PEBB Retiree Enrollment Guide

Your PEBB benefits for
2023

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Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

HCA 51-0205 (02/23)

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Welcome

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

Your benefit options include:

- Medical coverage
- Dental coverage
- Retiree term life insurance
- SmartHealth (for subscribers not enrolled in both Medicare Part A and Part B)
- Auto and home insurance

Five steps to enroll

1. Submit Form A (and any other required forms) to enroll in or defer PEBB retiree insurance coverage.
    - We (the PEBB Program) must receive your form **no later than 60 days** after your employer-paid, COBRA, or continuation coverage ends — or, for elected or full-time appointed officials, 60 days after you leave public office. If you choose a Medicare Advantage plan, enrollment may not be retroactive; we encourage you to submit Form A so we receive it no later than the last day of the month before the date PEBB retiree insurance coverage is to begin. Otherwise, you and your enrolled dependents will be enrolled in another medical plan during the gap months prior to when the Medicare Advantage plan begins.
    - If you are a dependent becoming eligible as a survivor, please see page 14 for enrollment timelines. To learn more, see "How to enroll" on page 15 or "Deferring your coverage" on page 28.
2. If you are enrolling dependents, you may need to prove their eligibility by submitting documents. Learn more about this process on page 13.
3. Along with submitting Form A (and any other required forms and documents), you must make your first payment for PEBB retiree insurance coverage, including applicable premium surcharges, before we can enroll you. To learn more, see "Paying for coverage" on page 17.
4. If you or your dependents are eligible for Medicare, you (or they) must enroll in Medicare Part A and Part B to enroll in PEBB retiree insurance coverage. You will need to submit proof of Medicare enrollment. To stay enrolled in a PEBB retiree health plan, you must stay enrolled in Part A and Part B.
5. Get your PEBB Program eligibility and enrollment questions answered. Visit HCA's website at **hca.wa.gov/pebb-retirees** or call PEBB Customer Service at 1-800-200-1004 (TRS: 711).

Good to know!

You must enroll in or defer (postpone) PEBB retiree insurance coverage when your employer-paid coverage, COBRA coverage, or continuation coverage ends. While deferred, you must stay continuously enrolled in other qualifying medical coverage. See important information about deferring on page 28. If you do not meet these requirements, future enrollment rights may be affected.

Quick start guide

Use this section to jump straight to topics that interest you. Throughout this guide, watch for references to page numbers where you'll find more information. Look for the "Good to know!" boxes throughout the booklet for quick tips, definitions, and where to find more information.

Need to know if you're eligible?
See page 11.

Ready to enroll in PEBB retiree insurance coverage?
Turn to page 15.

Not sure how to fill out your forms?
Flip to page 56 or check out our self-paced tutorial on HCA's website at **hca.wa.gov/pebb-retirees**.

Paying for PEBB retiree insurance coverage?
Find monthly premiums on page 7.

Ready to learn about your payment options?
That's on page 17.

Want to know which health plan is best for you?
Turn to page 31.

Curious about how Medicare works with PEBB coverage?
Learn about coordination of benefits on page 20.

Not ready to enroll in PEBB retiree insurance coverage yet?
Don't miss your chance to enroll later. Learn about deferring coverage on page 28.

Interested in retiree term life insurance?
See page 51.

Who to contact for help

Contact the health plans for help with:

- Specific benefit questions.
- Checking if your provider contracts with the plan.
- Checking if your medications are covered by the plan.
- Claims.
- ID cards.
- Checking if your wellness incentive was applied to your deductible (only for retirees not enrolled in Medicare Part A and Part B).

Go to HCA's website at hca.wa.gov/pebb-retirees to find information on:

- Eligibility and enrollment.
- Changes to your account (due to Medicare enrollment, divorce, etc.).
- Changing your name, address, or phone number.
- Enrolling or removing dependents.
- Finding forms.
- Premium surcharge questions.
- Eligibility complaints or appeals.

For eligibility and enrollment questions, you can also call us at 1-800-200-1004 (TRS: 711) or send us a secure message through HCA Support at **support.hca.wa.gov**, a secure website that allows you to log in to your own account to communicate with us. You will need to set up a SecureAccess Washington (SAW) account to use this option.

Medical plans

Kaiser Permanente NW[1] Classic, CDHP, or Senior Advantage
my.kp.org/wapebb
Non-Medicare members: 503-813-2000 (TRS: 711)
Medicare members: 1-877-221-8221 (TRS: 711)

Kaiser Permanente WA Classic, CDHP, Medicare, SoundChoice, or Value
kp.org/wa/pebb
1-866-648-1928 (TTY: 711)
Medicare Advantage: 1-888-901-4600 (TTY: 1-800-833-6388)

Premera Blue Cross Medicare Supplement Plan F and Plan G
Note: Plan F is closed to new enrollees.
hca.wa.gov/pebb-retirees under *Medical plans and benefits*
1-800-817-3049 (TRS: 711)

Uniform Medical Plan (UMP) Classic, UMP Select, or UMP CDHP
Administered by Regence BlueShield and Washington State Rx Services (WSRxS)
Medical services:
regence.com/ump/pebb
1-888-849-3681 (TRS: 711)
Prescription drugs:
regence.com/ump/pebb/benefits/prescriptions
1-888-361-1611 (TRS: 711)
Vision services:
Vision Service Plan
vsp.com
1-844-299-3041 (TTY: 1-800-428-4833)

UMP Plus–Puget Sound High Value Network
Administered by Regence BlueShield and WSRxS
Medical services:
pugetsoundhighvaluenetwork.org
1-855-776-9503 (TRS: 711)
Prescription drugs:
ump.regence.com/pebb/benefits/prescriptions
1-888-361-1611 (TRS: 711)

UMP Plus–UW Medicine Accountable Care Network
Administered by Regence BlueShield and WSRxS
Medical services:
pebb.uwmedicine.org
1-888-402-4237 (TRS: 711)
Prescription drugs:
ump.regence.com/pebb/benefits/prescriptions
1-888-361-1611 (TRS: 711)

UnitedHealthcare PEBB Balance and UnitedHealthcare PEBB Complete
retiree.uhc.com/wapebb
1-855-873-3268 (TRS: 711)

1 Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon. KFHPNW Medicare plans have a larger service area.

Dental plans

DeltaCare
deltadentalwa.com/pebb
1-800-650-1583
(TTY: 1-800-833-6384) or text 1-833-604-1246

Uniform Dental Plan
deltadentalwa.com/pebb
1-800-537-3406
(TTY: 1-800-833-6384) or text 1-833-604-1246

Willamette Dental Group
willamettedental.com/wapebb
1-855-433-6825 (TRS: 711)

Additional contacts

Auto and home insurance: Liberty Mutual Insurance Company
libertymutual.com/pebbretirees
1-800-706-5525 (TRS: 711)

Health savings account (HSA) trustee: HealthEquity, Inc.
healthequity.com/pebb
Kaiser Permanente members: 1-877-873-8823
(TRS: 711)
UMP members: 1-844-351-6853
(TRS: 711)

Retiree term life insurance: Metropolitan Life Insurance Company (MetLife)
metlife.com/wshca-retirees
1-866-548-7139 (TRS: 711)

SmartHealth
smarthealth.hca.wa.gov
1-855-750-8866 (TRS: 711)

Health reimbursement arrangement (HRA): Voluntary Employees' Beneficiary Association (VEBA) VEBA Plan or VEBA Medical Expense Plan (MEP)
veba.org
1-888-828-4953

HRA VEBA Plan
hraveba.org
1-888-659-8828

For help with eligibility and enrollment

Visit HCA's website at **hca.wa.gov/pebb-retirees** for forms and information updates.

Call the PEBB Program toll-free at 1-800-200-1004 (TRS: 711) 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 us at 360-725-0771.

Write to us at:
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

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

Note: Please visit our website at **hca.wa.gov/employee-retiree-benefits/contact-us** to check lobby hours and to ensure our office is open before your visit.

Good to know!

Do you want to receive PEBB Program information quickly? Sign up for email delivery and you will receive PEBB Program newsletters and other general information in your inbox. Once you are enrolled in PEBB retiree insurance coverage, you can sign up by visiting PEBB My Account at **hca.wa.gov/my-account**.

2023 PEBB Retiree Monthly Premiums

Effective January 1, 2023

Special requirements for Medicare premiums

- To qualify for the Medicare premium, at least one member on the account must be enrolled in Medicare Part A and Part B.
- Medicare premiums have been reduced by the state-funded contribution, up to the lesser of $183 or 50 percent of the plan rate per retiree per month.

For more information on these requirements, contact your medical plan's customer service department.
Note: These premiums do not include your Medicare Part B premium.

Medicare medical plan premiums (for members enrolled in Medicare Part A and Part B)

	Kaiser Foundation Health Plan of the Northwest[1]	Kaiser Foundation Health Plan of Washington				Uniform Medical Plan[2]	UnitedHealthcare[6]	
	Senior Advantage	Classic	Medicare (Original or Advantage)	SoundChoice	Value	Classic	PEBB Balance	PEBB Complete
Subscriber only								
1 eligible	$176.13[3]	N/A	$174.59	N/A	N/A	$438.34	$122.94	$145.63
Subscriber and spouse[4]								
1 eligible	$1,012.96[3]	$1,006.22	N/A[5]	$885.28	$933.74	$1,238.76	$923.36	$946.05
2 eligible	$347.32	N/A[5]	$344.24	N/A[5]	N/A[5]	$871.74	$240.95	$286.33
Subscriber and children								
1 eligible	$803.75[3]	$798.31	N/A[5]	$707.61	$743.95	$1,038.66	$723.26	$745.95
2 eligible	$347.32	N/A[5]	$344.24	N/A[5]	N/A[5]	$871.74	$240.95	$286.33
Subscriber, spouse,[4] and children								
1 eligible	$1,640.58[3]	$1,629.94	N/A[5]	$1,418.30	$1,503.10	$1,839.08	$1,523.68	$1,546.37
2 eligible	$974.94[3]	$967.96	N/A[5]	$877.26	$913.60	$1,472.06	$841.27	$886.65
3 eligible	$518.51	N/A[5]	$513.89	N/A[5]	N/A[5]	$1,305.14	$358.95	$427.02

1. Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon. KFHPNW Medicare plans have a larger service area.
2. Administered by Regence BlueShield and Washington State Rx Services.
3. If a Kaiser Permanente NW member is enrolled in Medicare Part A and Part B, and other enrolled members are not eligible for Medicare, the non-Medicare members will be enrolled in Kaiser Permanente NW Classic. The subscriber will pay the combined Medicare and non-Medicare premium shown for Kaiser Permanente NW Senior Advantage.
4. Or state-registered domestic partner.
5. If a Kaiser Permanente WA member is enrolled in Medicare Part A and Part B, and other enrolled members are not eligible for Medicare, the non- Medicare members must enroll in Kaiser Permanente WA Classic, SoundChoice, or Value plan. The subscriber will pay a combined Medicare and non-Medicare premium.
6. UnitedHealthcare (UHC) plans are Medicare Advantage plus Part D (MAPD) plans. If an MAPD plan is selected, non Medicare eligible members are enrolled in UMP Classic. The rates shown reflect the total due, including premiums for both plans.

Medicare supplement plan premiums

	Premera Blue Cross			
	Plan F (closed to new members)		Plan G	
	Age 65 or older, eligible by age	Under age 65, eligible by disability	Age 65 or older, eligible by age	Under age 65, eligible by disability
Subscriber only				
1 Medicare eligible	$115.16	$196.69	$98.53	$164.05
Subscriber and spouse[1]				
1 Medicare eligible[2]	$915.58	$997.11	$898.95	$964.47
2 Medicare eligible: 1 retired, 1 disabled	$306.91	$306.91	$257.64	$257.64
2 Medicare eligible	$225.38	$388.44	$192.12	$323.16
Subscriber and children				
1 Medicare eligible[2]	$715.48	$797.01	$698.85	$764.37
Subscriber, spouse,[1] and children				
1 Medicare eligible[2]	$1,515.90	$1,597.43	$1,499.27	$1,564.79
2 Medicare eligible: 1 retired, 1 disabled[2]	$907.98	$907.98	$858.71	$858.71
2 Medicare eligible[2]	$825.70	$988.76	$792.44	$923.48

Non-Medicare medical plan premiums (for members not enrolled in Medicare)

	Managed Care Plans						Preferred Provider Organization (PPO) Plans			
	Kaiser Foundation Health Plan of the Northwest[3]		Kaiser Foundation Health Plan of Washington				Uniform Medical Plan[4]			
	Classic	CDHP	Classic	CDHP	SoundChoice	Value	Classic	CDHP	Select	UMP Plus
Subscriber only	$841.77	$700.40	$836.57	$699.88	$715.63	$764.09	$805.36	$704.42	$729.13	$766.95
Subscriber & spouse[1]	$1,678.60	$1,394.08	$1,668.20	$1,393.04	$1,426.32	$1,523.24	$1,605.78	$1,402.12	$1,453.32	$1,528.96
Subscriber & children	$1,469.39	$1,235.24	$1,460.29	$1,234.33	$1,248.65	$1,333.45	$1,405.68	$1,242.28	$1,272.27	$1,338.46
Subscriber, spouse,[1] & children	$2,306.22	$1,870.59	$2,291.92	$1,869.16	$1,959.34	$2,092.60	$2,206.10	$1,881.65	$1,996.46	$2,100.47

1. Or state-registered domestic partner.
2. If a Medicare supplement plan is selected, non-Medicare enrollees are enrolled in UMP Classic. The rates shown reflect the total due, including premiums for both plans.
3. Kaiser Foundation Health Plan of the Northwest offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon.
4. Administered by Regence BlueShield and Washington State Rx Services.

Medical premium surcharges (for non-Medicare subscribers only)

Two premium surcharges may apply in addition to your monthly medical premium. You will be charged for them if the conditions described below apply, or if you do not attest to the surcharges when required.

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

For more guidance on whether these premium surcharges apply to you, see the *2023 PEBB Premium Surcharge Attestation Help Sheet* on the HCA website at **hca.wa.gov/erb** under *Forms & publications*.

Dental plan premiums

You must enroll in medical coverage to enroll in dental.

	Managed Care Plans		Preferred Provider Organization (PPO)
	DeltaCare	Willamette Dental Group	Uniform Dental Plan
Monthly premiums			
Subscriber only	$41.50	$44.45	$48.56
Subscriber & spouse[1]	$83.00	$88.90	$97.12
Subscriber & children	$83.00	$88.90	$97.12
Subscriber, spouse,[1] & children	$124.50	$133.35	$145.68

1. Or state-registered domestic partner.

Retiree term life insurance premiums[1]

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

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

Legacy retiree life insurance plan premiums[1]

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

1. Administered by Metropolitan Life Insurance Company.

Who's 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 we receive your election form.

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

If you or a dependent is eligible for Medicare, you (or they) must enroll and stay enrolled in Medicare Part A and Part B to be eligible for a PEBB retiree health plan.

You may be eligible for PEBB retiree insurance coverage if you are a retiring or separating employee of a:

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

If you return to work for a PEBB Program entity, you cannot waive coverage from your employer to remain in your PEBB retiree health plan. Once your PEBB Program employee coverage ends, you must complete and return a *PEBB Retiree Coverage Election Form* (form A) to reenroll in PEBB retiree insurance coverage.

