeth Peterson, Compliance/Privacy Officer PO Box 75983 Seattle, WA 98175 1-800-554-1907 (TTY: 1-800-833-6384)   Fax 206-729-5512 <b>Compliance@DeltaDentalWA.com</b>
<b>Willamette Dental of Washington, Inc.</b> (for discrimination concerns about Willamette Dental Group Plan)	Member Services Department 6950 NE Campus Way Hillsboro, OR 97124 1-855-433-6825 (TRS:711)   Fax 503-952-2684 <b>memberservices@willamettedental.com</b>

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](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf)** (to submit complaints electronically)  
**[hhs.gov/ocr/office/file/index.html](https://hhs.gov/ocr/office/file/index.html)** (to find complaint forms online)

[English] Language assistance services, including interpreters and translation of printed materials, are available free of charge. Employees: Contact your employer's personnel, payroll, or benefits office directly. Retirees, COBRA, and Continuation Coverage members only: Contact the PEBB Program at 1-800-200-1004. (TRS: 711).

[Amharic] የቋንቋ እገዛ አገልግሎት፣ አስተርጓሚ እና የሰነዶችን ትርጉም ጨምሮ በእገ ይገኛል። ተቀጣሪዎች፡ የቀጣሪዎችን ሰራተኛ፣ የደግሞ ወይም ጥቅማ-ጥቅም ክፍያ ጽ/ቤትን በቀጥታ ያነጋግሩ። ጡረታ የወጡ፣ COBRA እና ቀጣይነት ያለው ሽፋን አባላት ብቻ፡ የPEBB ፕሮግራምን በ1-800-200-1004. (TRS: 711) ያነጋግሩ።

[Arabic] خدمات المساعدة في اللغات، بما في ذلك المترجمين الفوريين وترجمة المواد المطبوعة، متوفرة مجاناً للموظفين: اتصل بمكتب شؤون العاملين بالشركة، أو مكتب المرتبات أو الاستحقاقات مباشرة. للمتقاعدين، وأعضاء COBRA وأعضاء التغطية المستمرة فقط: اتصل ببرنامج PEBB على الرقم 1-800-200-1004. (TRS: 711).

[Burmese] ဘာသာပြန်ဆိုင်ရာများနှင့် ထုတ်ပြန်ထားသည့် စာရွက်စာတမ်းများဘာသာပြန်ခြင်းအပါအဝင် အသိပညာ ဘာသာစကားအထောက်အကူပြုဆောင်ရွက်မှုများကို အခမဲ့ရရှိနိုင်ပါသည်။ အလုပ်သမားများ- သင့်အလုပ်ရှင်၏ကိုယ်ရေးအရာရှိ၊ လစာ သို့မဟုတ် အကျိုးခံစားခွင့်ဆိုင်ရာ ရုံးသို့ တိုက်ရိုက်ဆက်သွယ်ပါ။ ပင်စင်ယူသူများ COBRA နှင့် ဆက်လက်ပြီးအကျိုးခံစားခွင့်သည့် အဖွဲ့ဝင်များသာလျှင်- PEBB ပရိုဂရမ်သို့ 1-800-200-1004. (TRS: 711) ကိုဖုန်းခေါ်ဆိုပါ။

[Cambodian] សេវាជំនួយភាសា រួមមានទាំងអ្នកបកប្រែផ្ទាល់មាត់ និងការបកប្រែឯកសារបោះពុម្ព គឺអាចរកបានដោយឥតគិតថ្លៃ។ និយោជក៖ សូមទាក់ទងការិយាល័យបុគ្គលិកនិយោជករបស់អ្នក ការិយាល័យបុគ្គលិកកែវខេ ការិយាល័យអគ្គប្រយោជន៍ដោយផ្ទាល់។ អ្នកចូលនិវត្តន៍, COBRA, និងសមាជិក Continuation Coverage ប៉ុណ្ណោះ៖ សូមទាក់ទងកម្មវិធី PEBB តាមលេខ 1-800-200-1004. (TRS: 711)។

[Chinese] 免费提供语言协助服务，包括口译员和印制资料翻译。雇员：直接联系雇主的私人、工资或福利办公室。仅限退休人员、COBRA 和持续承保成员：联系 PEBB 计划处，电话为 1-800-200-1004 (TRS: 711)。

[Korean] 통역 서비스와 인쇄 자료 번역을 포함한 언어 지원 서비스를 무료로 이용하실 수 있습니다. 직원: 고용주의 인사, 급여 또는 수당을 관리하는 사무소에 직접 문의하십시오. 퇴직자, COBRA 및 Continuation Coverage 회원만 해당: 1-800-200-1004, TRS: 711 로 PEBB 프로그램에 문의하십시오.

