Your PEBB Benefits for 2018

Employee Enrollment Guide

Forms Inside

Washington State Health Care Authority

PUBLIC EMPLOYEES BENEFITS BOARD

HCA 50-100 (11/17)

Washington State Health Care Authority

PUBLIC EMPLOYEES BENEFITS BOARD

Now serving

Great coverage. Great networks of care. Great price.

The providers in the plans below have committed to:

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

What does this mean for you?

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

Great value menu

	Monthly premiums for subscriber/full family	Annual medical deductible for subscriber/full family
Kaiser Permanente NW*		
Classic	$137 / $387	$300 / $900
Consumer-Directed Health Plan (CDHP) with a health savings account	$27 / $84	$1,400 / $2,800
Kaiser Permanente WA (formerly Group Health)		
Classic	$162 / $456	$175 / $525
Consumer-Directed Health Plan (CDHP) with a health savings account	$25 / $79	$1,400 / $2,800
SoundChoice	$51 / $150	$250 / $750
Value	$78 / $225	$250 / $750
UMP Plus		
Puget Sound High Value Network	$45 / $134	$125 / $375
UW Medicine Accountable Care Network	$45 / $134	$125 / $375

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

Before you enroll...

1. Find out which medical plans serve the county you live in (see pages 31–32).
2. Contact the plan or check their provider directory to make sure your providers are in the plan's network (see page 2).
3. Ready to pick a plan? Submit a completed *Employee Enrollment/ Change* form to your personnel, payroll, or benefits office **no later than 31 days** after becoming eligible for PEBB benefits.

Contact the Plans

Medical Plans	Website addresses	Customer service phone numbers	TTY customer service phone numbers for deaf, hard of hearing, or speech impaired
Kaiser Permanente NW Classic or CDHP*	**https://my.kp.org/wapebb**	503-813-2000 or 1-800-813-2000	711
Kaiser Permanente WA (formerly Group Health) **Classic, SoundChoice, or Value**	**www.kp.org/wa/pebb**	206-630-4636 or 1-888-901-4636	711 or 1-800-833-6388
Kaiser Permanente WA (formerly Group Health Options, Inc.) **CDHP**	**www.kp.org/wa/pebb**	206-630-4636 or 1-888-901-4636	711 or 1-800-833-6388
Uniform Medical Plan Classic or CDHP, administered by Regence BlueShield	**www.hca.wa.gov/ump**	1-888-849-3681	711
UMP Plus—Puget Sound High Value Network	**www.pugetsound highvaluenetwork.org** **www.hca.wa.gov/ump/ plan-ump-plus**	1-855-776-9503	711
UMP Plus—UW Medicine Accountable Care Network	**www.uwmedicine.org/umpplus** **www.hca.wa.gov/ump/ plan-ump-plus**	1-855-520-9500	711

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

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

Blue ink indicates information only for subscribers who have PEBB dental, life, and long-term disability coverage.

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

Contact the plans for help with:

- Specific benefit questions.
- Verifying if your doctor or other provider contracts with the plan.
- Verifying if your medications are in the plan's drug formulary.
- ID cards.
- Claims.

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

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

The PEBB Program is saving the green

Help reduce our reliance on paper mailings—and their toll on the environment—by signing up to receive PEBB mailings by email.

To sign up, go to **www.hca.wa.gov/pebb** and select the green *My Account* button.

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

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

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HCA is committed to providing equal access to our services. If you need an accommodation, or require documents in another format, please call 1-800-200-1004. People who have hearing or speech disabilities please call 711 for relay services.

Blue ink indicates information only for subscribers who have PEBB dental, life, and long-term disability coverage.

How to "Shop the Guide"

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

Medical and dental plans

- ❑ Find the medical plans available in your county of residence. See pages 31–32. **Note:** PEBB dental plans do not require that you live in their service areas to enroll.
- ❑ Compare the medical plans' premiums (the amount you pay each month for medical coverage). See page 24.
- ❑ Compare the medical and dental plans' benefits, and your costs when you receive care. See pages 33–38 and page 40. Determine if the medical plan is a value-based plan, which rewards providers for high-quality care and patient satisfaction. **Note:** Kaiser Permanente NW, Kaiser Permanente WA, and UMP Plus plans are value-based plans.
- ❑ Once you've narrowed your plan choices, find providers in the plans' networks (or make sure your current providers, medical groups and hospitals are in the plans' networks). Ask the providers if they:
  - Are in the plan's network.
  - Commit to following best practices for treating patients.
  - Coordinate care with other providers in your plan's network.
  - Are expected to meet certain measures about the quality of care they provide.
  - Go to **www.hca.wa.gov/pebb** under 'Find a provider' for links to the plans' online provider directories, or see pages 2 and 3 for the plans' customer service phone numbers.
- ❑ Compare the medical plans on other features that may be important to you, such as:
  - Access to virtual care or a 24/7 nurse advice line.
  - Online access to your provider and medical records.
  - Extended office hours for providers.
  - Whether your medications are in the plan's formulary. See page 2 for the plans' websites and customer service. Also see pages 27–30 for information on selecting a plan.

Own Your Health

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

Optional life and accidental death and dismemberment (AD&D) insurance

- ❑ Review the optional life and AD&D insurance options and premiums. If you decide to enroll, you will need to name a beneficiary. See pages 41–42. **Note:** If your employer offers life and AD&D Insurance, you will be automatically enrolled in basic life and AD&D insurance at no cost to you.

Optional Long-term disability (LTD) insurance

- ❑ Review the LTD insurance options and premiums. See pages 43–44. **Note:** If your employer offers long-term disability insurance, you will be automatically enrolled in basic long-term disability insurance at no cost to you.

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

If you don't enroll in PEBB benefits by this deadline, you will be enrolled as a single subscriber in Uniform Medical Plan Classic, Uniform Dental Plan, basic life insurance, and basic LTD insurance.

Note: Deadlines and time limits depend on when your personnel, payroll, or benefits office, or applicable contracted vendor receives your form or information, regardless of when you send it.

Eligibility Summary

Who's eligible for PEBB insurance coverage?

This guide provides a general summary of employee eligibility for benefits administered by the PEBB Program. Your employer will determine if you are eligible for PEBB benefits based on your specific employment circumstances, and whether you qualify for the employer contribution (see WAC 182-12-114 and 182-12-131). Please contact your employer's personnel, payroll, or benefits office for when benefits begin once you are eligible. If you disagree with the determination, see "How can I appeal a decision?" on page 22.

Find it here

For complete details on PEBB eligibility and enrollment, refer to Washington Administrative Code (WAC) Chapter 182-12 at **www.hca.wa.gov/public-employee-benefits/rules-and-policies**.

Employees (other than higher-education faculty)

Employees (referred to in this booklet as "employees," "subscribers," or in some cases, "enrollees") are eligible for PEBB benefits upon employment if the employer anticipates the employee will work an average of at least 80 hours per month and is anticipated to work for at least 8 hours in each month for more than 6 consecutive months.

If the employer revises the employee's anticipated work hours, or anticipated duration of employment, and the employee will work an average of at least 80 hours per month and at least 8 hours in each month for more than 6 consecutive months, the employee becomes eligible when the revision is made.

If the employer determines the employee is ineligible, and the employee later works an average of at least 80 hours per month and at least 8 hours in each month for more than 6 consecutive months, the employee becomes eligible the first of the month following the six-month averaging period.

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

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

Employees must notify their employer if they believe they are eligible for benefits based on stacking.

Higher-education faculty

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

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

A faculty member who receives additional workload after the beginning of the anticipated work period (quarter, semester, or instructional year), such that their workload meets the eligibility criteria above, becomes eligible when the revision is made.

A faculty member may become eligible by working as faculty for more than one higher-education institution. When a faculty member works for more than one higher-education institution, the faculty member must notify both employers that he or she works at more than one institution and may be eligible for PEBB benefits through stacking.