You may also be eligible if you are a surviving dependent (see WAC 182-12-180, 182-12-250, or 182-12-265) or an elected or appointed official of the legislative or executive branch of state government who leaves public office (see WAC 182-12-180).

You must also be a vested member of 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. (Different rules apply to surviving dependents, elected or full-time appointed officials, and employees of an employer group that does not participate in a Washington State-sponsored retirement plan.) 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 (HERP) (for example, TIAA-CREF)
- School Employees' Retirement System (SERS) 2 or 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
- Civil Service Retirement System and Federal Employees' Retirement System (for Washington State University Extension employees covered under PEBB benefits at the time of retirement)

You must also immediately begin to receive a monthly retirement plan payment, unless one the following exceptions apply:

- If you receive a lump sum 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.
- If you are an employee retiring or separating under PERS Plan 3, TRS Plan 3, or SERS Plan 3, and you meet the plan's eligibility criteria.
- If you are an employee retiring under a Washington 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.
- If you are a retiring employee from a PEBB employer group who is eligible to retire under a retirement plan sponsored by an employer group or tribal government, and your employer does not participate in a Washington State-sponsored retirement plan. However, you must meet the same age and years of service requirement as members of PERS Plan 1 (if your date of hire with your employer group was before October 1, 1977) or Plan 2 (if your date of hire was on or after October 1, 1977).
- If you are an elected or full-time appointed official of the legislative or executive branch of state government, or a surviving dependent of such an official, as described in WAC 182-12-180.
- If you are a survivor of an emergency services person killed in the line of duty as described in WAC 182-12-250, or a surviving dependent who loses eligibility because of the death of a retiree as described in WAC 182-12-265.

Dependent eligibility

You may enroll the following dependents:

- Your legal spouse.
- Your state-registered domestic partner, as defined in RCW 26.60.020(1) and WAC 182-12-109. This includes substantially equivalent legal unions from other jurisdictions as defined in RCW 26.60.090. Strict requirements apply to these partnerships, including that one partner is age 62 or older and you live in the same residence. Individuals in a state-registered domestic partnership are treated the same as a legal spouse except when in conflict with federal law.
- Your children, through the last day of the month in which they turn age 26 regardless of marital status, student status, or eligibility for coverage under another plan. It also includes children age 26 or older with a disability as described in "Children with disabilities" below.

How are children defined?

For our purposes, children are defined as described in WAC 182-12-260(3). The definition includes:

- Your children based on the establishment of a parent-child relationship as described in RCW 26.26A.100, except when parental rights have been terminated.
- Children of your spouse or state-registered domestic partner based on the establishment of a parent-child relationship as described in RCW 26.26A.100, except when parental rights have been terminated.
- Children you are legally required to support ahead of adoption.
- Children named in a court order or divorce decree for whom you are legally required to provide support or health care coverage.
- Extended dependents who meet certain eligibility criteria. See "Extended dependents."
- Children of any age with a developmental or physical disability. See "Children with disabilities."

Extended dependents

Children may also include extended dependents (such as a grandchild, niece, nephew, or other children) for whom you, your spouse, or your state-registered domestic partner are legal custodians or legal guardians. The legal responsibility for them is shown by a valid court order and the child officially residing with the custodian or guardian.

An extended dependent does not include foster children unless you, your spouse, or your state-registered domestic partner are legally required to provide support ahead of adoption.

Children with disabilities

Eligible children include children of any age with a developmental or physical disability that leaves them incapable of self-sustaining employment and chiefly dependent upon the subscriber for support and ongoing care. Their condition must have occurred before they turned age 26. To enroll a child age 26 or older, or to continue such a child's enrollment, you must provide proof of the disability and dependency by submitting the *PEBB Certification of a Child with a Disability.*

The PEBB Program, with input from your medical plan, will verify the disability and dependency of the child starting at age 26. The first verification at age 26 lasts for at least two years. After that, we may periodically review their eligibility, but not more than once a year. These verifications may require renewed proof of the child's disability and dependence. If we do not receive your verification within the time allowed, the child will no longer be covered.

A child with a disability age 26 or older who becomes self-supporting is not eligible as of the last day of the month they become capable of self-support. If the child becomes capable of self-support and later becomes incapable, they do not regain eligibility.

Proving dependent eligibility

Verifying (proving) dependent eligibility helps us make sure we cover only people who qualify for health plan coverage. You provide this proof by submitting official documents. We will not enroll a dependent if we cannot prove their eligibility by the required deadline. We reserve the right to check a dependent's eligibility at any time.

Subscribers who are not eligible for Medicare Part A and Part B, or all subscribers who are enrolling a state-registered domestic partner, must prove their dependents are eligible before we will enroll them. If you are enrolling a dependent, submit the documents with your enrollment forms within PEBB Program timelines. The documents we will accept to prove dependent eligibility are listed below. A few exceptions apply to the dependent verification process:

- Extended dependents are reviewed through a separate process.
- Previous dependent verification data verified by the School Employees Benefits Board (SEBB) Program may be used when a subscriber moves from SEBB Program coverage to PEBB Program coverage and is requesting to enroll an eligible dependent who has been previously verified under the SEBB Program.

Submit the documents in English. Documents written in another language must include a translated copy prepared by a professional translator and notarized. These documents must be approved by the PEBB Program.

Documents to enroll a spouse

Provide a copy of (choose one):

- The most recent year's federal tax return filed jointly that lists your spouse (black out financial information).
- The most recent year's federal tax return for you and your spouse if filed separately (black out financial information).
- A marriage certificate[1] and evidence that the marriage is still valid (do not have to live together). For example: a life insurance beneficiary document, or a utility bill or bank statement dated within the last six months showing both your and your spouse's names (black out financial information).
- A petition for dissolution, petition for legal separation, or petition to invalidate (annul) marriage. Must be filed within the last six months.
- Defense Enrollment Eligibility Reporting System (DEERS) registration.
- Valid J-1 or J-2 visa issued by the U.S. government.

Documents to enroll a state-registered domestic partner or partner of a legal union

Provide a copy of (choose one):

- A certificate/card[1] of state-registered domestic partnership or legal union and evidence that the partnership is still valid (do not need to live together). For example: a life insurance beneficiary document, a utility bill or bank statement dated within the last six months showing both your and your partner's names (black out financial information).
- A state-registered domestic partnership, or petition to invalidate (annul) state-registered domestic partnership. Must be filed within the last six months.

If enrolling a partner of a legal union, proof of Washington State residency for both you and your partner is required, in addition to dependent verification documents described above. Additional dependent verification documents will be required within one year of your partner's enrollment for them to remain enrolled. More information can be found in PEBB Program Administrative Policy 33-1 on the HCA website at **hca.wa.gov/pebb-rules**.

Documents to enroll children

Provide a copy of (choose one):

- The most recent year's federal tax return that includes children (black out financial information). 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. If the dependent is the subscriber's stepchild, the subscriber must also verify the spouse or state-registered domestic partner to enroll the child, even if they are not enrolling the spouse or partner in health plan coverage.
- Certificate or decree of adoption showing the name of the parent who is the subscriber, the subscriber's spouse, or the subscriber's state-registered domestic partner.
- Court-ordered parenting plan.
- National Medical Support Notice.
- Defense Enrollment Eligibility Reporting System (DEERS) registration.
- Valid J-2 visa issued by the U.S. government.

Additional required documents

If you are enrolling a dependent listed below, you must submit the listed forms with your enrollment forms.

- State-registered domestic partner or their child, or other nonqualified tax dependent: *PEBB Declaration of Tax Status*
- Child with a disability age 26 or older: *PEBB Certification of a Child with a Disability*
- Extended dependent: *PEBB Extended Dependent Certification* and the *PEBB Declaration of Tax Status*

You must notify the PEBB Program in writing when your dependent is no longer eligible. See "What happens when a dependent loses eligibility?" on page 26 to learn more.

Good to know!

To find forms and get more information about proving dependent eligibility, go to HCA's website at **hca.wa.gov/employee-retiree-benefits/retirees/verify-and-enroll-my-dependents**, or call the PEBB Program at 1-800-200-1004.

1 If within six months of marriage or partnership, only the certificate/card is required.

If I die, are my surviving dependents eligible?

Your dependents may be eligible to enroll in or defer PEBB retiree insurance coverage as survivors. To do so, they must meet the eligibility and procedural requirements outlined in WAC 182-12-180 or 182-12-265. The PEBB Program must receive your *PEBB Retiree Election Form* (form A) and any other required forms and documents within the following timelines:

- For an eligible survivor of an employee, **no later than 60 days** after the date of the employee's death, or the date the survivor's educational service district coverage, PEBB insurance coverage, or School Employees Benefits Board (SEBB) insurance coverage ends, whichever is later.
- For an eligible survivor of a retiree, **no later than 60 days** after the retiree's death.

For details about how to continue coverage as a survivor, see "How does a survivor pay for coverage?" on page 18 and "What are my family's options if I pass away?" on page 27.

For more information about deferring coverage, see "Required timelines for survivors to defer" on page 29.

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 in or defer (postpone) PEBB retiree insurance coverage. To be eligible, you must meet both the procedural and eligibility requirements outlined in WAC 182-12-250. To learn more about this coverage, including deadlines to apply, call the PEBB Program at 1-800-200-1004.

If you are a retiring employee, we must receive your *PEBB Retiree Election Form* (form A) and any other required documents **no later than 60 days** after your employer-paid coverage, COBRA coverage, or continuation coverage ends.

If you select a Medicare Advantage plan, enrollment cannot be retroactive. We encourage you to submit Form A so that we receive it no later than the last day of the month in which your employer-paid coverage, COBRA coverage, or continuation coverage ends. Otherwise, you and your enrolled dependents will be enrolled in another medical plan during the gap months prior to when the Medicare Advantage plan begins. See "Choosing a PEBB medical plan" on page 31 for more information.

Good to know!

We offer an online tutorial that walks you through filling out Form A. If you need help with the form, the tutorial is available on HCA's website at **hca.wa.gov/forma-tutorial**.

If you are an elected or full-time appointed official as described in WAC 182-12-180(1), we must receive your forms **no later than 60 days** after you leave public office. If you select a Medicare Advantage plan, enrollment may not be retroactive. We encourage you to submit Form A before you leave public office or so that we receive the form no later than the last day of the month in which your PEBB insurance coverage ends. Otherwise, you and your enrolled dependents will be enrolled in another medical plan during the gap months prior to when the Medicare Advantage plan begins. See "Choosing a PEBB medical plan" on page 31 for more information.

If you are a dependent becoming eligible as a survivor, please see page 14.

Good to know!

It is better to submit an incomplete form than to miss your 60-day window to enroll or defer. If we receive your Form A by the deadline and it is incomplete, we will send you a letter asking for the missing information and giving you a deadline to respond. You must submit Form A even if you decide to defer (postpone) your enrollment. If you do not meet this requirement, future enrollment rights may be affected. See page 28 for more information.

If you miss the 60-day election period, you lose all rights to enroll in or defer enrollment in PEBB retiree insurance coverage unless you regain eligibility in the future. You can regain it, for example, by returning to work with a PEBB employing agency or with a SEBB organization in a position where you are eligible for PEBB or SEBB benefits and meeting procedural and eligibility requirements. You must enroll in medical to enroll in dental. If you choose dental coverage for yourself, you and your dependents must be enrolled in the same dental plan.

When do I send payment?

You must make the first payment of your monthly premiums and applicable premium surcharges by the required deadline before we can enroll you.

If you choose to pay with electronic debit service (EDS) or monthly invoice, we cannot enroll you until we receive your first payment of monthly premiums and applicable premium surcharges. You must make your first payment **no later than 45 days** after your 60-day election period ends.

If you choose to pay by pension deduction and you later receive an invoice for the first payment, you must make the payment by the deadline on the invoice. For details, see "Paying for coverage" starting on page 17.

If we do not receive your first payment by the deadline, you will not be enrolled, and you may lose your right to enroll in PEBB retiree insurance coverage.

Can I enroll or defer retroactively due to a disability?

Under some circumstances, yes. If you feel this situation may apply to you, contact us to learn more by sending a secure message through HCA Support at **support.hca.wa.gov** or by calling 1-800-200-1004.

What if I am eligible as a retiree and a dependent?

You cannot enroll in medical or dental coverage under two PEBB accounts. You could enroll only on your own account or defer (postpone) PEBB retiree insurance coverage for yourself and enroll as a dependent on your spouse's or state-registered domestic partner's PEBB medical.

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. A dependent may be enrolled in only one PEBB medical or dental plan.

Can I enroll in PEBB retiree insurance coverage and have SEBB insurance coverage as a dependent?

Yes. However, it may benefit you to defer your PEBB retiree insurance coverage and enroll in SEBB health plan coverage as a dependent. That way, you do not pay two monthly medical premiums. The potential cost savings makes it worthwhile to consider enrolling in SEBB benefits as a dependent. In general, SEBB employee medical premiums are lower than PEBB retiree medical premiums.

While you are allowed to enroll in both the PEBB and SEBB Programs, doing so may not give you a financial advantage. There is no added benefit if you enroll in both PEBB and SEBB dental coverage. Because coverage levels are similar in PEBB and SEBB medical plans, the second plan will likely offer little or no extra payment for most health care services.

If you are enrolled in PEBB retiree insurance coverage and as a dependent on your spouse or state-registered domestic partner's School Employees Benefits Board (SEBB) Program benefits, your PEBB coverage would be primary, and your SEBB coverage would be secondary. Both programs are administered by the Health Care Authority.

To defer enrollment in PEBB retiree insurance coverage, see page 28. To avoid enrollment in both programs, you should submit your forms to defer on or before the date SEBB health plan coverage begins.

As you make this decision, we suggest that you compare SEBB and PEBB benefits and premiums to decide which option best suits your needs. Visit HCA's website at **hca.wa.gov/pebb-retirees** and **hca.wa.gov/sebb-employee** to get premiums and benefit information.

What can I expect after I submit my form?

After you submit your forms and documents, we will process them and send you a letter notifying you of next steps. Remember, you must make the first payment of your monthly premiums and applicable premium surcharges by the required deadline before we can enroll you. See "Paying for coverage" on the next page for details.

Your employer is responsible for terminating your coverage. In some cases, we cannot enroll you in retiree insurance coverage until this occurs.

When does coverage begin?

If you are an eligible retiring employee, your PEBB retiree insurance coverage will start on the first day of the month after your employer-paid coverage, COBRA coverage, or continuation coverage ends.

If you are an eligible elected or appointed official, your coverage will start on the first day of the month after you leave public office.

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 during a 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.

How much will my monthly premiums be?

The cost for your health plan coverage depends on which medical or dental plan you choose. The list of monthly premiums starts on page 7.

What are the premium surcharges?

Non-Medicare subscribers must attest (respond) to two premium surcharges:

- The tobacco use premium surcharge
- The spouse or state-registered domestic partner coverage premium surcharge (if you enroll one)

If you do not attest to these surcharges within the PEBB Program's timelines below, or if your attestation shows the surcharge applies to you, you will be charged the surcharge in addition to your monthly medical premium. See the *PEBB Premium Surcharge Attestation Help Sheet* in the back of this booklet for more information.

You do not have to attest to the premium surcharges if you (the subscriber) are enrolled in Medicare Part A and Part B. However, if your dependent is enrolled in Medicare and you are not, you must attest to the surcharges.