[Laotian] ການບໍລິການດ້ານພາສາ, ລວມທັງງານພິມພາສາ ແລະ ການ ພິມປອກສາມຕີພິມ, ມີໄວ້ໃຫ້ພຣິໂດຍບໍ່ຄິດຄ່າ. ພະນັກງານ: ຕິດຕໍ່ ຫາພະແນກທະບຽນພິມຂອງພະນັກງານ, ພະແນກບັນຊີເງິນເດືອນ, ຫລື ຫ້ອງການສະໄດດິການໂດຍກົງໂລດ. ຜູ້ອອກເບື້ອງງານ, COBRA, ແລະ ການຄຸ້ມກັນທຶດາເມີນຕໍ່ໄປສຳລັບສະມາຊິກເທົ່ານັ້ນ: ຕິດຕໍ່ຫາໂຄງການ PEBB ໄດ້ທຶເລດ 1-800-200-1004 (TRS: 711).

[Oromo] Tajajilwwan gargaarsa afaanii, turjumaanaafi i waantota maxxanfaman kan hiikan bilisaan jiru. Hojjetoota: Kallattiidhaan peeroolii personeelii ykn waajira faayidaawwanii hojjechiisaa kee qunnamii. COBRA fimiseensota Haguuggii Itti fufinsaa qofa: Sagantaa PEBB 1-800-200-1004 (TRS: 711) irratti qunnamuu dandeessu.

[Persian] خدمات کمک زبانی، از جمله مترجم شفاهی و ترجمه اسناد و مدارک (مطالب) چاپی، بصورت رایگان ارائه خواهد شد. قابل توجه کارگران: با بخش پرسنل کارفرمای خود لیست حقوق، یا اداره رفاه مستقیماً تماس بگیرید. بازنشستگان، COBRA، و اعضای که دارای طرح ادامه پوشش بیمه هستند فقط با برنامه PEBB با شماره 1-800-200-1004 (TRS: 711) تماس بگیرید.

[Punjabi] ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ—ਦੁਬਾਸੀਏ ਅਤੇ ਪ੍ਰਿੰਟ ਕੀਤੀ ਹੋਈ ਸਮੱਗਰੀ ਦੇ ਅਨੁਵਾਦ ਸਮੇਤ—ਮੁਫਤ ਉਪਲੱਬਧ ਹਨ। ਮੁਲਾਜ਼ਮ: ਆਪਣੇ ਰੁਜ਼ਗਾਰਦਾਤਾ ਦੇ ਮੁਲਾਜ਼ਮ, ਪੇਅਰੋਲ, ਜਾਂ ਲਾਬਰ ਵਾਲੇ ਦਫਤਰ ਨਾਲ ਸਿੱਧਾ ਸੰਪਰਕ ਕਰਨ। ਸੇਵਾ-ਮੁਕਤ ਮੁਲਾਜ਼ਮ, COBRA (ਕੋਬਰਾ), ਅਤੇ ਸਿਰਫ ਕੰਪਨੀ-ਉੱਚੇ ਸਨ ਕਵਰੇਜ ਮੈਂਬਰ: 1-800-200-1004. (TRS: 711) ਉੱਤੇ PEBB ਪ੍ਰੋਗਰਾਮ ਨਾਲ ਸੰਪਰਕ ਕਰਨ।

[Romanian] Serviciile de asistență lingvistică, inclusiv cele de interpretariat și de traducere a materialelor imprimate, sunt disponibile gratuit. Angajați: Contactați biroul pentru personal, salarii sau beneficii al angajatorului dvs. în mod direct. Numai pentru pensionari, membri COBRA sau Continuation Coverage: Contactați Programul PEBB la 1-800-200-1004. (TRS: 711).

[Russian] Языковая поддержка, в том числе услуги переводчиков и перевод печатных материалов, доступна бесплатно. Наемные работники: обратитесь непосредственно в отдел кадров, бухгалтерию или социальный отдел вашего работодателя. Только пенсионеры, пользователи COBRA или программ продленного страхового покрытия: обратитесь в программу PEBB отдел по телефону 1-800-200-1004. (TRS: 711).

[Somali] Adeego caawimaad luuqada ah, ay ku jirto turjubaano afka ah iyo turjumid lagu sameeyo waraaqaha la daabaco, ayaa lagu helayaa lacag la'aan. Shaqaalaha: La xirii shaqaalaha qofka aad u shaqaysid, liiska mushaarka shaqaalaha, ama si toos ah xafiiska dheefaha. Dadka hawlgabka ah, COBRA, iyo kaliya xubnaha Sii wadista Ceymiska: Kalaxirii Barnaamijka PEBB lambarkan 1-800-200-1004. (TRS: 711).