Faculty members may continue any combination of medical, dental, and life insurance during periods when they are not eligible for the employer contribution by self-paying for benefits (for a maximum of 12 months). See WAC 182-12-142 for continuation coverage information. The employee's election to self-pay benefits must be received by the PEBB Program **no later than 60 days** from the date the health plan coverage ends or from the postmark date on the election notice sent by the HCA; whichever is later.

Seasonal employees

Seasonal employees are eligible if they are anticipated to work, or the employer anticipates they will work, an average of at least 80 hours per month and are anticipated to work for at least 8 hours in each month of at least 3 consecutive months of the season. (A season means any recurring, annual period of work at a specific time of year that lasts 3 to 11 consecutive months.)

If an employer revises a seasonal employee's anticipated work hours such that he or she meets the eligibility criteria above, the employee becomes eligible when the revision is made.

Blue ink indicates information only for subscribers who have PEBB dental, life, and long-term disability coverage.

A seasonal employee who is determined ineligible for benefits, but who later works an average of at least 80 hours per month and works for at least 8 hours in each month for more than 6 consecutive months, becomes eligible the first of the month following the 6-month averaging period.

If a seasonal employee works in more than one position or job within one state agency, the employee may stack or combine hours to establish and maintain eligibility. See WAC 182-12-114(2) for details on when a seasonal employee becomes eligible.

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

- Is eligible for the employer contribution through the off season following each season worked.
- Eligibility may not exceed a total of twelve consecutive months for the combined season and off season.

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

- Is not eligible for the employer contribution during the off season.
- Is eligible for the employer contribution in any month of the season in which they are in a pay status of 8 or more hours during that month.
- May continue enrollment between periods of eligibility for a maximum of 12 months by self-paying benefits. See WAC 182-12-142 for continuation coverage information. The employee's election to self-pay benefits must be received by the PEBB Program **no later than 60 days** from the date the health plan coverage ends or from the postmark date on the election notice sent by the HCA; whichever is later.

Elected and appointed officials

Legislators are eligible for PEBB benefits on the date their term begins. All other elected and full-time appointed officials of the legislative and executive branches of state government are eligible on the date their terms begin or the date they take the oath of office, whichever occurs first. The employee's election to self-pay benefits must be received by the PEBB Program **no later than 60 days** from the date the health plan coverage ends or from the postmark date on the election notice sent by the HCA; whichever is later.

Justices and judges

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

Can I cover my family members?

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

- **Your lawful spouse.**
- **Your state-registered domestic partner.** As defined in RCW 26.60.020(1) and substantially equivalent legal unions from other jurisdictions as defined in RCW 26.60.090.
- **Your children up to the last day of the month in which they became age 26,** except for children with a disability.

How are children defined?

Children are defined as your biological children, stepchildren, legally adopted children, children for whom you have assumed a legal obligation for total or partial support in anticipation of adoption, children of your state-registered domestic partner, children specified in a court order or divorce decree, or persons with whom you have a parent-child relationship as defined in RCW 26.26.101.

Children may also include extended dependents in your, your spouse's, or your state-registered domestic partner's legal custody or legal guardianship. An extended dependent may be your grandchild, niece, nephew, or other child for whom you, your spouse, or state-registered domestic partner have legal responsibility as shown by a valid court order and the child's official residence with the custodian or guardian. This does not include foster children for whom support payments are made to you through the state Department of Social and Health Services (DSHS) foster care program.

Eligible children with disabilities

Eligible children also include children of any age with a developmental disability or physical handicap that renders the child incapable of self-sustaining employment and chiefly dependent upon the employee for support and ongoing care, provided the condition occurred before age 26. You must provide evidence of the disability and evidence the condition occurred before age 26. The PEBB Program, with input from the health plan (if applicable), will periodically verify the disability and dependency of a child with a disability beginning at age 26, but no more than annually after the two-year period following the child's 26th birthday. If PEBB does not receive your verification within the time allowed, the child will no longer be covered and you will not be able to add the child back onto your coverage.

A child with a developmental disability or physical handicap who becomes

(continued)

self-supporting is not eligible as of the last day of the month in which he or she becomes capable of self-support. If the child becomes capable of self-support and later becomes incapable of self-support, the child does not regain eligibility as a child with a disability.

You must notify the PEBB Program in writing when your dependent with a disability is no longer eligible. The PEBB Program must receive notice **no later than 60 days** after the date your dependent is no longer eligible.

If I die, are my surviving dependents eligible?

As an eligible employee, your surviving spouse, state-registered domestic partner, or dependent child may be eligible to enroll in or defer PEBB retiree insurance coverage as a survivor if they meet both the procedural and eligibility requirements outlined in WAC 182-12-265.

A surviving spouse, state-registered domestic partner, or dependent child who meets eligibility requirements and chooses to defer may enroll in a PEBB health plan by meeting the requirements described in WAC 182-12-200 and 182-12-205.

All required forms must be received by the PEBB Program to enroll in or defer enrollment in retiree insurance coverage **no later than 60 days** after the date of the employee's death.

Verifying family member eligibility

The PEBB Program verifies the eligibility of all dependents. You must submit proof of a dependent's eligibility. The PEBB Program will not enroll a dependent if the PEBB Program cannot verify the dependent's eligibility. You can find a list of documents you must provide to verify your dependent's eligibility on page 9. Submit the required documents with your enrollment form.

If adding an extended dependent, or a dependent with a disability age 26 or older, you must complete the required dependent certification form in addition to the enrollment form and submit them to the address on the form. You can find these forms at **www.hca.wa.gov/public-employee-benefits/employees/dependent-verification**.

Valid Dependent Verification Documents

Dependent verification helps make sure the PEBB Program covers only people who qualify. If you are not enrolled in Medicare Part A and Part B and want to add family members to your coverage, you must provide verification documents to show they're eligible before they can be enrolled under your coverage.

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

Use the list(s) below to determine which verification document(s) to submit with your required form(s). If you submit a tax return, you may submit just one copy if it includes all family members that require verification, such as your spouse and children. Submit the document(s) with your enrollment form(s) within PEBB Program's enrollment timelines.

To find forms and for more information, go to **www.hca.wa.gov/public-employee-benefits/employees/how-enroll**, or contact your agency's personnel, payroll, or benefits office.

To enroll a spouse

Provide a copy of (choose one):

- Most recent year's 1040 Married Filing Jointly federal tax return that lists the spouse
- Subscriber's and spouse's most recent 1040 Married Filing Separately federal tax return
- Proof of common residence (example: a utility bill) and marriage certificate*
- Proof of financial interdependency (example: a shared bank statement—black out financial information) and marriage certificate*
- Petition for dissolution of marriage (divorce)
- Legal separation notice
- Defense Enrollment Eligibility Reporting System (DEERS) registration
- Valid J-1 or J-2 visa issued by the U.S. government

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

Include the *Declaration of Tax Status* form to enroll a non-qualified tax dependent.

Provide a copy of (choose one):

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

*If within two years of a marriage, state-registered domestic partnership or establishment of a legal union from another jurisdiction as defined in statute, only the marriage certificate or certification/card of state-registered domestic partnership is required.

To enroll children

Use the *Extended Dependent Certification* form to enroll an extended (legal) dependent child.

Provide a copy of (choose one):

- Most recent year's federal tax return that includes the child(ren) as a dependent and listed as a son or daughter
- Birth certificate (or hospital certificate with the child's footprints on it) showing the name of the parent who is the subscriber, the subscriber's spouse, or the subscriber's state-registered domestic partner**
- Certificate or decree of adoption
- Court-ordered parenting plan
- National Medical Support Notice
- Defense Enrollment Eligibility Reporting System (DEERS) registration
- Valid J-2 visa issued by the U.S. government

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

Enrollment Summary

Find it here

If you need more forms, go to **www.hca.wa.gov/public-employee-benefits/forms-and-publications** or contact your personnel, payroll, or benefits office.