Tobacco use premium surcharge

This $25-per-account premium surcharge will apply in addition to your monthly medical premium if you or one of your enrolled dependents (age 13 or older) has used tobacco products in the past two months. You must attest to this surcharge for each dependent age 13 or older you want to enroll.

If a provider finds that ending tobacco use or participating in your medical plan's tobacco cessation program will negatively affect your or your dependent's health, read about your options in PEBB Program Administrative Policy 91-1 on HCA's website at **hca.wa.gov/pebb-rules**.

If someone on your account has a change in tobacco use status, or enrolled in or accessed one of the tobacco cessation resources described in the *PEBB Premium Surcharge Attestation Help Sheet*, you may report the change anytime in one of two ways:

- Go to PEBB My Account at **hca.wa.gov/my-account**.
- Submit a *PEBB Premium Surcharge Attestation Change Form.*

If the change you report means that the surcharge applies to you, the surcharge is effective the first day of the month after the change in tobacco use. If that day is the first of the month, then the surcharge begins on that day.

If the change in tobacco use means the surcharge no longer applies to you, the surcharge will be removed from your account effective the first day of the month after we receive your new attestation. If that day is the first of the month, then the change to your account begins on that day.

Good to know!

Your medical plan can help you live tobacco free! You and your enrolled dependents 18 and older can sign up for a tobacco cessation program through your medical plan. Visit our *Living tobacco free* webpage at **hca.wa.gov/tobacco-free** for how to get started.

For enrolled dependents 17 and under, contact your medical plan for programs they offer. Additional resources are available at **teen.smokefree.gov**.

Spouse or state-registered domestic partner coverage premium surcharge

This $50 premium surcharge will apply in addition to your monthly medical premium 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. Find out more on HCA's website at **hca.wa.gov/pebb-retirees** under *Surcharges*.

How do I pay for coverage?

In most cases, you must make your first payment by check before we can enroll you. Send your first payment to HCA **no later than 45 days** after your 60-day election period ends. If we do not receive your first payment by the deadline, you will not be enrolled, and you may lose your right to enroll in PEBB retiree insurance coverage.

Make checks payable to Health Care Authority and send to:

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

When you enroll, you must pay premiums and applicable premium surcharges back to the date 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 premiums and applicable premium surcharges for January and February to enroll in PEBB retiree insurance coverage. We must receive your payment before we can enroll you. You have three options to pay for PEBB retiree insurance coverage.

Pension deduction

Your payments are taken from your end-of-the-month pension through the Department of Retirement Systems (DRS). 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. We will send you an invoice if a first payment is needed. If you receive an invoice, your payment is due by the deadline listed on it.

Electronic debit service (EDS)

You can pay through automatic bank account withdrawals. To choose this option, submit the *PEBB Electronic Debit Service Agreement*, available in the back of this booklet. You cannot make your first payment through EDS because approval takes six to eight weeks. In the meantime, please make payments as invoiced until you receive a letter from us with your EDS start date.

Monthly invoice

We will send you a monthly invoice. Payments are due on the 15th of each month for that month of coverage. Send your payment to the address listed on the invoice.

How does a survivor pay for coverage?

When you become eligible as a survivor, if you were already enrolled as a dependent of a retiree, you will move from being a dependent to having your own 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 their dependent) Note: PEBB insurance coverage is for an entire month. Coverage is terminated at the end of the month and premiums are not prorated, including for the month of death.
- The invoice for your first month under your own PEBB account.

If premiums and applicable premium surcharges were deducted from the subscriber's pension through the Department of Retirement Systems (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 the first invoice listed above remains unpaid, your PEBB retiree health plan coverage will be terminated back to the last day of the month in which you paid. This may cause a gap in coverage, which means that any claims paid from the month the subscriber passed away to the current month would be your financial responsibility. If you were enrolled in a Medicare Advantage plan, termination will occur at the end of the month after your termination notice was sent. If your coverage is terminated, you may not be able to enroll again in PEBB coverage unless you regain eligibility in the future.

When you become eligible as a survivor, either as the survivor of an eligible employee or the survivor of a retiree, and you were not enrolled in PEBB retiree insurance coverage when the retiree passed away, along with the required forms, we must receive your first payment of monthly premiums and applicable premium surcharges. You must make your first payment **no later than 45 days** after your 60-day election period ends as described in "If I die, are my surviving dependents eligible" on page 14. If we do not receive your first payment by the deadline, you will not be enrolled, and you may lose your right to enroll in PEBB retiree insurance coverage.

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:

- You make no payment for 30 days past the due date.
- You make a payment, but it is less than the total due by an amount greater than an insignificant shortfall (described in WAC 182-08-015). The remaining balance is considered underpaid for 30 days past the due date.

If either of these events occur and the payment stays unpaid for 60 days from the original due date, the PEBB Program will terminate your PEBB retiree health plan coverage back to the last day of the month for which the monthly premium and applicable premium surcharges were paid. If you were enrolled in a Medicare Advantage plan, it will terminate at the end of the month after your termination notice was sent. We will also terminate coverage for any enrolled dependents.

You cannot enroll again unless you regain eligibility. You can regain eligibility, for example, by returning to work with a PEBB employing agency or a School Employees Benefits Board (SEBB) organization in which you are eligible for PEBB or SEBB benefits.

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.

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.

Your VEBA MEP account is a health reimbursement arrangement (HRA). Certain limits apply:

- Retiree rehire limitation: You must notify the VEBA MEP if the employer that set up your account rehires you. Only certain "excepted" medical expenses that you incur while re-employed are eligible for reimbursement.
- HSA contribution eligibility limitation: If you enroll in a consumer-directed health plan (CDHP) or other high-deductible health plan (HDHP) and want to become eligible for health savings account (HSA) contributions, you must limit your VEBA MEP HRA coverage by submitting a Limited HRA Coverage Election form to VEBA.

More information and forms, including the Automatic Premium Reimbursement form and Limited HRA Coverage Election form, are available after logging in to the VEBA website at **veba.org** or by calling the VEBA MEP customer care center at 1-888-828-4953.

Medicare enrollment

When you or a covered dependent are eligible for Medicare, you or your dependent must enroll and stay enrolled in Medicare Part A and Part B to enroll in or remain eligible for a PEBB retiree health plan.

Medicare Part A does not usually have a premium if you or your spouse paid Medicare taxes for a certain amount of time while working. Check with the Social Security Administration (SSA) to see if you must pay. Medicare Part B has a monthly premium you must pay in addition to your monthly premium for PEBB retiree insurance coverage.

You can call the SSA at 1-800-772-1213 (TTY: 1-800-325-0778) or visit their website at **socialsecurity.gov/benefits/medicare**.

What is Medicare?

Medicare is the federal health insurance program. It is administered by the Centers for Medicare and Medicaid Services (CMS). It provides health insurance for people age 65 and older and for people under age 65 with certain disabilities. Medicare has four main parts:

- Part A: inpatient hospital care, skilled nursing facility care, and hospice services.
- Part B: outpatient services, provider office visits, preventive services, and durable medical equipment.
- Part C (called Medicare Advantage): allows members to choose between plans offering coverage, in addition to what is covered by Parts A and B. The PEBB Program offers several Medicare Advantage plans.
- Part D: prescription drugs. All PEBB medical plans except Medicare Supplement Plan G offer prescription drug coverage that is as good or better than Medicare Part D.

When should I enroll in Medicare?

Because the Social Security Administration and the PEBB Program have different timelines for Medicare, we encourage you to apply for Medicare three months before turning age 65. Doing so will make sure that you can enroll (or meet the requirements to stay enrolled) in PEBB retiree insurance coverage within our timelines.

To enroll in Medicare, call the Social Security Administration at 1-800-772-1213 (TTY: 1-800-325-0778) or visit their website at **socialsecurity.gov/benefits/medicare**.

To learn more about Medicare benefits, call Medicare at 1-800-633-4227 or go to the Medicare website at **medicare.gov**.

Once you or your dependent have applied for Medicare Part A and Part B, you must send us proof of the Medicare enrollment or denial.

If you are enrolling in PEBB retiree insurance coverage for the first time, submit one of the following documents with your *PEBB Retiree Election Form* (form A).

If you or your dependent are already enrolled in PEBB retiree insurance coverage, send us one of the following documents 30 days before turning age 65, so we can properly adjust your premium (if applicable). (If Medicare coverage is delayed, send us the document **no later than 60 days** after turning age 65.)

- A copy of the Medicare card or entitlement letter showing the effective date of Medicare Part A and Part B
- A copy of the Medicare denial letter from the Social Security Administration

Write your (the subscriber's) full name and the last four digits of your Social Security number on the copy so we can identify your account. Mail, send a secure message, or fax it to:

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

Fax 360-725-0771

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

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

If you do not meet the requirements above, you will not be enrolled in PEBB retiree insurance coverage, or your eligibility will end, as described in the termination notice we sent to you.

Enrolling in Medicare is a special open enrollment event that allows you to change your medical plan. For details, see "What is a special open enrollment?" on page 24.

If I have Medicare coverage, why would I also enroll in PEBB retiree insurance coverage?

CMS estimates that Medicare covers about half of enrollees' medical expenses. Medicare enrollees without other coverage may face substantial health care costs.

How do PEBB medical plans work with Medicare?

The PEBB Program offers several types of plans to support your Medicare coverage. They interact with Medicare in different ways. In general, these plans offer more benefits and help lower your costs for covered services.

Original Medicare plans

Sometimes called classic Medicare plans, these plans start to pay benefits after Medicare pays benefits. Generally, your provider bills Medicare for covered services, and then bills the plan for the rest. In some cases, the provider may bill you for the rest, in which case you would ask for reimbursement from the plan.

Original Medicare plans through the PEBB Program all offer comparable drug coverage to Medicare Part D (called "creditable drug coverage"). They may offer some benefits beyond what Medicare Part D covers.

These plans may be more expensive than other options, with higher deductibles and out-of-pocket limits.

Medicare Advantage plans

Medicare Advantage plans cover the same services as Original Medicare Part A and Part B. They also offer benefits and services that Original Medicare does not cover, like gym memberships. They have an out-of-pocket limit, which includes most of the deductibles and coinsurance costs. The providers bill the plans and the plans coordinate with Medicare, so you won't need to submit claims. Because these plans are subsidized by the federal government, their costs may be lower.

All Medicare Advantage plans offer drug coverage, either creditable drug coverage or Medicare Part D. Plans that include Part D are called Medicare Advantage Prescription Drug (MAPD) plans. Medicare Advantage plans have creditable drug coverage and use a formulary set by the organization for the plan. **Note:** You cannot enroll in an MAPD plan and an individual Medicare plan (either MA or standalone Part D) at the same time.

Some Medicare Advantage plans will have specific provider networks you must use. These networks can be called health maintenance organizations (HMOs) or preferred provider organization (PPO) plans. Check with the plan before you enroll to see if there is a difference in cost share for providers in-network and out-of-network and if they offer coverage where you travel or live part of the year.

Medicare Supplement plans

Like the PEBB Medicare Advantage plans, Medicare Supplement plans pay most deductibles, coinsurance, and copays for services covered by Medicare Part A and Part B. They may also offer some additional benefits, but these are less extensive than other Medicare plans.

Medicare Supplement plans do not include prescription drug coverage. If you don't have creditable drug coverage (for example, through your spouse's insurance), you will need to enroll in a standalone Medicare Part D plan. The PEBB Program does not offer such a plan, but they are available through private insurance companies.

Medicare Supplement plans have the lowest monthly premiums of the Medicare plans offered by the PEBB Program. Members still must pay the deductible and monthly premium for their Part B coverage.

Medicare plan comparison

The table on the next page helps you compare some benefits under the different types of Medicare plans offered by the PEBB Program. All PEBB Medicare plans cover hospital, primary and specialist care, outpatient surgery, and emergency care.

Benefits	Medicare plan options				
	Original Medicare		Medicare Advantage		Medicare Supplement
	Kaiser Original Medicare	UMP Classic Medicare	Kaiser Senior Advantage, Kaiser WA Medicare Advantage	UnitedHealthcare PEBB Balance & PEBB Complete	Premera Plan G
Medical deductible	Yes	Yes	No	No	Yes
Pharmacy deductible	Yes	Yes	No	Yes	N/A
Drug coverage	Yes	Yes	Yes	Yes	No
Hearing aids Glasses/contacts Massage therapy	Yes	Yes	Yes	Yes	No
International coverage for **nonemergency** care	No	Yes	No	Yes	No
Gym membership	No	No	Yes	Yes	No
Defined provider network	Yes	No	Yes	No	No
Must live in service area	Yes	No	Yes	No	No

Can I enroll in a CDHP, UMP Select, or a 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), UMP Select, or a UMP Plus plan, you must change medical plans when you or someone on your account enrolls in Medicare Part A or Part B. The PEBB Program must receive your change form **no later than 60 days** after the Medicare enrollment date. If you choose a Medicare Advantage plan, the PEBB Program must receive your change form no later than two months after the date your previously selected health plan becomes unavailable.

Since you must change plans, and enrolling in Medicare Part A and Part B may lower your premium, we encourage you to submit your change form as soon as possible, but especially before your Medicare enrollment date. Doing so will help you avoid paying a higher non-Medicare plan premium. It will also end applicable premium surcharges.

The effective date of the plan change will be the first of the month after the date the medical plan becomes unavailable, or the date we receive your form, whichever is later. If that day is the first of the month, the change in the medical plan begins on that day, unless you are enrolling in an MAPD plan, in which case your medical plan will start the first day of the following month.

After you leave a CDHP, you will still have access to your existing HSA funds, but you can no longer contribute to the HSA. If you are enrolled in a CDHP and fail to select a new medical plan, you will be liable for any tax penalties resulting from contributions made to your HSA after you are no longer eligible.

Here are your options, depending on which member is enrolled in Medicare Part A and Part B:

- You (the subscriber): Must choose a different type of medical plan. Your annual deductible and annual out-of-pocket maximum will restart with your new plan.
- Your covered dependent (choose one):
    - You must choose a different type of medical plan for your family to 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.
    - To keep your CDHP, UMP Select, or UMP Plus plan, you may choose to remove your dependent from your PEBB health plan coverage before they enroll in Medicare Part A or Part B. They will not qualify for PEBB Continuation Coverage.

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

All PEBB medical plans (except Medicare Supplement plans) have prescription drug coverage that is "creditable coverage." That means it is as good as or better than the standard Medicare prescription drug coverage, called Medicare Part D. Check with the plans to see if they cover your prescription drugs.

UnitedHealthcare PEBB Balance and UnitedHealthcare PEBB Complete include Medicare Part D coverage. The PEBB Program does not offer a plan that covers only Medicare Part D coverage (called a "standalone" Part D plan), and you are not required to enroll in Medicare Part D.

If you decide to enroll in a standalone Part D plan, the only PEBB medical plan you can choose is Premera Blue Cross Medicare Supplement Plan G. If you are enrolled in any other PEBB medical plan when you enroll in a Part D plan, you must switch to Plan G. If you do not change plans or send us proof of your Medicare Part D cancellation, you or your dependent may lose PEBB retiree health plan coverage.

You can enroll in a standalone Medicare Part D plan when you first become eligible for Medicare, during the Medicare Part D yearly open enrollment period (October 15 through December 7), or if you lose creditable prescription drug coverage through your current medical plan.

If your PEBB medical plan includes creditable prescription drug coverage, you can keep your plan and not pay a late enrollment penalty if you decide to enroll in a standalone Medicare Part D plan later.