[Spanish] Hay servicios de asistencia con idiomas, incluyendo intérpretes y traducción de materiales impresos, disponibles sin costo. Empleados: Comuníquense directamente con la oficina de personal, nómina o beneficios de su empleador. Sólo para jubilados y miembros de COBRA y cobertura continua: Comuníquense con el Programa PEBB al 1-800-200-1004. (TRS: 711).

[Swahili] Huduma za msaada wa lugha, ikiwa ni pamoja na wakalimani na tafsiri ya nyaraka zilizochapishwa, zinapatikana bure bila ya malipo. Wafanyakazi: wasiliana moja kwa moja na ofisi ya utumishi ya mwajiri wako, ofisi ya malipo, au ya mafao. Wastaafu, wanachama wa COBRA na wenye bima ya kuendelea tu: Wasiliana na Programu ya PEBB kwa nambari 1-800-200-1004. (TRS: 711).

[Tagalog] Mga serbisyong tulong sa wika, kabilang ang mga tagapagsalin at pagsasalin ng nakalimbag na mga kagamitan, ay magagamit ng walang bayad. Mga empleyado: Makipag-ugnay nang direkta sa mga tauhan, payroll, o tanggapan ng mga benepisyo ng iyong employer. Mga Pensyonado, COBRA, at mga kasapi ng Continuation Coverage lamang: Makipag-ugnay sa Program ng PEBB sa 1-800-200-1004. (TRS: 711).

[Tigrigna] ተርጓሚትን ናይ ዝተፅሓፉ ማተርያላት ትርጉምን ሓዊስ ናይ ቋንቋ ሓዝ ግልጋሎት፣ ብዘይ ምንም ክፍሊት ይርከቡ። ሰራተኛታት፡ ንናይ ማተርያላት ስልጠና ዝርከብ ደግሞ ወይ ቤት ጽሕፈት ጥቕምታት ብቕጥታ ርኽቡ። ጡረተኛታት፡ COBRA፣ ኣባላት ማቕጻጸታ ሽፋን ጥራሕ፡ ንመደብ PEBB ብ1-800-200-1004 ርኽቡ (TRS: 711)።

[Ukrainian] Мовна підтримка, у тому числі послуги перекладачів та переклад друкованих матеріалів, доступна безкоштовно. Наймані робітники: зверніться безпосередньо до відділу кадрів, бухгалтерії або соціального відділу вашого роботодавця. Лише пенсіонери, користувачі COBRA або програм продовженого страхового покриття: зверніться у програму PEBB за телефоном 1-800-200-1004. (TRS: 711).

[Vietnamese] Các dịch vụ trợ giúp ngôn ngữ, bao gồm thông dịch viên và bản dịch tài liệu in, hiện có miễn phí. Người lao động: Liên hệ trực tiếp với phòng nhân sự, tiền lương, hoặc phúc lợi của sở làm quý vị. Chỉ những người hồi hưu, các thành viên COBRA, và thành viên chương trình Bảo Hiểm Tiếp Tục: Liên hệ với Chương Trình PEBB theo số 1-800-200-1004. (TRS: 711).



# Completing the Retiree Forms

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

## If you are enrolling for the first time or enrolling after a deferral

Use the *Retiree Coverage Election Form* (form A). Refer to the instruction sheet attached to Form A for detailed information.

**Step 1:** Check the enclosed “2019 Medical Plans Available by County” to find the plans available to you based on your home address.

**Step 2:** Locate your plan choice using the table on the next page and complete the form(s) listed there in addition to Form A. Be sure to include all eligible dependents you wish to enroll.

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

## If you are deferring (postponing) enrollment when you first become eligible

Use the *Retiree Coverage Election Form* (form A). Refer to the instruction sheet attached to Form A for detailed information.

**Step 1:** Complete all sections marked “Required” on Form A, as well as Sections 1 and 10. If they apply to you, also complete Sections 8 and 9.

**Please note:** When deferring, you must maintain continuous enrollment in qualifying medical coverage if you wish to enroll in a PEBB retiree health plan in the future.

**Step 2:** Submit the completed form to the PEBB Program. The PEBB Program must receive the form within the deadline provided.

## If you are making changes to your existing account

Use the *Retiree Coverage Change Form* (form E). Refer to the instruction sheet attached to Form E for detailed information.

**Step 1:** If you are changing medical plans, check the enclosed “2019 Medical Plans Available by County” to make sure the plan you have selected is available based on your home address.

**Step 2:** Locate your plan choice using the table on the next page and complete the form(s) listed there in addition to Form E. If you or a covered dependent is enrolled in a Medicare Advantage plan and changing to a plan that is not a Medicare Advantage plan (or removing a Medicare-eligible dependent), also complete a *Medicare Advantage Plan Disenrollment Form* (form D).

**Step 3:** Submit the completed form(s) and any other requested documents to the PEBB Program within the required deadline.