For complete details on PEBB Program enrollment, refer to Chapters 182-08 and 182-12 WAC at **www.hca.wa.gov/public-employee-benefits/rules-and-policies.**

How do I enroll?

Your personnel, payroll, or benefits office must receive the following forms within the required timelines when you become eligible for PEBB benefits:

- *Employee Enrollment/Change* or *Employee Enrollment/Change for Medical Only Groups* form:
  No later than 31 days after you become eligible for PEBB benefits
- *Long Term Disability (LTD) Enrollment/Change Form:*
  No later than 31 days after you become eligible for PEBB benefits

Ask your personnel, payroll, or benefits office when your eligibility and benefits begin. See "When does coverage begin?" on page 11 for more information.

MetLife must receive the *MetLife Enrollment/Change Form* within 31 days of when you become eligible for benefits.

If you enroll family members on your PEBB insurance coverage, the PEBB Program must receive proof of their eligibility within 31 days of when you become eligible for PEBB benefits or the family members will not be enrolled (and in most cases you will not be able to enroll them until the annual open enrollment period). A list of documents we will accept as proof is on page 9.

If your personnel, payroll, or benefits office doesn't receive your completed form(s) and verification documents for your dependents (if any) within the 31-day window, we will enroll you as a single subscriber in Uniform Medical Plan (UMP) Classic, and Uniform Dental Plan (UDP), basic life insurance, and basic long-term disability (LTD) insurance (if your employer offers these coverages). If enrolled as a single subscriber due to missed timelines, you will owe medical premiums and the tobacco use premium surcharge back to your effective date of eligibility for PEBB benefits. Your dependents (if any) will not be enrolled.

You cannot change plans or enroll your eligible dependents until the next PEBB Program annual open enrollment (November 1–30), unless you have a special open enrollment event that allows the change.

For more information on enrollment timelines for life insurance, long-term disability insurance, Medical Flexible Spending Arrangement (FSA), Dependent Care Assistance Program (DCAP), and the SmartHealth Wellness Program, see pages 41–48. You can enroll in auto or home insurance at any time.

Which forms do I use?

You will find these forms in the back of this guide. If your employer offers PEBB medical, dental, life, and LTD insurance, complete those forms:

- *Employee Enrollment/Change* form (for medical and dental coverage)
- Long-Term Disability (LTD) Enrollment/Change Form (for long-term disability insurance).
- *MetLife Enrollment/Change Form* and *MetLife Beneficiary Designation form* (for life insurance) in the back of this book. If you have questions about enrollment in life insurance, please contact MetLife at 1-866-548-7139.

If your employer offers PEBB medical coverage only, complete the *Employee Enrollment/Change for Medical Only Groups*.

To enroll in other PEBB-sponsored benefits:

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

If you enroll the family members shown in the box below, you must also submit the required forms.

Am I required to enroll in this health coverage?

Employees may waive PEBB medical if they are enrolled in other employer-based group medical, TRICARE, or Medicare. You must submit the *Employee Enrollment/Change* form to waive PEBB medical. If you waive coverage for yourself, you cannot enroll your eligible dependents in PEBB medical coverage.

If your employer offers PEBB dental, basic life insurance, and basic LTD insurance, you must enroll in these coverages for yourself.

See "Waiving Medical Coverage" on page 19 for instructions and timelines for waiving PEBB medical coverage.

Additional required forms

If enrolling a ...	... then complete this form
Non-qualified tax dependent	*Declaration of Tax Status*
Dependent child with a disability	*Certification of Dependent With a Disability*
Extended (legal) dependent child	*Extended Dependent Certification*

Blue ink indicates information only for subscribers who have PEBB dental, life, and long-term disability coverage.

Can I enroll in two PEBB medical or dental plans?

A person may be enrolled in only one PEBB medical or dental plan. If you and your spouse or state-registered domestic partner are both eligible for PEBB benefits, you need to decide which of you will cover yourselves and any eligible children on your medical or dental plans. You could waive medical coverage for yourself and enroll as a dependent on your spouse's, state-registered domestic partner's, or parent's medical coverage. **However, you must enroll in dental, basic life insurance, and basic LTD insurance under your own account.** See "Waiving Medical Coverage" on page 19.

ID cards

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

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

When does coverage begin?

When newly eligible—Medical, dental, basic life insurance, and basic LTD insurance begins on the first day of the month following the date an employee becomes eligible for PEBB benefits. If the employee becomes eligible on the first working day of the month, PEBB benefits begin on that day. Contact your personnel, payroll, or benefits office for when your benefits begin, once you are eligible.

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

Annual event	When coverage begins
PEBB open enrollment (November 1–30)	January 1 of the following year
Special open enrollment events	**When coverage begins**
Marriage or establishment of a state-registered domestic partnership	The first of the month after the date of the event or the date your personnel, payroll, or benefits office receives your completed enrollment form, whichever is later. If that day is the first of the month, coverage begins on that day. Also, provide proof of your dependent's eligibility.
Birth, adoption, or assumed legal obligation for total or partial support in anticipation of adoption of a child	The date of birth (newborn children), adoption (placement), or the date you assume legal obligation for the child's support in anticipation of adoption, whichever is earlier. If you enroll yourself in order to enroll a newly born or newly adopted child, medical will begin the first day of the month in which the event occurs. If you add your eligible spouse or state-registered domestic partner to your PEBB insurance coverage due to your child's birth or adoption, his or her medical coverage begins the first day of the month in which the birth or adoption occurs. **Note:** If the child's date of birth or adoption is before the 16th day of the month, you pay the higher premium for the full month (if adding the child increases the premium). If the child's date of birth or adoption is on or after the 16th, the higher premium will begin the next month. If elected, Dependent Child Life Insurance for newborns begins on the 14th day after birth.
Child becomes eligible as an extended dependent	The first day of the month after eligibility certification.
Other events that create a special open enrollment (see pages 16–17)	The first of the month after the date of the event or the date your personnel, payroll, or benefits office receives your completed enrollment form, whichever is later. If that day is the first of the month, coverage begins on that day. Also, provide proof of the event.

Enrollment Summary

When making a change during the PEBB Program's annual open enrollment (November 1–30) or when a special open enrollment event occurs—Coverage will begin as noted in the table below. For annual open enrollment, the required form(s) and proof of your dependent's eligibility must be received no later than the last day of the annual open enrollment.

For a special open enrollment, the completed enrollment form(s) and proof of your dependent's eligibility and/or the event must be received **no later than 60 days** after the special open enrollment event. In many instances, the date you turn in your form affects the date that coverage begins; you may want to turn the form in sooner. When the special open enrollment is for birth or adoption, the required forms and proof of your dependent's eligibility and/or the event must be received as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the enrollment form and proof of your dependent's eligibility and/or the event must be received no later than 12 months after the date of birth, adoption, or the date you assume legal obligation for total or partial support in anticipation of adoption. See "What is a special open enrollment?" for more information and a list of special open enrollment events starting on page 16.

What if I'm entitled to Medicare?

Medicare Parts A and B

When you or your covered dependents become entitled to Medicare Part A and Part B, the person entitled to Medicare should contact the nearest Social Security office to ask about the advantages of immediate or deferred enrollment in Medicare Part B. Be sure you understand the Medicare enrollment timelines, especially if you will be leaving employment within a few months of becoming eligible for Medicare.

For employees and their enrolled spouses ages 65 and older, PEBB medical plans provide primary coverage, and Medicare coverage is ordinarily secondary. However, you may choose to waive your enrollment in PEBB medical and have Medicare as your coverage.

If you waive PEBB medical, you can reenroll during the PEBB Program's annual open enrollment (for coverage effective January 1 of the following year), or if you have a special enrollment event that allows the change. However, you will remain enrolled in PEBB dental, life, and long-term disability coverage.