Making changes in coverage

To make changes, such as enrolling a dependent or switching to a different health plan, you must submit the required forms. You can make some changes anytime, but others you can only make during the PEBB Program's annual open enrollment, typically held in the fall, or when a life event creates a special open enrollment.

What changes can I make anytime?

You can make the changes below anytime during the year. Use the *PEBB Retiree Change Form (*form E) to report the change, unless otherwise noted below.

Change your or your dependent's tobacco use premium surcharge attestation

Use the *PEBB Premium Surcharge Attestation Change Form* or log in to PEBB My Account at **hca.wa.gov/my-account**.

Change your name or address

Send the PEBB Program a written request with your new name or address using one of the following methods. Write your full name and the last four digits of your Social Security number on the copy so we can identify your account.

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

Fax
360-725-0771

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

To report an address or contact information change, you can also call 1-800-200-1004 (TRS: 711). We cannot accept a name change over the phone.

Terminate or defer (postpone) your coverage

See "How do I terminate coverage?" on page 26 or "Deferring your coverage," starting on page 28.

Remove a dependent

See "When does PEBB insurance coverage end?" on page 27.

Change your retiree term life insurance beneficiary information

Visit MetLife's website at **mybenefits.metlife.com/wapebb** or call 1-866-548-7139. (See "Retiree term life insurance" on page 51.)

Apply for, terminate, or change auto or home insurance coverage

See "Auto and home insurance" on page 54.

Start, stop, or change your contributions to your health savings account (HSA)

Contact HealthEquity. UMP members, call 1-844-351-6853 (TRS: 711). Kaiser Permanente members, call 1-877-873-8823 (TRS: 711).

Change your HSA beneficiary information

Use the HealthEquity Beneficiary Designation Form available at **learn.healthequity.com/pebb/hsa/documents**.

What changes can I make during annual open enrollment?

The PEBB Program's annual open enrollment is held in the fall (usually November 1 through 30). To make any of the changes below, the PEBB Program must receive the required forms no later than the last day of open enrollment. The change will become effective January 1 of the next year. During annual open enrollment, you can:

- Change your medical or dental plan.
- Add dental coverage.
- Enroll an eligible dependent.
- Remove a dependent.
- Terminate or defer (postpone) your coverage.
- Enroll in a PEBB retiree health plan if you deferred coverage in the past. You will need to provide proof of continuous enrollment in other qualifying coverage. (See "Deferring your coverage" starting on page 28.)

What is a special open enrollment?

A special open enrollment is a period after specific life events (such as a birth or marriage) when subscribers may make changes outside of the PEBB Program's annual open enrollment. You must provide proof of the event that created the special open enrollment. Some examples of this proof include a birth certificate or marriage certificate.

Generally, to make a change, you must submit the *PEBB Retiree Change Form* (form E) and any other required forms or documents. The PEBB Program must receive them **no later than 60 days** after the event that created the special open enrollment.

If you are changing your medical plan to Premera Blue Cross Medicare Supplement Plan G, the PEBB Program must receive Form E and the *Group Medicare Supplement*

Enrollment Application (form B) **no later than six months** after you or your dependent enroll in Medicare Part B.

If you are changing your medical plan to a Medicare Advantage or Medicare Advantage Prescription Drug (MAPD) plan, you have seven months to enroll. The seven-month period begins three months before you or your dependent first enrolled in both Medicare Part A and Part B. It ends three months after the month of Medicare eligibility, or before their last day of the Medicare Part B initial enrollment period. The PEBB Program must receive Form E no later than the last day of the month before the month you or your dependent enroll in the Medicare Advantage or MAPD plan.

If you are changing from a Medicare Advantage Plan, also include a *PEBB Medicare Advantage Plan Disenrollment Form* (form D). To disenroll from a Medicare Advantage plan or MAPD plan, the change must be allowable under 42 C.F.R. Secs. 422.62(b) and 423.38(c).

In most cases, the change will occur the first of the month after the event date or the date we receive your forms, whichever is later. If that day is the first of the month, the change in enrollment begins on that day.

One exception is PEBB Medicare Advantage or MAPD plans, which start the first of the month after the PEBB Program receives your forms, per federal rules.

Another exception is the addition of a child (such as a newborn, adopted child, or a child you are legally required to support ahead of adoption), in which case PEBB health plan coverage will start or end as follows:

- For a newborn child, PEBB health plan coverage will start on the date of birth.
- For a newly adopted child, PEBB health plan coverage will start on the date of placement or the date you assume legal responsibility for their support ahead of adoption, whichever is earlier.
- For a spouse or state-registered domestic partner being enrolled because of a birth or adoption, PEBB health plan coverage will start the first day of the month in which the event occurs. If removing the spouse or partner, their coverage will end as of the last day of the month in which the event occurred.
- For a child becoming eligible as an extended dependent or a dependent child age 26 or older with a disability, PEBB health plan coverage will start the first day of the month following either the event date or the date we confirm their eligibility, whichever is later.

Good to know!

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

Events that create special open enrollments

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

The following events allow you to enroll dependents and change medical or dental plans:

- Marriage or registering a state-registered domestic partnership (as defined by WAC 182-12-109).
- Birth or adoption, including assuming a legal responsibility for support ahead of adoption.
- Child becoming eligible as an extended dependent through legal custody or legal guardianship.
- Subscriber or dependent losing other coverage under a group health plan or through health insurance, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
- Subscriber having a change in employment status that affects the subscriber's eligibility for the employer contribution toward their employer-based group health plan.
- The subscriber's dependent has a change in their employment status that affects their eligibility or their dependent's eligibility for the employer contribution under their employer-based group health plan ("Employer contribution" means contributions made by the dependent's current or former employer toward health coverage, as described in Treasury Regulation 26 C.F.R. 54.9801-6.)
- A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber.
- Subscriber or a subscriber's dependent enrolls in coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or loses eligibility for coverage under Medicaid or CHIP.
- Subscriber or a dependent becoming eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.

The following events allow you to enroll dependents:

- 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.
- Subscriber's dependent moving from another country to live within the United States, or from the United States to another country, and that change in residence resulted in the dependent losing their health insurance.
- Subscriber's dependent loses eligibility for Medicare.

The following events allow you to change medical and dental plans:

- Subscriber or dependent having a change in residence that affects health plan availability.
- Subscriber's or their dependent's current medical plan becoming unavailable because the subscriber or their enrolled dependent is no longer eligible for a health savings account (HSA).
- Subscriber or dependent experiencing a disruption of care for active and ongoing treatment that could function as a reduction in benefits for the subscriber or their dependent (requires approval by the PEBB Program).

The following event allows you to change your medical plan:

- Subscriber or dependent enrolls in Medicare or loses eligibility under Medicare; or enrolls (or terminates enrollment) in a Medicare Advantage Prescription Drug plan or a Medicare Part D plan.

What happens when a dependent loses eligibility?

You must notify the PEBB Program in writing when your dependent no longer meets the eligibility criteria described in WAC 182-12-260. Some examples of reasons a dependent may lose eligibility include turning age 26, or the subscriber's divorce, annulment, or dissolution.

We must receive your notice within 60 days of the last day of the month your dependent loses eligibility. For example, if your dependent child age 26 or older with a disability becomes self-supporting on March 15, their last day of eligibility is March 31. You must notify the PEBB Program that they are no longer eligible by May 30 (60 days after March 31).

If eligibility is lost due to divorce, you must submit a copy of the divorce decree. If eligibility is lost due to dissolution of a state-registered domestic partnership, you must submit a copy of the dissolution document.

We will remove the dependent on the last day of the month in which the dependent meets the eligibility criteria.

WAC 182-12-262 (2)(a) explains the consequences for not submitting written notice within 60 days. They may include, but are not limited to, the following.

- The dependent may lose eligibility to continue PEBB medical or dental under one of the continuation coverage options described in WAC 182-12-270.
- You may be billed for claims your health plan paid for services that happened after the dependent lost eligibility.
- You may not be able to recover premiums you paid for dependents who lost eligibility.

How do I terminate coverage?

To terminate all or part of your PEBB health plan coverage, you must submit your request in writing using one of the three methods below. Write your full name and the last four digits of your Social Security number on your request so we can identify your account.

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

Fax
360-725-0771

Secure message
Send a secure message through HCA Support at **support.hca.wa.gov**, a secure website that allows you to log in to your own account to communicate with us. You will need to set up a SecureAccess Washington (SAW) account to use this option. Attach your written request to the secure message. We cannot terminate your coverage in response to a secure message alone.

Your health plan coverage will terminate on the last day of the month in which we receive your written request (or a future date if you ask for one).

If we receive your request on the first day of the month, coverage will terminate on the last day of the previous month, unless you or a dependent is enrolled in a PEBB Medicare Advantage plan. If so, you must also submit a *PEBB Medicare Advantage Plan Disenrollment Form* (form D). Coverage will terminate on the last day of the month in which we receive Form D.

If you terminate all your PEBB retiree health plan coverage, your enrolled dependents will also be terminated. You cannot enroll again later unless you regain eligibility, for example, by returning to work with a PEBB employing agency or a SEBB organization in which you are eligible for PEBB or SEBB benefits.

When does PEBB insurance coverage end?

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

- Coverage for you or a dependent 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. If you or a dependent are enrolled in a Medicare Advantage plan, termination will occur at the end of the month after your termination notice was sent.
- Coverage for you or an enrolled dependent ends if you fail to respond to a request from the PEBB Program for information about Medicare Part A and Part B enrollment or an action required due to enrolling in Medicare Part D.

If you or a dependent loses eligibility for PEBB retiree insurance coverage, you and your dependents may be eligible to continue PEBB health plan coverage under PEBB Continuation Coverage (COBRA). If you enroll, you must pay the full premiums and any applicable premium surcharges. We will mail you a *PEBB Continuation Coverage Election Notice* when your coverage ends with more information about this option. This notice explains eligibility and deadlines, and it contains the form you need to enroll. To learn more about this option, visit the HCA website at **hca.wa.gov/pebb-continuation**.

What are my family's options if I pass away?

Your dependents lose eligibility when you (the retiree) die. However, they may be eligible for PEBB retiree insurance coverage as survivors, even if they were not covered at the time of your death. To apply for coverage, we must receive their forms and any other required documents **no later than 60 days** after the date of your death.

Your surviving spouse or state-registered domestic partner may continue PEBB retiree insurance coverage indefinitely as long as they pay for coverage on time. Your other dependents may continue coverage until they are no longer eligible under PEBB Program rules. The survivor must pay monthly premiums and applicable premium surcharges as they become due.

Deferring your coverage

Deferring means pausing or postponing your enrollment in PEBB retiree insurance coverage so you keep your eligibility to enroll later. You may choose to defer when you first become eligible for PEBB retiree insurance coverage or after you enroll.

You must be eligible to enroll in PEBB retiree insurance coverage to defer your enrollment. You must also submit the required form to defer by the deadline. If we do not receive the form by the deadline, it may affect your ability to enroll in PEBB retiree insurance coverage in the future.

Why would I defer?

You may want to defer if you have other qualified 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 a PEBB retiree health plan.

Good to know!

There are strict requirements for returning to a PEBB retiree health plan after deferring. Please read WAC 182-12-200 and 182-12-205 to learn more.

How do I defer?

To defer your enrollment, you must:

- Be eligible for PEBB retiree insurance coverage.
- Submit the required forms to the PEBB Program within the required timeline.
- Be continuously enrolled in other qualified medical coverage, as described below.

If you are already enrolled in PEBB retiree insurance coverage and you return to work and become eligible for the employer contribution toward PEBB benefits, PEBB retiree insurance coverage is automatically deferred. You do not need to submit a form.

When you defer, you are postponing both medical and dental coverage. Retirees cannot enroll only in dental. Except as stated below, when you defer, your dependents' coverage is also deferred.

What allows me to defer?

You may defer enrollment in a PEBB retiree health plan:

- If you are enrolled in a Washington State educational service district-sponsored, PEBB-sponsored, or SEBB-sponsored health plan as a dependent, including COBRA or continuation coverage.
- Beginning January 1, 2001, if you are enrolled in employer-based group medical as an employee or employee's dependent, including coverage continued under COBRA or continuation coverage. It 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.
- Beginning January 1, 2006, if you are enrolled in Medicare Part A and Part B **and** a Medicaid program that provides creditable coverage. To count as creditable, your Medicaid coverage must include medical and hospital benefits. Any dependents who are not eligible for creditable coverage under Medicaid may stay enrolled in a PEBB retiree health plan.
- Beginning January 1, 2014, if you are not eligible for Medicare Part A and Part B, and you are enrolled in qualified health plan coverage through a health benefit exchange established under the Affordable Care Act. This does not include Medicaid coverage (known as Apple Health in Washington State).
- Beginning July 17, 2018, if you are enrolled in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).

You must provide proof of continuous enrollment in one or more qualifying medical coverages to return to a PEBB retiree health plan after deferral. A gap in coverage of 31 days or less is allowed between the date you defer PEBB retiree insurance coverage and the start date of a qualified coverage, and between each qualified coverage during the deferral period. 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 enroll in PEBB retiree insurance coverage in the future.

Required timelines for retirees to defer

To defer enrollment in PEBB retiree insurance coverage, you must submit the required forms to the PEBB Program.

- If you are an eligible retiring employee (or in some cases, a separating employee), the PEBB Program must receive the *PEBB Retiree 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 after the date your employer-paid coverage, COBRA coverage, or continuation coverage ends.
- If you are an employee found eligible for disability retirement, contact us to learn more by sending a secure message through HCA Support at **support.hca.wa.gov** or by calling 1-800-200-1004.
- If you are an eligible elected or full-time appointed official leaving public office, we must receive the *PEBB Retiree Election Form* (form A) **no later than 60 days** after you leave public office. We will defer your enrollment the first of the month after the date you leave public office.
- If you are already enrolled in PEBB retiree insurance coverage and want to defer because you have other qualifying medical coverage, we must receive the *PEBB Retiree Change Form* (form E) and any other required forms before we can defer your coverage. Enrollment will be deferred effective the first of the month after we receive all the required forms. If we receive the forms on the first day of the month, enrollment will be deferred that day. When a member is enrolled in a PEBB Medicare Advantage Plan, enrollment will be deferred effective the first of the month after the date we receive the *PEBB Medicare Advantage Plan Disenrollment Form* (form D).
- If you enrolled as a dependent in a Washington State educational service district-sponsored, PEBB-sponsored, or SEBB-sponsored health plan (including 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 subscriber must defer enrollment as described in WAC 182-12-205.
- If you are already enrolled in PEBB retiree insurance coverage and you return to work and become eligible for the employer contribution toward PEBB benefits, PEBB retiree insurance coverage will be automatically deferred. You do not need to submit a form. When you are no longer eligible for the employer contribution toward PEBB benefits, you must enroll or defer as described in WAC 182-12-171, 182-12-200, or 182-12-205.

Required timelines for survivors to defer

To defer PEBB retiree insurance coverage, except as stated below, a survivor must submit a *PEBB Retiree Election Form* (form A) to the PEBB Program.