## If you are deferring or terminating your coverage (after you have already enrolled)

Use the *Retiree Coverage Change Form* (form E). Refer to the instruction sheet attached to Form E for detailed information.

**Step 1:** Complete all sections marked “Required” on Form E, as well as Sections 1 and 11.

**Please note:** When deferring, you must maintain continuous enrollment in qualifying health plan coverage if you wish to enroll in PEBB retiree health plan coverage in the future.

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

**Step 3:** Submit the completed form(s) to the PEBB Program within the required deadline. Your PEBB retiree health plan coverage will end on the last day of the month in which the PEBB Program receives all of your completed forms.

## Locate your plan choice under the action you are taking and complete the form(s) listed.

If you are enrolling for the first time, enrolling after a deferral, or deferring enrollment when you first become eligible:

Use	To enroll in these plans or defer (when first becoming eligible for PEBB coverage):
Form A only	<ul style="list-style-type: none"> <li>• Kaiser Permanente NW Classic* or CDHP*</li> <li>• Kaiser Permanente WA Classic, CDHP, Original Medicare, SoundChoice, or Value</li> <li>• Uniform Medical Plan Classic, UMP CDHP, UMP Plus–PSHVN, or UMP Plus–UW Medicine ACN</li> </ul>
Use	To enroll in these plans:
Forms A and C	<ul style="list-style-type: none"> <li>• Kaiser Permanente NW Senior Advantage</li> <li>• Kaiser Permanente WA Medicare Advantage</li> </ul>
Forms A and B	<ul style="list-style-type: none"> <li>• Premera Blue Cross Medicare Supplement Plan F</li> </ul>

If you are making changes to your account, terminating coverage, or deferring after you have already enrolled:

Use	To terminate, remove a dependent, or defer from these plans (after enrolling):
Forms E and D	<ul style="list-style-type: none"> <li>• Kaiser Permanente NW Senior Advantage</li> <li>• Kaiser Permanente WA Medicare Advantage</li> </ul>
Use	To make changes or switch to these plans, terminate coverage, or defer (after enrolling):
Form E only	<ul style="list-style-type: none"> <li>• Kaiser Permanente NW Classic* or CDHP*</li> <li>• Kaiser Permanente WA Classic, CDHP, Original Medicare, SoundChoice, or Value</li> <li>• Uniform Medical Plan Classic, UMP CDHP, UMP Plus–PSHVN, or UMP Plus–UW Medicine ACN</li> </ul> <p><b>Note:</b> Also include Form D if switching from one of the Kaiser Permanente plans listed above.</p>
Use	To make changes or switch to these plans:
Forms E and C	<ul style="list-style-type: none"> <li>• Kaiser Permanente NW Senior Advantage</li> <li>• Kaiser Permanente WA Medicare Advantage</li> </ul>
Forms E and B	<ul style="list-style-type: none"> <li>• Premera Blue Cross Medicare Supplement Plan F</li> </ul> <p><b>Note:</b> Also include Form D if switching from one of the Kaiser Permanente Medicare or Senior Advantage plans listed above.</p>

\* Kaiser Foundation Health Plan of the Northwest, with plans offered in Clark and Cowlitz counties in Washington and select counties in Oregon.

## Additional forms may be required if enrolling a dependent

If enrolling a ...	Also complete this form ...
Non-qualified tax dependent	<i>Declaration of Tax Status</i>
Dependent child with a disability	<i>Certification of a Child With a Disability</i>
Extended (legal) dependent child	<i>Extended Dependent Certification</i>

If you have questions or need additional forms, visit [www.hca.wa.gov/pebb-retirees](http://www.hca.wa.gov/pebb-retirees) under *Forms & Publications*, or call the PEBB Program at 1-800-200-1004 and select menu option 5 to request them.

# Retiree Forms Section

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**2019 Retiree Election/Change (form A)**

<https://www.hca.wa.gov/assets/pebb/51-403F-2019.pdf>

**2019 Premium Surcharge Help Sheet**

<https://www.hca.wa.gov/assets/pebb/50-226-2019.pdf>

**Premera Blue Cross Group Medicare Supplement Enrollment Application (form B)**

<https://www.hca.wa.gov/assets/pebb/premerab.pdf>

**2019 Medicare Advantage Plan Election form (Form C)**

<https://www.hca.wa.gov/assets/pebb/51-576-2019.pdf>

**PEBB Medicare Advantage Plan Disenrollment Form (Form D)**

<https://www.hca.wa.gov/assets/pebb/51-556-2019.pdf>

**MetLife Retiree Enrollment/Change form**

<http://hca.wa.gov/assets/pebb/metlife-retiree-enrollment.doc>

**Electronic Debit Service Agreement**

<https://www.hca.wa.gov/assets/pebb/42-450.pdf>