If you retire and are eligible for PEBB retiree insurance coverage, you must enroll and maintain enrollment in Medicare Parts A and B, if entitled, to retain your PEBB retiree insurance coverage. Medicare will become the primary insurer, and PEBB medical becomes secondary.

Medicare coordination of benefits guidelines direct that state-registered domestic partners who are ages 65 and older must have Medicare as their primary insurer, if entitled.

Medicare Part B

In most situations, employees and their spouses can elect to defer Medicare Part B enrollment, without penalty, up to the date the employee terminates employment or retires. Contact your nearest Social Security office for information on deferring or reinstating Medicare Part B. Also make sure you understand the Medicare enrollment timelines.

If your entitlement is due to a disability, contact a Social Security office regarding deferred enrollment.

Medicare Part D

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

All PEBB medical plans available to employees provide creditable prescription drug coverage. This means the plans provide prescription drug benefits that are as good as or better than Medicare Part D coverage. After you become entitled to Medicare Part A and/or Part B, you can keep your PEBB coverage and not pay a late enrollment penalty if you decide to enroll in a Medicare Part D plan later. To avoid a premium penalty, you cannot be without creditable prescription drug coverage for more than 63 days.

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

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

For questions about Medicare Part D, call the Centers for Medicare & Medicaid Services at 1-800-633-4227 or visit **www.medicare.gov**.

(continued)

How much do the plans cost?

For state agency and higher-education employees, see the "2018 Monthly Premiums" on page 24. There are no employee premiums for dental, basic life insurance, and basic LTD insurance. School district, educational service district, and charter school employees, and those who work for a city, tribal government, county, port, water district, hospital, etc., must contact their personnel, payroll, or benefits office to get their monthly premiums.

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

Your premiums pay for a full calendar month of coverage. Your employer cannot prorate the premiums for any reason, including when a member dies before the end of the month.

Some subscribers must also pay a tobacco use premium surcharge and/or a spouse or state-registered domestic partner coverage premium surcharge in addition to their medical plan's monthly premium:

- A monthly $25-per-account tobacco use premium surcharge will apply if you or one of your family members (ages 13 and older) enrolled in PEBB medical uses tobacco products (or if you do not attest to the surcharge within the PEBB Program's timelines).
- A monthly $50 spouse or state-registered domestic partner coverage premium surcharge will apply if you enroll your spouse or state-registered domestic partner on your PEBB medical, and the spouse or state-registered domestic partner has chosen not to enroll in other employer-based group medical insurance that is comparable to Uniform Medical Plan (UMP) Classic. You will also pay the surcharge if you enroll your spouse or state-registered domestic partner and do not attest within the PEBB Program's timelines.

For more details on whether these surcharges will apply to you, see "Premium Surcharges" on pages 25–26.

How do I pay for coverage?

Eligible state agency and higher-education institution employees may pay medical premiums with pretax dollars from their salary under the state's premium payment plan. Internal Revenue Code Section 125 allows your employer to deduct money from your paycheck before calculating federal withholding, Social Security, and Medicare taxes. If you are not a state agency or higher-education employee, ask your personnel, payroll, or benefits office if they offer a pretax deduction benefit under their own Section 125 plan.

Why should I pay my monthly premiums with pretax dollars?

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

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

No. If you are a new employee who enrolls in a medical plan, and your employer offers this benefit, your payroll office may automatically have the premiums deducted before calculating taxes. If you do not want to pay your medical premiums with pretax earnings, your personnel, payroll, or benefits office must receive your completed *Premium Payment Plan Election/Change Form* to waive (opt out of) participation in the premium payment plan **no later than 31 days** after you become eligible for PEBB benefits (see WAC 182-08-197). The form is available from your personnel, payroll, or benefits office.

PEBB Program forms and information are available at **www.hca.wa.gov/pebb.**

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

You may change your participation under the state's premium payment plan (enroll, waive enrollment, or change election) during an annual open enrollment or a special open enrollment as described in WAC 182-08-199.

Enrollment Summary

How do I pay the premium surcharges?

Premiums and any applicable premium surcharges are automatically deducted from your paychecks before taxes unless you request otherwise. **Exception:** If you enroll a state-registered domestic partner and he or she does not qualify as an Internal Revenue Code Section 152 dependent, then the $50 monthly spouse or state-registered domestic partner coverage premium surcharge (if it applies to you) will be a post-tax deduction from your paycheck.

If you do not want your PEBB medical premiums or applicable premium surcharges paid with pretax earnings, you must complete and submit the *Premium Payment Plan Election/Change Form* to your personnel, payroll, or benefits office **no later than 31 days** after you become eligible for PEBB benefits.

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

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

- **Social Security**—If your base salary is under the annual maximum, Section 125 participation saves you money now by reducing your Social Security taxes. However, your lifetime Social Security benefit would be calculated using the lower salary. The 2018 annual maximum is $128,700.
- **Unemployment compensation**—Section 125 also reduces the base salary used to calculate unemployment compensation.

To learn more about Section 125, talk to a qualified financial planner or your local Social Security office.

Making Changes in Coverage

How do I make changes?

To make changes to your enrollment or health plan elections, your personnel, payroll, or benefits office must receive the required form(s) during the annual open enrollment or when a special open enrollment event occurs, within the PEBB Program's timelines noted below.
Note: University of Washington employees must enroll through Workday.

What changes can I make any time?

You can make some changes during the year without a special open enrollment event.

- Change your name and/or address. Use the *Employee Enrollment/Change* form.
- Apply for, cancel, or change coverage amounts, and update beneficiary information for optional life and accidental death and dismemberment (AD&D) insurance. (See "Group Term Life and AD&D Insurance" on pages 41–42.)
- Apply for, cancel, or change auto or home insurance coverage. (See "Auto and Home Insurance" on page 48.)
- Remove dependent(s) from coverage due to loss of eligibility (required). Your personnel, payroll, or benefits office must receive a complete *Employee Enrollment/Change* form **no later than 60 days** after the event.
- Enroll in or cancel optional long-term disability coverage, or decrease or increase the waiting period. Use the *Long-Term Disability Enrollment/Change* form.
- Start, stop, or change your contribution to your health savings account (HSA). Use the *Employee Authorization for Payroll Deduction to Health Savings Account* form at **www.hca.wa.gov/pebb**.
- Change your HSA beneficiary information. Use the *Health Savings Account Beneficiary Designation* form available at **www.healthequity.com/pebb**.

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

To make any of the changes below, your personnel, payroll, or benefits office must receive the required form(s) during the PEBB Program's annual open enrollment (November 1–30). You may also make some of these changes online during open enrollment using *My Account* at **www.hca.wa.gov/pebb**.
Exception: *My Account* is not available to University of Washington (UW) employees. UW employees must enroll through Workday.

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

During the annual open enrollment, you can:	By submitting this form:
• Change your medical or dental plans. • Enroll or remove eligible dependents. • Enroll in a medical plan, if you previously waived PEBB medical for other employer-based group medical, TRICARE, or Medicare (see "Waiving Medical Coverage" on page 19). • Waive enrollment in PEBB medical if you have or are enrolling in other employer-based group medical, TRICARE, or Medicare effective January 1 (see "Waiving Medical Coverage"on page 19).	*Employee Enrollment/Change* form (if you have PEBB medical, dental, life, and long-term disability insurance) OR *Employee Enrollment/Change for Medical Only Groups* (if you have PEBB medical only)
• Enroll or reenroll in a Medical Flexible Spending Arrangement (PEBB benefits-eligible state agency and higher-education employees only). • Enroll or reenroll in the Dependent Care Assistance Program (PEBB benefits-eligible state agency and higher-education employees only).	*Medical Flexible Spending Arrangement and Dependent Care Assistance Program Enrollment Form* OR Enroll at **pebb.naviabenefits.com**. (Check the enrollment form for submission directions.) **Exception:** UW employees must use Workday.
Enroll or waive your participation under the state's premium payment plan (see "How do I pay for coverage?" on page 13).	*Premium Payment Plan Election/Change Form*

(continued)

Making Changes in Coverage

What is a special open enrollment?