- In the event of an employee's death, we must receive the form **no later than 60 days** after the date of the employee's death, or the date the survivor's educational service district coverage, PEBB insurance coverage, or SEBB insurance coverage ends, whichever is later.
- In the event of an elected or full-time appointed official's death, we must receive the form **no later than 60 days** after the date of the official's death, or the date the survivor's PEBB insurance coverage ends, whichever is later.
- In the event of a retiree's death, we must receive the form **no later than 60 days** after the death.
- If a survivor enrolls in PEBB retiree insurance coverage and later wants to defer because they have other qualifying medical coverage, they must submit the *PEBB Retiree Change Form* (form E) and any other required forms. Enrollment will be deferred as of the first of the month after the date we receive the forms. If we receive them on the first day of the month, enrollment will be deferred that day. When a member is enrolled in a PEBB Medicare Advantage Plan, coverage will be deferred as of the first of the month after the date we receive the *PEBB Medicare Advantage Plan Disenrollment Form* (form D).
- In the event of the death of emergency service personnel killed in the line of duty, we 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 (including COBRA coverage) through the emergency service worker's employer.

How do I enroll after deferring?

If you deferred enrollment in PEBB retiree insurance coverage, you may enroll in a PEBB retiree health plan under the following circumstances. You must have been continuously enrolled in one or more qualifying medical coverages during your deferral. A gap in coverage of 31 days or less is allowed between the date you defer PEBB retiree insurance coverage and the start date of a qualified coverage, and between each qualified coverage during the deferral period. You can enroll:

- **During any PEBB Program annual open enrollment.** We must receive the *PEBB Retiree Open Enrollment Election/Change* form (form A-OE), any other required forms, and proof of continuous enrollment in one or more qualified medical coverages no later than the last day of open enrollment. Your enrollment will begin January 1 of the next year.
- **When other qualifying medical coverage ends.** We must receive the *PEBB Retiree Election Form* (form A), any other required forms, and proof of continuous enrollment in one or more qualified medical coverages **no later than 60 days** after the date your other qualifying medical coverage ends. Enrollment will begin the first day of the month after the other coverage ends. Although you have 60 days to enroll, you must pay premiums and applicable premium surcharges back to when your other coverage ended. Proof of continuous enrollment in one or more qualifying medical coverages must list the dates the coverage began and ended. **Exception:** If you select a Medicare Advantage or Medicare Advantage Prescription Drug (MAPD) plan, enrollment may not be retroactive. We encourage you to submit the required forms so that we receive them no later than the last day of the month before the date PEBB retiree insurance coverage is to begin. Otherwise, you and your enrolled dependents will be enrolled in another medical plan during the gap months prior to when the Medicare Advantage plan or MAPD plan begins. See "Choosing a PEBB medical plan" on page 31 for more information.

If you deferred while enrolled in Medicare Part A and Part B and a Medicaid program that provides creditable coverage, you may enroll in a PEBB retiree health plan as described above, or no later than the end of the calendar year in which your Medicaid coverage ends. See WAC 182-12-205 (6)(c)(iii) to learn more.

You have a one-time opportunity to enroll in a PEBB retiree health plan if you deferred 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.

If you deferred, you may later enroll in a PEBB retiree health plan if you receive formal notice that the Health Care Authority has determined it is more cost-effective to enroll you or your eligible dependents in PEBB medical than a medical assistance program.

Your medical plan options are based on eligibility and where you live. If you cover dependents, everyone must enroll in the same medical plan (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 a PEBB Medicare Advantage or Medicare Supplement plan. Also, not everyone qualifies to enroll in a consumer-directed health plan (CDHP) with a health savings account (HSA), UMP Select, or a UMP Plus plan. See "Can I enroll in a CDHP, UMP Select, or a UMP Plus plan and Medicare Part A and Part B?" on page 22.

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" starting on page 37.) Be sure to call the plans 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. Otherwise, you may have limited access to network providers and covered services. You must report your new address to the PEBB Program **no later than 60 days** after your move.

Types of medical plans

In general, the type of plan you choose depends on whether you are eligible for Medicare Part A and Part 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 plans (CDHP). A CDHP lets you use a health savings account (HSA) to help pay for out-of-pocket medical expenses tax-free. These plans have a lower monthly premium, a higher deductible, and a higher out-of-pocket limit than most other plans. These plans are not compatible with Medicare coverage.
- Managed-care plans. These plans may require you to choose a network primary care provider to meet or coordinate your health care needs. You can change network providers at any time. The plan may not pay benefits if you see a noncontracted provider.
- Preferred provider organization (PPO) plans. PPOs allow you to self-refer to any approved provider type in most cases. They usually provide a higher level of coverage if the provider contracts with the plan.

Good to know!

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.

How can I compare the plans?

All medical plans cover the same basic health care services, except for Premera Blue Cross Medicare Supplement Plan G. The plans vary in other ways, such as provider networks, premiums, out-of-pocket costs, and drugs they cover. When choosing a plan to best meet your needs, here are some things to consider.

Premiums

A premium is the monthly amount the subscriber pays to cover the cost of insurance. It does not cover copays, coinsurance, or deductibles. Premiums vary by plan. A higher premium doesn't necessarily mean higher quality of care or better benefits. Generally, plans with higher premiums may have lower annual deductibles, copays, or coinsurance costs. Plans with lower premiums may have higher deductibles, coinsurance, copays, and more limited networks. Premiums are listed starting on page 7.

Deductibles

A deductible is a fixed dollar amount you must pay each calendar year for covered health care expenses before the plan starts paying for covered services. Medicare plans may also have a separate annual deductible for prescription drugs. The deductible does not apply to covered preventive care services when you see a network provider. This means you do not have to pay your deductible before the plan pays for the covered preventive service.

Coinsurance or copays

Some plans require you to pay a copay, a fixed fee, when you receive care. Other plans require you to pay coinsurance, a percentage of an allowed amount.

Out-of-pocket limit

The annual out-of-pocket limit is the most you pay in a calendar year for covered benefits. Once you have reached the out-of-pocket limit, the plan pays 100 percent of the allowed amount for most in-network covered services for the rest of the calendar year. Certain charges (such as your annual deductible, copays, and coinsurance) may count toward your out-of-pocket limit. Others, such as your monthly premiums, do not. Read each plan's certificate of coverage for details.

Referral procedures
Some plans allow you to self-refer to network providers for specialty care. Others require you to have a referral from your primary care provider. When you enroll in a medical plan, you may choose your primary care provider. Although some medical plans may not require a referral from your primary care provider to see a specialist, the specialist may require you to have one prior to seeing them for services.

Your providers
If you want to see a particular provider, you should check whether they are in the plan's network before you join. After you join a plan, you may change your provider, although the rules vary by plan.

Network adequacy
All health carriers in Washington are required to maintain provider networks that offer members reasonable access to covered services. Check the plans' provider directories to see how many providers are accepting new patients and what the average wait time is for an appointment.

Paperwork
In general, PEBB plans don't require you to file claims. However, Uniform Medical Plan (UMP) members may need to file a claim if they receive services from a non-network provider. Or if you have a Kaiser Permanente plan, you may need to file a claim if you receive services out of the plan's service area, including out of country. Urgent or emergency care may also require you to submit claims. CDHP members also should keep paperwork from providers and from qualified health care expenses to verify eligible payments from their health savings account.

Coordination with your other benefits
All PEBB medical plans coordinate benefit payments with other group plans, Medicaid, and Medicare. This ensures the highest level of reimbursement for services when a person is covered by more than one plan. Payment will not exceed the benefit amount.

If you are also covered by another health plan, call the plan to ask how they coordinate benefits. This is especially important for those coordinating benefits between the PEBB and SEBB Programs, and those enrolled in Medicaid.

One exception to coordination of benefits: 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 G.) If you enroll in a standalone Medicare Part D plan, you must enroll in Plan G or terminate your PEBB retiree health plan coverage.

What tools do I have to compare these features?

Benefit comparison tables

You'll find benefits comparison tables for health plans on pages 37–48. These tables will help you compare the costs and availability of the most widely used features of plans.

Benefits booklets

The health plans produce benefits booklets, also called certificates of coverage (COCs) or evidence of coverage (EOC), to provide detailed information about plan benefits and what is and is not covered. You can find the benefits booklets for all PEBB health plans on the *Medical plan and benefits* webpage at **hca.wa.gov/pebb-retirees**.

Summary of Benefits and Coverage

Summaries of Benefits and Coverage (SBCs) are required under the federal Affordable Care Act to help members understand plan benefits and medical terms. SBCs help you compare things like:

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

Most PEBB Program medical plans provide SBCs, or explain how to get them, at different times throughout the year (like when you apply for coverage or renew your plan). SBCs are available upon request in your preferred language. Medicare plans are not required to provide SBCs.

You can get SBCs on the *Medical plans and benefits* webpage at **hca.wa.gov/pebb-retirees** or from the medical plans' websites. You can also call the plan's customer service or the PEBB Program at 1-800-200-1004 to request a copy at no charge. Medical plan websites and customer service phone numbers are listed at the front of this guide. SBCs do not replace medical benefits comparisons or the plans' certificates of coverage.

Virtual benefits fair

The virtual benefits fair is a convenient way to learn about your benefit options through an online experience that's available anytime, day or night.

The virtual benefits fair includes an exhibit hall where each plan administrator has a booth that displays information about their plan options to help you choose the right plans for you and your dependents. You can get information about medical and dental plans, life insurance, and SmartHealth (a voluntary wellness program). Learn about SmartHealth on page 53. Visit the virtual benefits fair on the HCA website at **hca.wa.gov/vbf-pebb**.

Behavioral health coverage

Ensuring timely access to care

Your mental health affects your physical health. If you or a loved one need access to services for mental health or substance use disorders, you can use this guide to research each plan's network and timely access to services for substance use, mental health, and recovery care.

All health carriers in Washington State must maintain provider networks that provide enrollees reasonable access to covered services. To find a provider for mental health, physical health, or substance use, you can start by checking your plans' provider directory. If you need more information, you can call the plan's customer service number. The plan will know what providers are accepting new patients. Wait times may vary, depending on whether you are seeking emergent, urgent, or routine care. Make sure to specify how quickly you need care when scheduling appointments.

All carriers must provide information on their websites for mental health and substance use disorder treatment providers' ability to ensure timely access to care. For more information, see RCW 48.43.765.

If you are having trouble receiving services from your plan, including scheduling an appointment, you can file a complaint on the Office of the Insurance Commissioner website at **insurance.wa.gov/file-complaint-or-check-your-complaint-status** or by calling 1-800-562-6900.

Compare coverage by plan

When you need information about what mental health or substance use disorders are covered, you can read the PEBB medical plans' certificates of coverage, which are on the *Medical plans and benefits* webpage at **hca.wa.gov/pebb-retirees**. Key words to look for in these documents are: inpatient and outpatient coverage, mental health, chemical dependency, residential treatment facility, and substance use disorder. The "Medical benefits comparison" on page 40 and the "Medicare plans benefits comparison" on page 45 include high-level summaries of coverage by plan.

You can also visit the *Behavioral health services by plan* webpage at **hca.wa.gov/bh-pebb** to find mental health and substance use disorder treatment services available from your plan and learn how to access them.

Crisis information

If you or a family member is experiencing a mental health or substance abuse crisis:

- For immediate help: Call 911 for a life-threatening emergency or 988 for a mental health emergency.
- For immediate help with a mental health crisis or thoughts of suicide: Call the National Suicide Prevention Lifeline at 1-800-273-8255 (TTY: 1-800-799-4889); or call, text, or chat 988. The line is free, confidential, and available 24/7/365. You can also dial 988 if you are worried about a loved one who may need crisis support.
- For additional support: Find county-based crisis support assistance options on the HCA website at **hca.wa.gov/mental-health-crisis-lines**.
- Washington Recovery Help Line: Call 1-866-789-1511 anytime, day or night. This anonymous and confidential help line provides crisis intervention and referral services for individuals in Washington State experiencing substance use disorder, problem gambling, or a mental health challenge. Professionally trained volunteers and staff are available to provide emotional support 24 hours a day, seven days a week. In addition, they can suggest local treatment resources for substance use, problem gambling, and mental health, as well as other community services.

Medicare options

These medical plan options are for members enrolled in Medicare Part A and Part B. Value-based plans are noted in bold.

- **Kaiser Permanente NW[1] Senior Advantage**
- **Kaiser Permanente WA Medicare Plan** (Medicare Advantage or Original Medicare coordination plan)
- Premera Blue Cross Medicare Supplement Plan G
- UMP Classic (Medicare), administered by Regence BlueShield
- **UnitedHealthcare PEBB Balance**
- **UnitedHealthcare PEBB Complete**

Non-Medicare options

These medical plan options are for members not eligible for Medicare or enrolled in Part A only. Value-based plans are noted in bold.

Consumer-directed health plans (CDHPs)

These are not available if any member is enrolled in Medicare.

- **Kaiser Permanente NW[1] 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[1] Classic**
- **Kaiser Permanente WA Classic**
- **Kaiser Permanente WA SoundChoice**
- **Kaiser Permanente WA Value**

1 Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon. KFHPNW Medicare plans have a larger service area.

Preferred-provider plans

- UMP Classic, administered by Regence BlueShield
- UMP Select, 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 with a health savings account (HSA). They generally have lower premiums with higher out-of-pocket costs than other types of medical plans.

If you cover dependents, you must pay the whole family deductible before the CDHP starts paying benefits.

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 (like deductibles, copays, and coinsurance), including some that your health plans may not cover. See IRS Publication 969, Health Savings Accounts and Other Tax -Favored Health Plans on the IRS website at **irs.gov** for details. Your HSA balance can grow over the years, earn interest, and build savings that you can use to pay for health care as needed or pay for Medicare Part B premiums. The HSA is set up by your health plan with HealthEquity, Inc., the HSA trustee for all PEBB CDHPs.

Who is eligible?

You cannot enroll in a CDHP with an HSA if:

- You or a covered dependent is enrolled in Medicare Part A or Part B.
- You or a covered dependent is enrolled in Medicaid (called Apple Health in Washington).
- You are enrolled in another health plan that is not a high-deductible health plan (HDHP) unless the health plan coverage is limited-purpose 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). However, you may enroll if you convert it to limited HRA coverage.
- You have CHAMPVA or a TRICARE plan.
- 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. However, you can enroll in a CDHP with an HSA if you enroll in the Limited Purpose FSA or for a post-deductible Medical FSA.
- You are claimed as a dependent on someone else's tax return.

Other exclusions apply. To check whether you qualify, check the HealthEquity Complete HSA Guidebook at **healthequity.com/doclib/hsa/guidebook.pdf**, see IRS Publication 969, Health Savings Accounts and Other Tax-Favored Health Plans on the IRS website at **irs.gov**, contact your tax advisor, or call HealthEquity toll-free at 1-877-873-8823.

PEBB Program contributions

The PEBB Program will contribute the following amounts to your HSA:

- $58.34 each month for an individual subscriber, up to $700.08 for 2023; or
- $116.67 each month for a subscriber with one or more enrolled dependents, up to $1,400.04 for 2023.
- $125 if you qualify for the SmartHealth wellness incentive in 2023. This amount will be deposited in your first HSA installment by the end of January 2024.

Contributions from the PEBB Program are deposited into your HSA in monthly installments on the last day of each month — except for the SmartHealth wellness incentive, which is a one-time deposit by the end of January.

Your contributions

You can also choose to contribute to your HSA through direct deposits to HealthEquity. You may be able to deduct your HSA contributions from your federal income taxes. The IRS has an annual limit for HSA contributions from all sources. In 2023, the limits are $3,850 (for subscriber-only accounts) and $7,750 (for you and one or more dependents). If you are age 55 or older, you may contribute up to $1,000 more per year.