The PEBB Program allows changes outside of the PEBB Program's annual open enrollment when certain events create a special open enrollment. The Internal Revenue Code and Treasury Regulations require the change must correspond and be consistent with the event that affects eligibility for coverage.

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

To make a change, your personnel, payroll, or benefits office must receive the appropriate *Employee Enrollment/Change* form and proof of the qualifying event **no later than 60 days** after the event that created the special open enrollment. In many instances, the date you turn in your form affects the date that coverage begins; see the table on page 11 for effective dates. However, if adding a newborn or newly adopted child, and adding the child increases your premium, your employer must receive this form and proof of your dependent's eligibility no later than 12 months after the birth or adoption.

If you get married or have a child during the year, these events allow you to change your name and/or add your newborn to your medical coverage. Complete the *Employee Enrollment/Change* form with proof of the event (a marriage or birth certificate) and return it to your personnel, payroll, or benefits office **no later than 60 days** after the event. If adding the child increases your premium, return the form no later than 12 months after the birth or adoption.

If this event happens ...	These changes may be permitted as a special open enrollment:				
	Add dependent	Remove dependent	Change PEBB medical and/or dental plan	Waive PEBB medical	Enroll after waiving PEBB medical
Marriage or registering a state-registered domestic partnership.	Yes[1]	Yes[2]	Yes	Yes	Yes
Birth or adoption, including assuming a legal obligation for total or partial support in anticipation of adoption.	Yes	Yes	Yes	Yes	Yes
Child becomes eligible as an extended dependent. Also complete the *Extended Dependent Certification* form.	Yes	No	Yes	No	Yes
Employee or a dependent loses other coverage under a group health plan or through health insurance, as defined by the Health Insurance Portability and Accountability Act (HIPAA).	Yes	No	Yes	No	Yes
Employee has a change in employment status that affects his or her eligibility for his or her employer contribution toward his or her employer-based group health plan.	Yes	Yes	Yes	Yes	Yes
Employee's dependent has a change in his or her own employment status that affects his or her eligibility for the employer contribution under his or her employer-based group health plan.	Yes	Yes	Yes	Yes	Yes
Employee or a dependent has a change in enrollment under another employer-based group health plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment.	Yes	Yes	No	Yes	Yes

Blue ink indicates information only for subscribers who have PEBB dental, life, and long-term disability coverage.

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

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

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

For more information, see Policy 45-2A at **www.hca.wa.gov/public-employee-benefits/rules-and-policies**.

Making Changes in Coverage

What happens when a dependent loses eligibility?

Your personnel, payroll, or benefits office must receive your completed *Employee Enrollment/Change* form and proof of the qualifying event to remove a dependent from your account **no later than 60 days** after the date the dependent no longer meets PEBB eligibility criteria. Your dependent will be removed from coverage on the last day of the month in which he or she no longer meets the eligibility criteria.

Consequences for not submitting the form within **60 days** after your dependent loses eligibility may include, but are not limited to:

- The dependent may lose eligibility to continue health plan coverage under one of the continuation options described on page 20.
- The subscriber may be billed for claims paid by the health plan for services that were rendered after the dependent lost eligibility.
- The subscriber may not be able to recover subscriber-paid insurance premiums for dependents who lost eligibility.
- The subscriber may be responsible for premiums paid by the state for a dependent's health plan coverage after the dependent lost eligibility.

What happens when a dependent dies?

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

The HCA collects premiums for the full month and will not prorate them for any reason, including when a member dies before the end of the month. Any change to your premium will be effective first of the month after the date of the event or the date your personnel, payroll, or benefits office receives your completed *Employee Enrollment/Change* form, whichever is later. If that day is the first of the month, coverage begins on that day.

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

What if a National Medical Support Notice requires a change?

When a National Medical Support Notice (NMSN) requires you to provide health plan coverage for your dependent child, you may enroll the child and request changes to coverage as directed by the NMSN. You must complete and submit an *Employee Enrollment/Change* form and a copy of the NMSN to your personnel, payroll, or benefits office.

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

- If you have previously waived PEBB medical coverage, you will be enrolled in UMP Classic unless otherwise directed by the NMSN in order to enroll the child.
- If the child is already enrolled under another PEBB subscriber, the child will be removed from the other health plan and enrolled as directed by the NMSN. The child will be removed the last day of the month the NMSN is received. If that day is the first of the month, the change in enrollment will be made the last day of the previous month.

Health plan enrollment will begin the first day of the month following receipt of the NMSN. If the NMSN is received on the first day of the month, the change to health plan enrollment will begin on that day.

Blue ink indicates information only for subscribers who have PEBB dental, life, and long-term disability coverage.

Waiving Medical Coverage

How do I waive coverage?

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

For information on waiving PEBB medical for Medicare, see page 12.

If your employer offers PEBB dental, basic life insurance, and basic long-term disability (LTD) insurance, you must enroll in these coverages for yourself (if eligible), regardless of whether you waive PEBB medical.

To waive enrollment in medical, your employer must receive your completed *Employee Enrollment/Change* form indicating that you want to waive enrollment in medical **no later than 31 days** after the date you become eligible for PEBB benefits, or during an annual or special open enrollment as described on pages 16–17.

Note, if you waive PEBB medical:

- The premium surcharges will not apply to you. (See "Premium Surcharges" on pages 25–26 for more details.)
- You will not be eligible for the $125 SmartHealth wellness incentive (see page 47).

What if I'm already enrolled in PEBB insurance coverage?

If you are a newly eligible employee who is already enrolled in PEBB insurance coverage as a dependent under your spouse's, state-registered domestic partner's, or parent's account, you may either choose to:

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

   To waive enrollment in PEBB medical and enroll in PEBB dental, your personnel, payroll, or benefits office must receive your completed *Employee Enrollment/Change* form, as well as your completed *Long-Term Disability (LTD) Enrollment/Change Form* to enroll in basic LTD insurance. MetLife must also receive your completed *MetLife Enrollment/Change Form* to enroll in basic life insurance.

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

   OR

2. **Enroll in PEBB medical under your own account.** To do this, complete the *Employee Enrollment/Change* form. In addition, your spouse, state-registered domestic partner, or parent will also need to complete and submit the required enrollment/change form(s) to remove you from their PEBB account and prevent dual enrollment in PEBB insurance coverage.

How do I enroll after waiving coverage?

Once you waive PEBB medical coverage, you may enroll during an open enrollment period (November 1–30) or if you have a qualifying special open enrollment event. Your personnel, payroll, or benefits office must receive your completed *Employee Enrollment/Change* form before the end of the PEBB Program's annual open enrollment period or **no later than 60 days** after the special open enrollment event. In many instances (outside of open enrollment), coverage will begin the first of the month after the date of the event or the date your personnel, payroll, or benefits office receives your completed enrollment form and required documents, whichever is later. If that day is the first of the month, coverage will begin on that day (see the table on page 11). You may want to turn the form in sooner so your benefits can begin. You must provide proof of eligibility for any enrolled dependents (see "Valid Dependent Verification Documents" on page 9) and proof of the event that created the special open enrollment. For more information, see WAC 182-12-128.

What happens if I don't waive PEBB insurance coverage?

If your personnel, payroll, or benefits office does not receive a completed form indicating your intent to enroll in or waive PEBB medical coverage within the required timeframes, you will be enrolled as a single subscriber in Uniform Medical Plan (UMP) Classic, and Uniform Dental Plan (UDP), basic life insurance, and basic LTD insurance (if your employer offers these coverages). If defaulted as a single subscriber, you will owe medical premiums back to your effective date for PEBB benefits. You will also incur the $25 monthly tobacco use premium surcharge in addition to your monthly premiums. Your dependents (if any) will not be enrolled.

When Coverage Ends

When does PEBB insurance coverage end?

PEBB insurance covers an entire month and must end as follows:

- When you or a dependent loses eligibility for PEBB benefits, coverage ends on the last day of the month in which eligibility ends. To remove a dependent, your personnel, payroll, or benefits office must receive a completed *Employee Enrollment/ Change* form and proof of the qualifying event **no later than 60 days** after the date he or she lost eligibility.
- When you or a dependent misses a required enrollment deadline to continue PEBB benefits, or chooses not to continue enrollment in a PEBB health plan under one of the options for continuing PEBB benefits, then coverage ends on the last day of the month in which you or your dependent lost eligibility under PEBB rules.

The HCA collects premiums for the full month and will not prorate them for any reason, including when a member dies before the end of the month.

What are my options when coverage ends?

You, your dependents, or both may be able to temporarily continue your PEBB insurance coverage by self-paying the premiums and any applicable premium surcharges on a post-tax basis with no contribution from your employer after eligibility for employer-paid coverage ends.

Options for continuing coverage vary based on the reason eligibility is lost. The PEBB Program will mail a *PEBB Continuation Coverage Election Notice* booklet to you or your dependent at the address we have on file when your employer-paid coverage ends.

This booklet explains the coverage options and includes enrollment forms to apply for continuation coverage.

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

There are three possible continuation coverage options you and your eligible family members may qualify for:

1. COBRA
2. PEBB Continuation Coverage (which includes Leave Without Pay [LWOP] coverage)
3. PEBB retiree insurance coverage

The first two options temporarily extend PEBB health plan coverage in certain circumstances when you would otherwise lose medical and dental coverage.

COBRA eligibility is defined in federal law and governed by federal rules.

PEBB Continuation Coverage is an alternative created for PEBB enrollees who are not eligible for COBRA. LWOP coverage is an alternative that is available to employees in specific situations (such as a layoff, approved leave of absence, educational leave, or when called to active duty in the uniformed services, etc.).

PEBB retiree insurance coverage is available only to:

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

The PEBB Program administers all continuation coverage options. For information about your rights and obligations under PEBB rules and federal law, refer to your *PEBB Initial Notice of COBRA and Continuation Coverage Rights* booklet (mailed to you after you enroll in PEBB insurance coverage), the *PEBB Continuation Coverage Election Notice* booklet, or the *Retiree Enrollment Guide* for specific details, or call the PEBB Program at 1-800-200-1004.

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

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

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

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

What happens to my Consumer Directed Health Plan (CDHP) with a Health Savings Account (HSA) when coverage ends?

If you enroll in a CDHP with an HSA, then later decide to switch to another type of plan, leave employment, or retire, any unspent funds in your HSA will remain unless you close your account. There is a fee for account balances below a certain threshold; contact HealthEquity for information about fees. You can use your HSA funds on qualified medical expenses, or you can leave them for the future. However, you, your employer, the PEBB Program, and others may no longer contribute to your HSA.

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

See "Selecting a PEBB Medical Plan" starting on page 27 to learn more about the CDHP/HSA options.

PEBB Appeals

How can I appeal a decision?

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

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

A current or former **state agency** or **higher-education employee** (or his or her dependent)	Disagree with a decision **made by your employer** about your:
	• Premium surcharges
	• Eligibility for or enrollment in:
	  • Medical
	  • Dental
	  • Life insurance
	  • Long-term disability insurance
	  • Medical Flexible Spending Arrangement (FSA)
	  • Dependent Care Assistance Program (DCAP)
	And are requesting your employer's review.
		Complete Sections 1–4 of the *Employee Request for Review/Notice of Appeal* form and submit it to your employer's personnel, payroll, or benefits office.
		Your employer must receive the form **no later than 30 calendar days** after the date of the initial denial notice.

	Disagree with a review decision **made by your employer or agree that an error occurred** and are now requesting the Public Employees Benefits Board (PEBB) Program's review of your employer's decision.	Complete Section 8 of the *Employee Request for Review/Notice of Appeal* form and submit it to the PEBB Appeals Manager. The PEBB Appeals Manager must receive this form **no later than 30 calendar days** after your employer's review decision date in Section 7 of the form.

	Disagree with a decision **from the PEBB Program** about:
	• Eligibility and enrollment in:
	  • Premium payment plan
	  • Medical FSA
	  • DCAP
	  • Life insurance
	• Eligibility to participate in the PEBB SmartHealth wellness program or receive a wellness incentive
	• Dependent, extended dependent, or disabled dependent eligibility
	• Premium surcharges
	• Premium payments
		Complete Sections 1–4 of the *Employee Request for Review/Notice of Appeal* form. Check with your employer to see if they need to review the form before you submit it to the PEBB Appeals Manager (see Section 8 of the form).
		The PEBB Appeals Manager must receive the form **no later than 30 calendar days** after the date of the initial denial notice or decision you are appealing.

 Blue ink indicates information only for subscribers who have PEBB dental, life, and long-term disability coverage.

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

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

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

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

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

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

2018 Monthly Premiums

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

PEBB Medical Plans	Employee	Employee & Spouse[2]	Employee & Child(ren)	Full Family
Kaiser Permanente NW[1] Classic	$137	$284	$240	$387
Kaiser Permanente NW[1] Consumer-Directed Health Plan (with a health savings account)	$27	$64	$47	$84
Kaiser Permanente WA (formerly Group Health) Classic	$162	$334	$284	$456
Kaiser Permanente WA (formerly Group Health) Consumer-Directed Health Plan (with a health savings account)	$25	$60	$44	$79
Kaiser Permanente WA (formerly Group Health) SoundChoice	$51	$112	$89	$150
Kaiser Permanente WA (formerly Group Health) Value	$78	$166	$137	$225
Uniform Medical Plan Classic	$102	$214	$179	$291
UMP Consumer-Directed Health Plan (with a health savings account)	$25	$60	$44	$79
UMP Plus—Puget Sound High Value Network	$45	$100	$79	$134
UMP Plus—UW Medicine Accountable Care Network	$45	$100	$79	$134

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

[2] *Or state-registered domestic partner*

Monthly premium surcharges

You will pay the following surcharges in addition to your medical premium if they apply to you.

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

See "Premium Surcharges" on pages 25–26 for more information. For more guidance on whether these surcharges apply to you, see the *2018 Premium Surcharge Help Sheet* on page 69.

Premium Surcharges

In 2013, the Legislature established two premium surcharges:

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

These surcharges are applicable if you:

- Are enrolled in a PEBB medical plan.

AND

- Do not have Medicare Part A and Part B as their primary coverage.

Premium surcharge reminders:

When you enroll a dependent on your PEBB medical coverage, you must attest on your enrollment form to whether the tobacco use and spouse or state-registered domestic partner coverage premium surcharges apply, if applicable. See the *2018 Premium Surcharge Help Sheet* on page 69 for more details. You may not have to pay premium surcharges, depending on your answers.

Tobacco use premium surcharge

You will pay a monthly $25-per-account surcharge in addition to your medical plan premium if you or a family member (age 13 or older) enrolled on your PEBB medical has used a tobacco product in the past two months (whether your enrolled dependent lives with you or not), or if you do not attest to the tobacco use premium surcharge for all enrolled dependents.

To determine whether the tobacco use surcharge applies to your account, use the *2018 Premium Surcharge Help Sheet* (found on page 69) and attest by completing and submitting the *2018 Employee Enrollment/Change* form or *2018 Employee Enrollment/Change for Medical Only Groups*. If your form is not **received within 31 days** of becoming eligible for PEBB benefits, or if the response results in incurring the premium surcharge, you will pay the monthly $25-per-account surcharge in addition to your monthly premium.