To make sure you do not go beyond the limit, consider the PEBB Program's contributions, your contributions, and the SmartHealth wellness incentive in January (if you qualify for it).

CDHP and Medicare do not mix

If you choose a CDHP and you or a covered dependent enrolls in Medicare Part A or Part B during the year, you must change to a different type of medical plan. If your covered dependent enrolls in Medicare, you may choose to remove the Medicare-enrolled dependent from PEBB coverage to keep your CDHP. You cannot contribute to an HSA when you or your dependent are enrolled in Medicare.

What happens to my HSA when I leave the CDHP?

You can keep any unspent funds in your HSA. You can spend them on qualified medical expenses in the future. However, you, the PEBB Program, and other individuals can no longer contribute to your HSA.

If you leave employment or retire, 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. For details, call HealthEquity toll-free at 1-877-873-8823.

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

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

These plans provide all Medicare-covered benefits. Most also cover the deductibles, coinsurance, and additional benefits that Medicare doesn't cover. You must also live within the plan's service area unless the plan offers nationwide coverage.

UnitedHealthcare Medicare Advantage Prescription Drug (MAPD) plans are available nationwide, including American Samoa, Guam, the Northern Marianas, Puerto Rico, and the U.S. Virgin Islands. There is no difference in copays between in-network and out-of-network services. If you choose an MAPD plan, any enrolled members who are not eligible for Medicare will be enrolled in UMP Classic.

Medicare Advantage plans offered by Kaiser Permanente NW[1] and Kaiser Permanente WA are not available in every county. Check "Medical plans available by county" starting on page 37. 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. 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. Neither the health plan nor Medicare will pay for services received outside of the plan's network, except for authorized referrals and emergency care.

Enrollment in the Medicare Advantage or MAPD plans is effective the first of the month after we receive your enrollment forms or when you enroll in both Medicare Part A and Part B, whichever is later. This date may be different from your retirement date. **Your enrollment in these plans cannot be retroactive.** If you enroll in a Medicare Advantage plan offered by Kaiser Permanente NW or Kaiser Permanente WA, and we receive the required forms after the date the PEBB retiree insurance coverage is to begin, you and your enrolled dependents will be enrolled in a plan with the same contracted vendor during the gap months prior to when the Medicare Advantage plan begins. If you elect to enroll in a UnitedHealthcare MAPD plan, and we receive the required forms after the date PEBB retiree insurance coverage is to begin, you and your enrolled dependents will be enrolled in UMP Classic during the gap months prior to when the MAPD plan begins.

Premera Blue Cross Medicare Supplement Plan G lets you use any Medicare-contracted physician or hospital nationwide. This plan supplements your Original Medicare coverage by reducing most of your out-of-pocket expenses. It pays most coinsurance and copays covered by Medicare. Plan G offers nationwide coverage and is accepted by any provider who accepts Medicare. If you choose Plan G, any enrolled members who are not eligible for Medicare will be enrolled in UMP Classic.

Good to know!

If you enroll in Premera Medicare Supplement Plan G, you must submit Form B along with your enrollment or change form. Plan G does not include prescription drug coverage. If you choose this plan, you may have to enroll in a standalone Medicare Part D plan to get your prescriptions, unless you have other creditable prescription drug coverage.

1 Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon. KFHPNW Medicare plans have a larger service area.

2023 PEBB retiree and continuation coverage medical plans available by county

If you move out of your medical plan's service area, you may need to change your plan. You must report your new address and any request to change your medical plan to the PEBB Program at 1-800-200-1004 no later than 60 days after you move. In addition to the locations in the table below, Premera Blue Cross, Uniform Medical Plan (except UMP Plus), and United HealthCare plans are available nationwide.

✓ Available ⊘ Unavailable 98541 Available in listed ZIP code(s) only

	Kaiser Permanente NW[1]			Kaiser Permanente WA						Premera Blue Cross	Uniform Medical Plan (UMP)					United HealthCare	
	Classic	CDHP	Senior Advantage	Classic	CDHP	Value	Medicare Advantage	Original Medicare	SoundChoice	Medicare Supplement Plans F & G	Classic	Select	CDHP	UMP Plus–Puget Sound High Value Network	UMP Plus–UW Medicine Accountable Care Network	PEBB Balance	PEBB Complete
Available to Medicare members	⊘	⊘	✓	⊘	⊘	⊘	✓	✓	⊘	✓	✓	⊘	⊘	⊘	⊘	✓	
Washington																	
Adams	⊘			⊘						✓	✓		⊘	⊘		✓	
Asotin	⊘			⊘						✓	✓		⊘	⊘		✓	
Benton	⊘			✓	✓	✓	⊘	✓	⊘	✓	✓		⊘	⊘		✓	
Chelan	⊘			⊘						✓	✓		✓	⊘		✓	
Clallam	⊘			⊘						✓	✓		⊘	⊘		✓	
Clark	✓			⊘						✓	✓		⊘	⊘		✓	
Columbia	⊘			✓	✓	✓	⊘	✓	⊘	✓	✓		⊘	⊘		✓	
Cowlitz	✓			⊘						✓	✓		⊘	⊘		✓	
Douglas	⊘			⊘						✓	✓		✓	⊘		✓	
Ferry	⊘			⊘						✓	✓		⊘	⊘		✓	
Franklin	⊘			✓	✓	✓	⊘	✓	⊘	✓	✓		⊘	⊘		✓	
Garfield	⊘			⊘						✓	✓		⊘	⊘		✓	
Grant	⊘			⊘						✓	✓		⊘	⊘		✓	
Grays Harbor	⊘			⊘	⊘	⊘	98541 98557 98559 98568	⊘	⊘	✓	✓		⊘	⊘		✓	
Island	⊘			✓	✓	✓	✓	⊘	⊘	✓	✓		⊘	⊘		✓	
Jefferson	⊘			⊘						✓	✓		⊘	⊘		✓	

1. *Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon. KFHPNW Medicare plans have a larger service area.*

	Kaiser Permanente NW[1]			Kaiser Permanente WA						Premera Blue Cross	Uniform Medical Plan (UMP)					United HealthCare	
	Classic	CDHP	Senior Advantage	Classic	CDHP	Value	Medicare Advantage	Original Medicare	SoundChoice	Medicare Supplement Plans F & G	Classic	Select	CDHP	UMP Plus–Puget Sound High Value Network	UMP Plus–UW Medicine Accountable Care Network	PEBB Balance	PEBB Complete
King		⊘		✓	✓	✓	✓	⊘	✓	✓	✓		✓	✓		✓	
Kitsap		⊘		✓	✓	✓	✓	⊘	✓	✓	✓		✓	✓		✓	
Kittitas		⊘					⊘			✓	✓		⊘	⊘		✓	
Klickitat		⊘					⊘			✓	✓		⊘	⊘		✓	
Lewis		⊘		✓	✓	✓	✓	⊘	⊘	✓	✓		⊘	⊘		✓	
Lincoln		⊘					⊘			✓	✓		⊘	⊘		✓	
Mason		⊘		✓	✓	✓	98524 98528 98546 98548 98555 98584 98588 98592	98560	⊘	✓	✓		⊘	⊘		✓	
Okanogan		⊘					⊘			✓	✓		⊘	⊘		✓	
Pacific		⊘					⊘			✓	✓		⊘	⊘		✓	
Pend Oreille		⊘					⊘			✓	✓		⊘	⊘		✓	
Pierce		⊘		✓	✓	✓	✓	⊘	✓	✓	✓		✓	✓		✓	
San Juan		⊘					⊘			✓	✓		⊘	⊘		✓	
Skagit		⊘		✓	✓	✓	✓	⊘	⊘	✓	✓		⊘	✓		✓	
Skamania	⊘	⊘	✓				⊘			✓	✓		⊘	⊘		✓	
Snohomish		⊘		✓	✓	✓	✓	⊘	✓	✓	✓		✓	✓		✓	
Spokane		⊘		✓	✓	✓	✓	⊘	✓	✓	✓		⊘	✓		✓	
Stevens		⊘					⊘			✓	✓		⊘	⊘		✓	
Thurston		⊘		✓	✓	✓	✓	⊘	✓	✓	✓		⊘	✓		✓	
Wahkiakum	⊘	⊘	98612 98647				⊘			✓	✓		⊘	⊘		✓	
Walla Walla		⊘		✓	✓	✓	⊘	✓	⊘	✓	✓		⊘	⊘		✓	
Whatcom		⊘		✓	✓	✓	✓	⊘	⊘	✓	✓		⊘	⊘		✓	
Whitman		⊘		✓	✓	✓	⊘	✓	⊘	✓	✓		⊘	⊘		✓	

1. *Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon. KFHPNW Medicare plans have a larger service area.*

	Kaiser Permanente NW[1]			Kaiser Permanente WA						Premera Blue Cross	Uniform Medical Plan (UMP)					United HealthCare	
	Classic	CDHP	Senior Advantage	Classic	CDHP	Value	Medicare Advantage	Original Medicare	SoundChoice	Medicare Supplement Plans F & G	Classic	Select	CDHP	UMP Plus–Puget Sound High Value Network	UMP Plus–UW Medicine Accountable Care Network	PEBB Balance	PEBB Complete
Yakima		⊘		✓	✓	✓	⊘	✓	⊘	✓		✓		✓	⊘	✓	
Oregon																	
Benton	97321 97330 97331 97333 97339 97370 97383 97456	97321 97330 97331 97333 97339 97370 97383 97456	97321 97330 97331 97333 97339 97370 97383				⊘			✓		✓		⊘	⊘	✓	
Clackamas		✓					⊘			✓		✓		⊘	⊘	✓	
Columbia		✓					⊘			✓		✓		⊘	⊘	✓	
Hood River	97014	97014	✓				⊘			✓		✓		⊘	⊘	✓	
Lane		✓					⊘			✓		✓		⊘	⊘	✓	
Linn	97321 97322 97335 97348 97355 97358 97360 97374 97377 97383 97389		97321 97322 97335 97355 97358 97360 97374 97383 97389				⊘			✓		✓		⊘	⊘	✓	
Marion		✓					⊘			✓		✓		⊘	⊘	✓	
Multnomah		✓					⊘			✓		✓		⊘	⊘	✓	
Polk		✓					⊘			✓		✓		⊘	⊘	✓	
Wahkiakum	⊘		98612 98647				⊘			✓		✓		⊘	⊘	✓	
Washington		✓					⊘			✓		✓		⊘	⊘	✓	
Yamhill		✓					⊘			✓		✓		⊘	⊘	✓	
All other Oregon counties		⊘					⊘			✓		✓		⊘	⊘	✓	
Idaho																	
All counties		⊘					⊘			✓		✓		⊘	⊘	✓	

1. *Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon. KFHPNW Medicare plans have a larger service area.*

2023 PEBB Medical Benefits Comparison

Use the following charts to compare the deductibles, out-of-pocket limits, per-visit out-of-pocket costs, and prescription drug costs for PEBB medical plans.

Most coinsurance does not apply until after you have paid your annual deductible unless noted that the deductible is waived. Some copays apply regardless of meeting your deductible, unless enrolled in a consumer-directed health plan (CDHP) with a health savings account. You must pay the deductible first for most covered services before copays or coinsurance apply to a CDHP.

Benefits and visit limits listed as per year are based on calendar years (January 1 through December 31). Call the plans directly for specific benefit information, including preauthorization requirements and exclusions. If anything in these tables conflicts with the plan's benefits booklet (also called evidence of coverage or certificate of coverage), the benefits booklet takes precedence and prevails.

What you pay	Managed Care and Health Management Organization (HMO) Plans					
	Kaiser Foundation Health Plan of the Northwest[1]		Kaiser Foundation Health Plan of Washington			
	Classic	CDHP	Classic	SoundChoice	Value	CDHP
Annual costs						
Medical deductible	$300/person $900/family	$1,500/person $3,000/family	$175/person $525/family	$125/person $375/family	$250/person $750/family	$1,500/person $3,000/family
Medical out-of-pocket limit	$2,500/person $5,000/family	$5,100/person $10,200/family	$2,000/person; $4,000/family		$3,000/person $6,000/family	$5,100/person $10,200/family
Prescription drug deductible	None	Combined with medical deductible	$100/person; $300/family (does not apply to Value or Tier 1 drugs)			Combined with medical deductible (does not apply to preventive drugs)
Prescription drug out-of-pocket limit	Combined with medical limit		$2,000/person; $8,000/family			Combined with medical limit
Emergency services						
Ambulance	15%		20%[2]			10%
Emergency room			$250	$75 + 15%	$300	
Hearing services						
Hearing aids	$0[2] one per ear every 60 months	$0 one per ear every 60 months	$0[2] one per ear any consecutive 60 months			$0 one per ear any consecutive 60 months
Routine annual hearing exam	$35[2]	$30	$15 ($30[3])	$0 (15%[3])	$30 ($50[3])	10%

1. Kaiser Foundation Health Plan of the Northwest offers plans in Clark and Cowlitz counties in Washington and select counties and ZIP codes in Oregon.
2. Deductible waived.
3. Specialist copay/coinsurance.

What you pay	Preferred Provider Organization (PPO) Plans			
	Uniform Medical Plan[1]			
	Classic	Plus	Select	CDHP
Annual costs				
Medical deductible	$250/person $750/family	$125/person $375/family	$750/person $2,250/family	$1,500/person $3,000/family
Medical out-of-pocket limit	$2,000/person $4,000/family		$3,500/person $7,000/family	$4,200[2]/person $8,400[2]/family
Prescription drug deductible	$100[3]/person; $300[3]/ family	None	$250[3]/person; $750[3]/ family	Combined with medical deductible
Prescription drug out-of-pocket limit	$2,000/person; $4,000/family			Combined with medical out-of-pocket limit[2]
Emergency services				
Ambulance	20%			
Emergency room	$75 + 15%		$75 + 20%	15%
Hearing services				
Hearing aids	$0 (one per ear every 5 years)[4]			$0 (one per ear every 5 years)
Routine annual hearing exam	$0[4]			15%

1. Administered by Regence BlueShield and Washington State Rx Services.
2. Not to exceed $7,000/member.
3. Applies to Tier 2 only, except covered insulins.
4. Deductible waived.

What you pay	Managed Care and Health Management Organization (HMO) Plans					
	Kaiser Foundation Health Plan of the Northwest[1]		Kaiser Foundation Health Plan of Washington			
	Classic[2]	CDHP	Classic	SoundChoice	Value	CDHP
Hospital care						
Inpatient	15%		$150/day up to $750/admission	$500/admission	$250/day up to $1,250/ admission	10%
Outpatient			$150	15%	$200	
Office visits						
Behavioral health	$25[3]	$20[3]	$15	$0	$30	10%
Preventive care (deductible waived)	$0		$0			
Primary care	$25[3]	$20[3]	$15	$0	$30	10%
Specialist	$35	$30	$30	15%	$50	
Telemedicine/virtual care	$0		$0			
Urgent care	$45	$40	$15 ($30[4])	15%	$30 ($50[4])	10%
Therapies (max number of visits/year)						
Acupuncture	$35 (Self-referred: 12 visits/year; Physician-referred: no limit)	$30 (Self-referred: 12 visits/year; Physician-referred: no limit)	$15 (12 visits/year)	$0 (12 visits/year)	$30 (12 visits/year)	10% (12 visits/year)
Chiropractic/spinal manipulations			$15 ($30[4]) (10 visits/year)	$0 (15%[4]) (10 visits/year)	$30 ($50[4]) (10 visits/year)	10% (10 visits/year)
Massage therapy	$25 (Self-referred: 12 visits/year)		$30[4] (60 combined therapy visits/ year) No NDT limit	15%[4] (16 separate visits/year)	$50[4] (60 combined therapy visits/ year) No NDT limit	10% (60 combined therapy visits/ year) No NDT limit
Physical, occupational, speech, and neurodevelopmental therapy (NDT)	$35 (60 combined visits/year)	$30 (60 combined visits/year)		15%[4] (60 combined visits/year) No NDT limit		
Vision care						
Glasses and contact lenses	Any amount over $150 every 2 years[5]		Any amount over $150 every 24 months[3]			
Routine annual eye exam	$25	$20	$15 ($30[4])	$0 (15%[4]) (deductible waived)	$30 ($50[4])	10%

1. Kaiser Foundation Health Plan of the Northwest offers plans in Clark and Cowlitz counties in Washington and select counties and ZIP codes in Oregon.
2. Deductible waived for KPNW Classic copays.
3. $0 ages 17 and under.
4. Specialist copay/coinsurance.
5. Includes contact lens fitting fee.

What you pay	Preferred Provider Organization (PPO) Plans			
	Uniform Medical Plan[1]			
	Classic	Plus	Select	CDHP
Hospital care				
Inpatient	$200/day up to $600 Professional services: 15%; 0% for behavioral health		$200/day up to $600 Professional services: 20%; 0% for behavioral health	15%
Outpatient	15%		20%	15%
Office visits				
Behavioral health	15%		20%	15%
Preventive care (deductible waived)	$0			
Primary care	15%	$0	20%	15%
Specialist	15%		20%	15%
Telemedicine/virtual care	Varies, see certificate of coverage			
Urgent care	15%		20%	15%
Therapies (max number of visits/year)				
Acupuncture	$15 (24 visits/year)			$15 after deductible (24 visits/year)
Chiropractic/spinal manipulations	$15 (24 visits/year)			$15 after deductible (24 visits/year)
Massage therapy	$15 (24 visits/year)			$15 after deductible (24 visits/year)
Physical, occupational, speech, and neurodevelopmental therapy	15% (60 combined visits/year)		20% (60 combined visits/year)	15% (60 combined visits/year)
Vision care				
Glasses and contact lenses	$0 up to the allowed amount for one pair of standard lenses and frames once every 2 years; or any amount over $150 for elective contact lenses instead of frames and lenses once every 2 years ($30 fitting fee for contact lenses)			
Routine annual eye exam	$0			

1. Administered by Regence BlueShield and Washington State Rx Services.

Prescription drug benefits

Amounts in the following tables show what you pay for prescription drugs. Under the prescription drug benefit, most copays and coinsurance do not apply until after you have paid your annual deductible unless noted that the deductible is waived.
Note: All plans cover legally required preventive prescription drugs at 100 percent of allowed amount with no deductible and you pay no more than $35 per 30-day supply for covered insulins.

Drug tiers	Kaiser Foundation Health Plan of the Northwest[1]			
	Retail (up to 30-day supply)		**Mail-order** (up to 90-day supply)	
	Classic	CDHP	Classic	CDHP
Generic	$15		$30	
Preferred brand-name	$40		$80	
Non-preferred brand-name	$75		$150	
Specialty	50% up to $150		Not covered	

Drug tiers	Kaiser Foundation Health Plan of Washington							
	Retail (up to 30-day supply)				**Mail-order** (up to 90-day supply)			
	Classic	SoundChoice	Value	CDHP	Classic	SoundChoice	Value	CDHP
Value	$5			N/A	$10			N/A
Preferred generic	$20	$15	$25	$20	$40	$30	$50	$40
Preferred brand-name	$40	$60	$50	$40	$80	$120	$100	$80
Non-preferred generic and brand-name	50% up to $250	50%		50% up to $250	50% up to $750	50%		50% up to $750
Preferred specialty	Not covered	$150		Not covered	Not covered			
Non-preferred specialty		50% up to $400						

Drug tiers	Uniform Medical Plan[2]							
	Retail and mail order (up to 30-day supply)				**Retail and mail order** (up to 90-day supply)			
	Classic	Plus	Select	CDHP	Classic	Plus	Select	CDHP
Value	5% up to $10			15%; covered insulins 5% up to $10	5% up to $30			15%; covered insulins 5% up to $30
Tier 1 (Primarily low-cost generic)	10% up to $25			15%; covered insulins 10% up to $25	10% up to $75			15%; covered insulins 10% up to $75
Tier 2 (Preferred brand-name, high-cost generic, and specialty drugs)	30% up to $75; covered insulins 30% up to $35			15%; covered insulins 30% up to $35	30% up to $225; covered insulins 30% up to $105			15%; covered insulins 30% up to $105

1. Kaiser Foundation Health Plan of the Northwest offers plans in Clark and Cowlitz counties and ZIP codes in Washington and select counties in Oregon.
2. Administered by Regence BlueShield and Washington State Rx Services.

2023 PEBB Medicare Plan Comparison

Use the following charts to compare the per-visit costs for some in-network benefits, as well as prescription drug costs for PEBB Medicare 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. If anything in these tables conflicts with the plan's benefits booklet (also called evidence of coverage or certificate of coverage), the benefits booklet takes precedence and prevails.

Kaiser Permanente NW and Kaiser Permanente WA offer Medicare Advantage plans, but not in all areas. Premera Blue Cross offers Medicare Supplement Plan F and Medicare Supplement Plan G. Plan F is closed to new enrollees as of January 1, 2020. **Note:** All PEBB Medicare plans cover hospital, primary and specialist care, as well as outpatient surgery. You can compare each plan's additional benefits in the tables below.

What you pay	Original Medicare			Medicare Advantage			Medicare Supplement
	Uniform Medical Plan[1]	Kaiser Foundation Health Plan of Washington		Kaiser Foundation Health Plan of the Northwest[2]	UnitedHealthcare		Premera Blue Cross
	Classic	Original Medicare	Medicare Advantage	Senior Advantage	PEBB Balance	PEBB Complete	Plan G
Annual costs							
Medical deductible	$250/person $750/family	$250/person $750/family	$0	$0	$0		Part B deductible: $226/person
Medical out-of-pocket limit	$2,500/person $5,000/family	$2,000/person $4,000/family	$2,500/person	$1,500/person	$2,000/person	$500/person	$226/person
Prescription drug deductible	$100[4]/person, $300[4]/family	None		None	$100 (tiers 2, 3, and 4)	$100 (tiers 2, 3, and 4)	N/A
Prescription drug out-of-pocket limit	$2,000/person, $4,000/family	Combined with medical out-of-pocket limit	None	None	$2,000/person	$2,000/person	N/A
Emergency services							
Ambulance	20%	20%[3]	$150	$50	$100	$0	$0
Emergency room	$75 + 15%	$250	$65	$50	$65	$65	$0
Hearing services							
Hearing aids	$0 one per ear every 5 years[3]	Any amount over $1,400 per ear any consecutive 60 months[3]		Any amount over $1,400 per ear every 60 months	Any amount over $2,500 every 5 years (only from UnitedHealthcare Hearing)		Not covered
Routine annual hearing exam	$0[3]	$15 (primary care) $30 (specialist)	$15 (primary care) $30 (specialist)	$35	$0	$0	Medicare-covered only

1. Administered by Regence BlueShield and Washington State Rx Services.
2. Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon. KFHPNW Medicare plans have a larger service area.
3. Deductible waived.
4. Applies to Tier 2 only, except covered insulins.

What you pay	Original Medicare	Medicare Advantage					Medicare Supplement
	Uniform Medical Plan[1]	Kaiser Foundation Health Plan of Washington		Kaiser Foundation Health Plan of the Northwest[2]	UnitedHealthcare		Premera Blue Cross
	Classic	Original Medicare	Medicare Advantage	Senior Advantage	PEBB Balance	PEBB Complete	Plan G
Hospital care							
Inpatient	$200/day up to $600/admission[3]	$150/day up to $750/admission	$200/day for first 5 days up to $1,000/admission	$500/admission	$500/admission	$0	$0
Outpatient	15%	$150	$200	$50	$250	$0	
Office visits							
Behavioral health	15%	$15		$25	$30 (individual) $15 (group)	$0	$0
Preventive care[4]	$0	$0		$0	$0		
Primary care	15%	$15		$25	$15	$0	
Specialist		$30		$35	$30	$0	
Urgent care		$15 (primary care) $30 (specialty)		$35	$15		
Telemedicine/ virtual care	15%	$0		$0	See note[5]	$0	$0

1. Administered by Regence BlueShield and Washington State Rx Services.
2. Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon. KFHPNW Medicare plans have a larger service area.
3. Professional services: 15%; 0% for behavioral health.
4. Deductible waived.
5. $0 for Doctor on Demand, AmWell, or Teledoc; $15 for other providers; $30 for behavioral health.

What you pay	Original Medicare			Medicare Advantage			Medicare Supplement
	Uniform Medical Plan[1]	Kaiser Foundation Health Plan of Washington		Kaiser Foundation Health Plan of the Northwest[2]	UnitedHealthcare		Premera Blue Cross
	Classic	Original Medicare	Medicare Advantage	Senior Advantage	PEBB Balance	PEBB Complete	Plan G
Therapies (max number of visits/year)							
Acupuncture	$15 (24 visits/year)	$15 (12 visits/year)	$15 (12 visits/year)	$35 (12 self-referred visits/year)[3]	$15 (24 visits/year)	$0 (24 visits/year)	Medicare-covered only
Chiropractic/ spinal manipulations	$15 (24 visits/year)	$15 (12 visits/year)	$15 (12 visits/ year for non-spinal, unlimited for spinal)	$35 (12 self-referred visits/year)[4]	$15 (24 visits/year)	$0 (24 visits/year)	
Massage therapy	$15 (24 visits/year)	$30 (60 visits/ year combined; no limit for NDT)	$30 (10 specialist visits)	$25 (12 self-referred visits/year)	$15 (30 visits/year)	$0 (30 visits/year)	Not covered
Physical, speech, occupational, and neurodev. therapy (NDT)	15% (60 visits/ year combined)		$30	$35	$15	$0	$0
Vision care							
Glasses and contact lenses	$0 up to $150 every 24 months	$0 up to $150 every 24 months	$0 up to $300 every 24 months	$0 up to $150 every 2 years	Any amount over $300 every 24 months		Medicare-covered only
Routine annual eye exam	$0	$15 (primary care) $30 (specialist)	$15 (optometry) $30 (ophthalmology)	$25	$0	$0	

1. Administered by Regence BlueShield and Washington State Rx Services.
2. Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon. KFHPNW Medicare plans have a larger service area.
3. $20 each for up to 12 physician-referred visits in 90 days for chronic low back pain, additional visits 20/year.
4. Additional visits with prior authorization; no visit limit for physician-referred.

Prescription drug benefits comparison

Amounts in the following tables show what you pay for prescription drugs. Under the prescription drug benefit, most copays and coinsurance do not apply until after you have paid your annual deductible unless noted that the deductible is waived.
For all plans, you pay no more than $35 per 30-day supply for covered insulins.
Note: Premera Blue Cross Medicare Supplement Plan G does not cover prescription drugs.

Drug tiers	Uniform Medical Plan[1]	
	Retail and mail-order (up to 30-day supply)	**Retail and mail-order** (up to 90-day supply)
Value tier	5% up to $10 (deductible waived)	5% up to $30 (deductible waived)
Tier 1 (primarily low-cost generic)	10% up to $25 (deductible waived)	10% up to $75 (deductible waived)
Tier 2 (preferred brand-name, high-cost generic, and specialty drugs)	30% up to $75; covered insulins 30% up to $35	30% up to $225; covered insulins 30% up to $105

Drug tiers	Kaiser Foundation Health Plan of Washington			
	Retail (up to 30-day supply)		**Mail-order** (up to 90-day supply)	
	Original Medicare	Medicare Advantage	Original Medicare	Medicare Advantage
Value tier	$5	N/A	$10	N/A
Tier 1 (preferred generic)	$20		$40	$40
Tier 2 (preferred brand)	$40		$80	$80
Tier 3 (non-preferred generic and brand-name drugs)	50% up to $250		50% up to $750	

Drug tiers	Kaiser Permanente NW	
	Retail (up to 30-day supply)	**Mail-order** (up to 90-day supply)
Generic	$20	$40
Preferred brand-name	$40	$80
Non-preferred brand name	50% up to $200	50% up to $400
Specialty	50% up to $200	N/A

Drug tiers	UnitedHealthcare			
	Retail (up to 30-day supply)		**Mail-order** (up to 90-day supply)	
	PEBB Balance	PEBB Complete	PEBB Balance	PEBB Complete
Tier 1: Preferred generic	$5		$10	
Tier 2: Preferred brand	$45		$90	
Tier 3: Non-preferred	$100		$200	
Tier 4: Specialty	$100 (limited to 30-day supply)		$100 (limited to 30-day supply)	

1. Administered by Regence BlueShield and Washington State Rx Services.
2. Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon. KFHPNW Medicare plans have a larger service area.

Choosing a PEBB dental plan

To enroll in dental, you must enroll in medical. You and any dependents must enroll in the same PEBB dental plan. If you terminate dental coverage for your dependents, they will also lose medical coverage.

Before you enroll, check with the plan (not your dentist) to make sure your provider is in the plan's network and group. The table below lists the dental plans' network and group numbers.

To find a provider, visit the dental plans' online directories, or contact them using phone numbers listed in the front of this booklet.

How do the DeltaCare and Willamette Dental Group plans work?

DeltaCare and Willamette Dental Group are managed-care plans. You must choose and receive care from a primary care dentist (PCD) in that plan's network. Your PCD must give you a referral to see a specialist. You may change network providers at any time. If you seek services from a dentist not in the plan's network, these plans will not pay your 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. When you receive dental services, you pay a set amount called a copay. Neither plan has an annual maximum that they pay for covered benefits, with some exceptions.

How does Uniform Dental Plan (UDP) work?

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 preferred provider, your out-of-pocket expenses are generally lower than if you chose a provider who is not part of this network or just a participating provider.

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 member, including preventive visits.

Dental plan options

Make sure you contact the dental plan before you enroll 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	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	WA82
Uniform Dental Plan (UDP)	Preferred-provider plan	Delta Dental of Washington	Delta Dental PPO	Group 3000

2023 PEBB Dental Benefits Comparison

The chart below shows what you pay for dental services. Before you select a plan or provider, compare dental plans to find out what services are covered, which providers are in-network, and your costs for care. For information on specific benefits and exclusions, refer to the plan's certificate of coverage (COC) or contact the plan directly. If anything in these charts conflict with the plan's COC, the COC takes precedence and prevails.

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.

Uniform Dental Plan is a preferred-provider organization (PPO) plan. You can choose any dental provider and change providers at any time. You must meet the deductible before the plan pays for most services under this plan.

All dental plans include a nonduplication of benefits clause, which applies when you have dental coverage under more than one account.