To report a change

If you or your enrolled dependent's tobacco use changes (or you or your dependent have used the tobacco cessation resources mentioned in the *2018 Premium Surcharge Help Sheet*), you may report the change one of two ways:

- Go to *My Account* at **www.hca.wa.gov/pebb** to change your attestation.
  Exception: University of Washington employees must use Workday.

OR

- Complete and submit a *2018 Premium Surcharge Change Form* (found at **www.hca.wa.gov/pebb**) to your personnel, payroll, or benefits office.

If you submit a change that results in incurring the premium surcharge, the change is effective the first of the month following the status change. If that day is the first of the month, then the change begins on that day.

If the change results in removal of the premium surcharge, the change is effective the first of the month following receipt of the attestation. If that day is the first of the month, then the change begins that day.

Spouse or state-registered domestic partner coverage premium surcharge

You will pay a monthly $50 surcharge in addition to your medical plan premium if you have a spouse or state-registered domestic partner enrolled on your PEBB medical, and your spouse or state-registered domestic partner has chosen not to enroll in employer-based group medical insurance that is comparable to Uniform Medical Plan (UMP) Classic (regardless of whether you enroll in UMP Classic). If you do not enroll a spouse or state-registered domestic partner on your PEBB medical, this surcharge does not apply to you.

If you enroll a spouse or state-registered domestic partner on your PEBB medical, use the *2018 Premium Surcharge Help Sheet* (found on page 69) to determine whether the spouse or state-registered domestic partner coverage surcharge applies to your account. Then respond by completing and submitting the *2018 Employee Enrollment/Change* form or *2018 Employee Enrollment/Change for Medical Only Groups*. If your form is not **received within 31 days** of becoming eligible for PEBB benefits, or if the response results in incurring the premium surcharge, you will pay the monthly $50 surcharge in addition to your monthly premium.

(continued)

Premium Surcharges

To attest during the PEBB Program's open enrollment

During open enrollment (November 1–30), you must attest if you enroll a spouse or state-registered domestic partner on your PEBB medical and you are:

- Incurring the surcharge.
- Not incurring the surcharge because the spouse's or state-registered domestic partner's share of medical premium through his or her employer-based group medical was not comparable to UMP Classic.
- Not incurring the surcharge because the benefits provided by the spouse's or state-registered domestic partner's employer-based group medical were not comparable to UMP Classic.

If required, you must update your attestation by either submitting the *Premium Surcharge Change Form* or logging in to *My Account* at **www.hca.wa.gov/pebb** and following the instructions. **Exception:** University of Washington employees must use Workday.

If your attestation is not received within the open enrollment timeframe, or if the response results in incurring the premium surcharge, you will pay the monthly $50 premium surcharge in addition to your monthly premium effective January 1 of the following plan year. You will owe the spouse or state-registered domestic partner coverage premium surcharge for the whole plan year unless there is a change in your spouse's or state-registered domestic partner's status that meets the requirements as described in WAC 182-08-185.

To report a change

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

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

You may report the change by completing and submitting a *2018 Premium Surcharge Change Form* or a *2018 Employee Enrollment/Change* form to your personnel, payroll, or benefits office. You must submit proof of the qualifying event.

If you submit a change that results in incurring the premium surcharge, the change is effective the first of the month following the status change. If that day is the first of the month, then the change begins on that day.

If the change results in removal of the premium surcharge, the change is effective the first of the month following the receipt of the attestation. If that day is the first of the month, then the change begins that day.

For more information on the premium surcharges, visit **www.hca.wa.gov/public-employee-benefits/employees/surcharges**.

Selecting a PEBB Medical Plan

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

- **Eligibility.** Not everyone qualifies to enroll in a CDHP with a health savings account (HSA) or a UMP Plus plan. See "Can I enroll in a CDHP or UMP Plus plan and Medicare Part A and Part B?" on page 28 and "What do I need to know about the consumer-directed health plans?" on page 29.
- **Where you live.** In most cases, you must live in the plan's service area to join the plan. See "2018 Medical Plans Available by County" on pages 31–32. Be sure to contact the plan(s) you're interested in to ask about provider availability in your county. If you move out of your plan's service area, you may need to change your plan. You must report your new address to your personnel, payroll, or benefits office **no later than 60 days** after your move.

How can I compare the plans?

All medical plans cover the same basic health care services, but vary in other ways such as provider networks, premiums, your out-of-pocket costs, and drug formularies. See a side-by-side comparison of the medical plans' benefits and costs on pages 33–38.

Find it here

Use an interactive comparison tool, find links to each plan's website, or view a comparison of benefits at **www.hca.wa.gov/public-employee-benefits/employees/compare-medical-plans.**

Plan differences to consider

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

Premiums. Premiums vary by plan. A higher premium doesn't necessarily mean higher quality of care or better benefits; each plan has the same basic level of benefits. See premiums for all PEBB medical plans on page 24. **If you are employed by a school district, educational service district, charter school, city, county, tribal government, port, water district, hospital, or other employer group, contact your personnel, payroll, or benefits office to find your monthly premium.**

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

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

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

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

Out-of-pocket limit. The annual out-of-pocket limit is the most you pay in a calendar year for covered benefits. UMP Classic and UMP Plus have a separate out-of-pocket limit for prescription drugs.

Once you have paid this amount, the plans pay 100 percent of allowed charges for most covered benefits for the rest of the calendar year. Certain charges incurred during the year (such as your annual deductible, copays, and coinsurance) count toward your out-of-pocket limit. There are a few costs that do not apply toward your out-of-pocket limit (see the certificate of coverage for an individual plan for specifics):

- Monthly premiums and applicable surcharges.
- Charges above what the plan pays for a benefit.
- Charges above the plan's allowed amount paid to a provider.
- Charges for services or treatments the plan doesn't cover.
- Coinsurance for non-network providers.
- Prescription drug deductible.

Referral procedures. Some plans allow you to self-refer to any network provider; others require you to have a referral from your primary care provider. All plans allow self-referral to a participating provider for women's health-care services.

Your provider. If you have a long-term relationship with your doctor or health care provider, you should verify whether he or she is in the plan's network. Contact the provider or plan before you join.

Your family members may choose the same provider, but it's not required. Each family member may select from any available provider in the plan's network. After you join a plan, you may change your provider, although the rules vary by plan.

Selecting a PEBB Medical Plan

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

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

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

Note: If you have other comprehensive health coverage, you may not enroll in a CDHP with an HSA. Call HealthEquity at 1-877-873-8823 to ask about certain exceptions.

What is a value-based plan and why should I choose one if available in my county of residence?

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

What type of plan should I select?

In general, you may choose from the plans available in the county where you live. Also see "What do I need to know about the consumer-directed health plans (CDHP) with a health savings account (HSA)" to find out if you qualify to enroll.

The PEBB Program offers three types of medical plans (value-based plans noted in **bold**):

Consumer-directed health plans (CDHPs). CDHPs let you use a health savings account (HSA) to help pay for out-of-pocket medical expenses tax free, have a lower monthly premium than most other plans, a higher deductible, and a higher out-of-pocket limit.

- **Kaiser Permanente NW CDHP***
- **Kaiser Permanente WA (formerly Group Health) CDHP**
- UMP CDHP

Managed-care plans. Managed-care plans may require you to select a primary care provider (PCP) within the plan's network to fulfill or coordinate all of your health needs. This type of plan may not pay benefits if you see a non-contracted provider.

- **Kaiser Permanente NW Classic***
- **Kaiser Permanente WA (formerly Group Health) Classic**
- **Kaiser Permanente WA (formerly Group Health) SoundChoice**
- **Kaiser Permanente WA (formerly Group Health) Value**

Preferred provider organization plans. PPOs allow you to self-refer to any approved provider type in most cases, but usually provide a higher level of coverage if the provider contracts with the plan.