Cost of Benefits (What you pay)	**Managed Care Plans**		**Preferred Provider Organization (PPO)**	
	DeltaCare (Group 3100)	**Willamette Dental Group**[1] (Group WA82)	**Uniform Dental Plan** (Group 3000 Delta Dental PPO)	
			PPO and out-of-state	**Non-PPO**
Annual Costs				
Deductible	None		You pay $50/person, $150/family	
Annual maximum	None		You pay amounts over $1,750	
Services				
Crowns	$100 to $175		50%	60%
Dentures	$140 for complete upper or lower		50%	60%
Fillings	$10 to $50		20%	30%
Nonsurgical TMJ	30% of costs, then any amount after plan has paid $1,000 per year, then any amount over $5,000 in member's lifetime	Any amount after plan has paid $1,000 per year, then any amount over $5,000 in member's lifetime	30% of costs until plan has paid $500, then any amount over $500 in member's lifetime	
Oral surgery	$10 to $50 to extract a tooth		20%	30%
Orthodontia	Up to $1,500 copay per case		50% of costs until plan has paid $1,750, then any amount over $1,750 in member's lifetime (deductible doesn't apply)	
Orthognathic surgery	30% of costs until plan has paid $5,000, 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)	$15 to $100		20%	30%
Preventive services	$0		$0 (deductible doesn't apply)	20%
Root canals (endodontics)	$100 to $150		20%	30%

1 Underwritten by Willamette Dental of Washington, Inc. Managed care plan.

Retiree term life insurance

Can I buy life insurance when I retire?

You may be eligible to purchase retiree term life insurance through Metropolitan Life Insurance Company (MetLife). Retiree term life insurance is available to subscribers who meet the eligibility and procedural requirements described in WAC 182-12-209. Retiree term life insurance is only available to those who:

- Meet the PEBB Program's retiree eligibility requirements.
- Had life insurance through the PEBB or SEBB Program as an employee.
- Are not on a waiver of premium due to disability.
- Submit the forms listed under "How do I enroll?" below by the deadline.

Your dependents are not eligible. **You cannot have a break in life insurance coverage.**

How do I enroll?

Submit the *PEBB Retiree Election Form* (form A) and the *MetLife Enrollment/Change Form for Retiree Plan* to apply for PEBB retiree term life insurance. These forms are available on HCA's website at **hca.wa.gov/pebb-retirees**. We must receive them **no later than 60 days** after your PEBB or SEBB employee basic life insurance ends. For elected or full-time appointed officials described in WAC 182-12-180(1), we must receive the required forms **no later than 60 days** after you leave public office.

Choose your payment method for retiree term life insurance on Form A. You will make monthly premium payments directly to MetLife for your coverage. If you wish to change your payment method in the future, call MetLife. If you enroll when you become eligible and pay premiums on time, your coverage is effective the first day of the month after the date your PEBB or SEBB employee basic life insurance coverage ends.

How much can I buy?

Eligible retirees can buy $5,000, $10,000, $15,000, or $20,000 of PEBB retiree term life insurance coverage.

How do I continue my employee life insurance coverage?

If your PEBB or SEBB employee life insurance ends due to retirement, you may have an opportunity to continue all or part of your coverage through "portability" or "conversion." When porting or converting, your coverage will become an individual policy that is not tied to the PEBB or SEBB Program. If you are eligible for these options, MetLife will send you information and an application. For more information, contact MetLife. PEBB employees should call 1-866-548-7139, and SEBB employees should call 1-833-854-9624.

Whom can I name as my beneficiary?

You may name any beneficiary you wish. If you die with no named living beneficiary, payment will be made as described in the certificate of coverage. To learn more, either go to the MetLife website at **mybenefits.metlife.com/wapebb** or call 1-866-548-7139.

How do my survivors file a claim?

If you die, your beneficiary should call MetLife at 1-866-548-7139. They 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 retiree term life insurance certificate?

The information in this guide is only a summary of PEBB retiree term life insurance. For more information, or to get a copy of the insurance certificate, call MetLife Customer Service at 1-866-548-7139 or visit the MetLife website at **metlife.com/wshca-retirees**.

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

Yes. You have the option to convert your retiree term life insurance if coverage ends because this group policy ends (as long as you've been enrolled for at least five straight years) or is reduced because of a policy change. You may also convert if this group policy changes to end life insurance for a class of people of which you are a member. If you decide not to convert your retiree term life insurance as described above, you will not have the option to do so later. Call MetLife at 1-866-548-7139 for details.

What happens to my retiree term life insurance if I start working again?

If you are enrolled in retiree term life insurance and return to work, becoming eligible for the employer contribution toward PEBB or SEBB employee basic life insurance, you can choose whether to keep or terminate your retiree term life insurance.

If you terminate retiree term life insurance when you return to work, you may be eligible to elect it again when your PEBB or SEBB employee basic life insurance ends. If you wish to enroll in retiree term life insurance at that point, we must receive the required forms within the timelines described in WAC 182-12-209.

If you become eligible for employee life insurance, enroll on the MetLife website at **metlife.com/wshca-retirees**, and call them with any questions. PEBB employees should call 1-866-548-7139. School employees should call 1-833-854-9624. You should also notify the PEBB Program at 1-800-200-1004 so we can update your records.

Legacy retiree life insurance plan premiums (administered by MetLife[1])

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[1])

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

1 Metropolitan Life Insurance Company

For retirees who are not enrolled in Medicare Part A and Part B, SmartHealth is included in your benefits. SmartHealth is a voluntary wellness program that supports you on your journey toward living well. Participate in activities to help support your whole person well-being, such as managing stress, building resiliency, and adapting to change. As you progress on your wellness journey, you can qualify for the SmartHealth wellness incentive each year.

Who is eligible?

Generally, a subscriber and their spouse or state-registered domestic partner enrolled in PEBB medical coverage can use SmartHealth. However, only the subscriber can qualify for the wellness incentive.

Are there exceptions?

If you defer PEBB retiree insurance coverage, you will not have access to SmartHealth. Subscribers enrolled in Medicare Part A and Part B are not eligible to participate in SmartHealth.

What is the wellness incentive?

Each year, eligible subscribers can qualify for a $125 wellness incentive. How you receive the $125 depends on the type of medical plan you enroll in.

- For a PEBB consumer-directed health plan (CDHP): a one-time deposit of $125 into the subscriber's health savings account (HSA).
- For all other PEBB medical plans: A $125 reduction to the subscriber's medical plan deductible for next year.

When do I get the wellness incentive?

If you (the subscriber) qualify for the $125 wellness incentive in 2023, you will receive the SmartHealth incentive at the end of January 2024 if you are still eligible to participate in the PEBB wellness incentive program and you are enrolled in PEBB medical as your primary coverage on January 1, 2024.

If you are enrolled in Medicare Part A and Part B as your primary coverage on January 1, 2024, you will not receive the incentive, even if you qualified for it in 2023.

How do I qualify for the wellness incentive each year?

You must:

- Be eligible as described above.
- Log in to SmartHealth at **smarthealth.hca.wa.gov**.
- Complete the SmartHealth well-being assessment. It takes about 15 minutes and is worth 800 points.
- Join and track more activities to earn at least 2,000 total points by your deadline.

What if I can't complete the activities?

SmartHealth will provide an alternate requirement that will allow the subscriber to qualify for the wellness incentive or waive the requirement.

Where do I go to get started?

Log in to SmartHealth at **smarthealth.hca.wa.gov**.

When is my deadline?

Your deadline to qualify for the $125 wellness incentive depends on the date your PEBB medical coverage becomes effective:

- If you are already enrolled in a PEBB medical plan, your deadline is November 30, 2023.
- If you are a new subscriber with a PEBB medical plan effective date of January through September 2023, your deadline is November 30, 2023.
- If you are a new subscriber with a PEBB medical plan effective date of October through December 2023, your deadline is December 31, 2023.

What if I don't have internet access?

Call SmartHealth Customer Service at 1-855-750-8866, Monday through Friday, 7 a.m. to 7 p.m. (Pacific) to learn more.

Who can I contact for more help?

For technical questions about using SmartHealth, contact Customer Service:

- Call 1-855-750-8866, 7 a.m. to 7 p.m. (Pacific), Monday through Friday
- Email **support@limeade.com**

To find the details about SmartHealth online, go to the HCA website at **hca.wa.gov/pebb-smarthealth**.

Auto and home insurance

The PEBB Program offers voluntary auto and home insurance through its agreement with Liberty Mutual Insurance Company.

What does Liberty Mutual offer?

As a PEBB member, you 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 retirees), electronic funds transfer, 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 anytime.

How do I enroll?

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

- 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 list below).
- Visit Liberty Mutual's website at **libertymutual.com/pebbretirees**.
- Look for auto/home insurance under *Life, auto & home benefits* on the HCA website at **hca.wa.gov/pebb-retirees**.

If you are already a Liberty Mutual policyholder and would like to take advantage of this group discount, call one of the local offices to find out how they can convert your policy at your next renewal.

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)

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

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

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

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

Outside Washington
1-800-706-5525

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
PO Box 45504
Olympia, WA 98504-5504

Fax
360-763-4709

Use the guide below to find instructions for filing your appeal. You will find more help on filing an appeal in chapter 182-16 WAC and on the HCA website at **hca.wa.gov/pebb-appeals**. If you have questions, please call the PEBB Appeals Unit at 1-800-351-6827.

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

You must provide us with an *Authorization for Release of Information* form naming your representative, or a copy of a valid power of attorney (and a doctor's note, if the power of attorney requires it) 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 on the HCA website at **hca.wa.gov/pebb-appeals** or by calling the PEBB Program at 1-800-200-1004.

Instructions and submission deadlines

If you are:

- An applicant for PEBB retiree insurance coverage
- A retiree
- A survivor of a deceased employee or retiree as described in WAC 182-12-265 or 182-12-180
- A survivor of an emergency service person killed in the line of duty as described in WAC 182-12-250
- The dependent of one of the above

And your appeal concerns

A decision from the PEBB Program about:

- Eligibility for benefits
- Enrollment
- Premium payments
- Premium surcharges
- Eligibility to participate in SmartHealth or receive a wellness incentive

Instructions

Complete the *PEBB Retiree/Continuation Coverage Notice of Appeal* form and submit it to the PEBB Appeals Unit as instructed above. The PEBB Appeals Unit must receive the form no later than 60 calendar days after the date of the denial notice regarding the decision you are appealing.

If you are:

Seeking a review of a decision by a PEBB medical or dental plan, insurance carrier, or benefit administrator

And your appeal concerns:

The administration of the medical, dental, or benefit plan about a benefit or claim

Instructions

Contact the medical or dental plan, insurance carrier, or benefit administrator to request information on how to appeal the decision. Do not use the *PEBB Retiree/Continuation Coverage Notice of Appeal* form.

Which retiree forms should I complete?

Please use dark ink to complete the forms. If you need forms, visit HCA's website at **hca.wa.gov/pebb-retirees** and click on *Forms & publications*.

Enrolling when first eligible or after deferring (postponing) coverage

Use the *PEBB Retiree Election Form* (form A).

1. Check the *PEBB Medical Plans Available by County* to find the plans available to you based on your home address.
2. Find your chosen medical plan in the table on the next page. Complete the forms listed there in addition to Form A. Include all eligible dependents you wish to enroll.
3. Submit the forms to the PEBB Program. We must receive your forms and any other requested documents, such as proof of dependent eligibility, by the deadline.

Need help with Form A?

Check out our online tutorial for Form A on HCA's website at **hca.wa.gov/forma-tutorial**. It walks you through the form at your own pace while offering specific help for each section.

Deferring (postponing) enrollment when you're first eligible

Use the *PEBB Retiree Election Form* (form A). Submit the form to the PEBB Program. We must receive it by the deadline.

Making changes to your existing account

Use the *PEBB Retiree Change Form* (form E).

1. If you are changing medical plans, check the *PEBB Medical Plans Available by County* to make sure the new plan is available based on your home address.
2. Find your chosen medical plan in the table **on the next page**. Complete the forms listed there in addition to Form E. Include all dependents you wish to enroll or continue covering.
3. Submit the forms and any other requested documents to the PEBB Program by the deadline.

Deferring or terminating coverage after you have already enrolled

Use the *PEBB Retiree Change Form* (form E). If deferring, you must maintain continuous enrollment in qualifying medical coverage if you wish to enroll in a PEBB retiree health plan in the future.

1. Complete sections 1, 2, and 8 on Form E. If you or a dependent is enrolled in a Medicare Advantage plan, also complete the *PEBB Medicare Advantage Plan Disenrollment Form* (form D).
2. Submit the forms to the PEBB Program.

First, find the action you are taking. Then find your plan and submit the forms listed.

If you are enrolling or deferring when you first become eligible, or enrolling after deferring

Use Form A only to enroll in these plans or defer

- Kaiser Permanente NW[1] Classic or Consumer-Directed Health Plan (CDHP)
- Kaiser Permanente WA Classic, CDHP, Original Medicare, SoundChoice, or Value
- Uniform Medical Plan (UMP) Classic, UMP Select, or UMP CDHP
- UMP Plus–Puget Sound High Value Network (PSHVN) or UMP Plus–UW Medicine Accountable Care Network (ACN)

Use Form A only to enroll in these plans

- Kaiser Permanente NW[1] Senior Advantage
- Kaiser Permanente WA Medicare Advantage
- UnitedHealthcare PEBB Balance or UnitedHealthcare PEBB Complete

Use Forms A and B to enroll in this plan

- Premera Blue Cross Medicare Supplement Plan G

If you are making changes, deferring, or terminating coverage (after you have already enrolled)

Use Forms E and D to terminate from these plans, remove a dependent, or defer

- Kaiser Permanente NW[1] Senior Advantage
- Kaiser Permanente WA Medicare Advantage
- UnitedHealthcare PEBB Balance or UnitedHealthcare PEBB Complete

Use Form E to make changes or switch to these plans, terminate coverage, or defer

- Kaiser Permanente NW[1] Classic or CDHP
- Kaiser Permanente WA Classic, CDHP, Original Medicare, SoundChoice, or Value
- UMP Classic, UMP Select, or UMP CDHP
- UMP Plus–PSHVN or UMP Plus–UW Medicine ACN

Also include Form D if switching out of Kaiser Permanente WA Medicare, Kaiser Permanente NW Senior Advantage, UnitedHealthcare PEBB Balance, or UnitedHealthcare PEBB Complete.

Use Form E to make changes or switch to these plans

- Kaiser Permanente NW[1] Senior Advantage
- Kaiser Permanente WA Medicare Advantage
- UnitedHealthcare PEBB Balance or PEBB Complete

Use Forms E and B to make changes or switch to this plan

- Premera Blue Cross Medicare Supplement Plan G

Also include Form D if switching out of Kaiser Permanente WA Medicare or Kaiser Permanente NW Senior Advantage, UnitedHealthcare PEBB Balance, or UnitedHealthcare PEBB Complete.

You may need to submit additional forms to enroll dependents. Learn more and find a list of documents we will accept to prove their eligibility on HCA's website at **hca.wa.gov/pebb-retirees**.

1 Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon. KFHPNW Medicare plans have a larger service area.

Forms links

Below are links to the forms that are found in the print version of this enrollment guide.

EDS Agreement (42 -0450)

Retiree Election Form A (51-4031)

MetLife Enrollment/Change Form for Retiree Plans

Medicare Advantage Plan Disenrollment Form (51-0556)

Premera Form B

Premium Surcharge Help Sheet (50-0226)