- UMP Classic
- **UMP Plus–Puget Sound High Value Network**
- **UMP Plus–UW Medicine Accountable Care Network**

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

Questions? Contact the medical plans or HealthEquity for questions about the HSA. Their phone numbers and websites are listed on page 2.

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

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

Blue ink indicates information only for subscribers who have PEBB dental, life, and long-term disability coverage.

What do I need to know about the consumer-directed health plans (CDHP) with a health savings account (HSA)?

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

The HSA is set up by your health plan with HealthEquity, Inc., to pay for or reimburse your costs for qualified medical expenses.

Who is eligible?

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

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

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

Employer contributions

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

- $58.34 each month for an individual subscriber, up to $700.08 for the 2018 calendar year; or
- $116.67 each month for a subscriber with one or more enrolled family members, up to $1,400.04 for the 2018 calendar year.
- $125 if you qualified for the SmartHealth wellness incentive in 2017 (from the PEBB Program).

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

Subscriber contributions

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

The IRS has an annual limit for contributions from all sources into an HSA. In 2018, the annual HSA contribution limit is $3,450 (subscriber only) and $6,900 (you and one or more family members). If you are age 55 or older, you may contribute up to $1,000 more annually in addition to these limits.

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

Other features of the CDHP/HSA

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

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

Selecting a PEBB Medical Plan

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

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

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

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

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

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

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

How do I find Summaries of Benefits and Coverage?

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

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

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

If you want to request an SBC from your current PEBB medical plan	If you want to request an SBC from another PEBB medical plan
You can either: • Go to your plan's website to review it online; • Go to **www.hca.wa.gov/public-employee-benefits/employees/benefits-and-coverage-plan** to review it online; or • Call your plan's customer services to request a paper copy at no charge.	You can either: • Go to **www.hca.wa.gov/public-employee-benefits/employees/benefits-and-coverage-plan** to review it online; or • Call the PEBB Program at 1-800-200-1004 to request a paper copy at no charge.
You can find the medical plan websites and customer service phone numbers on page 2.	

2018 Medical Plans Available by County

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

Washington			
Kaiser Permanente NW Classic[2] **Kaiser Permanente NW Consumer-Directed Health Plan (CDHP)**[1,2]	• Clark • Cowlitz		
Kaiser Permanente WA (formerly Group Health) **Classic** **Kaiser Permanente WA** (formerly Group Health) **Consumer-Directed Health Plan (CDHP)**[1] **Kaiser Permanente WA** (formerly Group Health) **Value**	• Benton • Columbia • Franklin • Grays Harbor (ZIP Codes 98541, 98557, 98559, and 98568) • Island • King • Kitsap • Kittitas	• Lewis • Lincoln (ZIP Codes 99008, 99029, 99032, and 99122) • Mason • Pend Oreille (ZIP Codes 99009 and 99180) • Pierce • San Juan • Skagit	• Snohomish • Spokane • Stevens (ZIP Codes 99006, 99013, 99026, 99034, 99040, 99110, 99148, and 99173) • Thurston • Walla Walla • Whatcom • Whitman • Yakima
Kaiser Permanente WA (formerly Group Health) **SoundChoice**	• King • Pierce	• Snohomish • Thurston	
Uniform Medical Plan (UMP) Classic **UMP Consumer-Directed Health Plan (CDHP)**[1]	Available in all Washington counties and worldwide.		
UMP Plus—Puget Sound High Value Network[3]	• Grays Harbor • King • Kitsap	• Pierce • Snohomish • Spokane	• Thurston • Yakima
UMP Plus—UW Medicine Accountable Care Network[3]	• Grays Harbor • King • Kitsap	• Pierce • Skagit	• Snohomish • Thurston

[1]You must meet certain eligibility requirements to enroll in a CDHP with a health saving account. See "What do I need to know about the consumer-directed health plans (CDHP) with a health savings account (HSA)?" on page 29 for details.

[2]Kaiser Foundation Health Plan of the Northwest, with plans offered only in Clark and Cowlitz counties in WA and the Portland, OR, area.

[3]Employees who are enrolled in Medicare Part A and Part B **are** eligible for UMP Plus. Employees' spouses are also eligible, even if the spouse is enrolled in Medicare. Due to federal Medicare regulations, employee's state-registered domestic partners who are enrolled in Medicare are **not** eligible for UMP Plus.

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2018 Medical Plans Available by County

continued from previous page

Oregon	
Kaiser Permanente NW Classic[2]	• Benton (ZIP Codes 97330, 97331, 97333, 97339, and 97370)
Kaiser Permanente NW Consumer-Directed Health Plan (CDHP)[1,2]	• Benton (ZIP Codes 97330, 97331, 97333, 97339, and 97370) • Clackamas • Columbia • Hood River (ZIP Code 97014) • Linn (ZIP Codes 97321-22, 97335, 97348, 97355, 97358, 97360, 97374, 97377, and 97389) • Marion • Multnomah • Polk • Washington • Yamhill
Kaiser Permanente WA (formerly Group Health) **Classic** **Kaiser Permanente WA** (formerly Group Health) **Consumer-Directed Health Plan (CDHP)**[1] **Kaiser Permanente WA** (formerly Group Health) **Value**	• Umatilla (ZIP Codes 97810, 97813, 97835, 97862, 97882, and 97886)
Uniform Medical Plan (UMP) Classic **UMP Consumer-Directed Health Plan (CDHP)**[1]	Available in all Oregon counties and worldwide.

Idaho	
Kaiser Permanente WA (formerly Group Health) **Classic** **Kaiser Permanente WA** (formerly Group Health) **Consumer-Directed Health Plan (CDHP)**[1] **Kaiser Permanente WA** (formerly Group Health) **Value**	• Kootenai • Latah
UMP Classic **UMP Consumer-Directed Health Plan (CDHP)**[1]	Available in all Idaho counties and worldwide.

[1]You must meet certain eligibility requirements to enroll in a CDHP with a health saving account. See "What do I need to know about the consumer-directed health plans (CDHP) with a health savings account (HSA)?" on page 29 for details.

[2]Kaiser Foundation Health Plan of the Northwest, with plans offered only in Clark and Cowlitz counties in WA and the Portland, OR, area.

2018 Medical Benefits Comparison

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

Annual Costs (You pay)	**Medical deductible** Applies to medical out-of-pocket limit	**Medical out-of-pocket limit**[1] (See separate prescription drug out-of-pocket limit for some plans.)	**Prescription drug deductible**	**Prescription drug out-of-pocket limit**[1]
Kaiser Foundation Health Plan of the Northwest				
Kaiser Permanente NW Classic[2]	$300/person $900/family	$2,000/person • $4,000/family Your deductible, copays, and coinsurance for most covered services apply.	None	Prescription drug copays and coinsurance apply to the medical out-of-pocket limit.
Kaiser Permanente NW CDHP[2]	$1,400/person $2,800/family*	$5,100/person • $10,200/family Your deductible, copays, and coinsurance for most covered services apply.	Prescription drug costs apply toward medical deductible.	
Kaiser Foundation Health Plan of Washington (formerly Group Health)				
Kaiser Permanente WA (formerly Group Health) **Classic**	$175/person $525/family	$2,000/person • $4,000/family Your deductible, copays, and coinsurance for all covered services apply.	$100/person $300/family (Tier 2 and 3 drugs only)	$2,000/person Your prescription drug deductible and coinsurance for all covered prescription drugs apply.
Kaiser Permanente WA (formerly Group Health) **CDHP** Individual	$1,400/person	$5,100/person Your deductible and coinsurance for all covered services apply.	Prescription drug costs apply toward medical deductible.	Prescription drug copays and coinsurance apply to the medical out-of-pocket limit.
Kaiser Permanente WA (formerly Group Health) **CDHP** Family	$2,800/person $2,800/family*	$5,100/person • $10,200/family Your deductible and coinsurance for all covered services apply.		
Kaiser Permanente WA (formerly Group Health) **SoundChoice**	$250/person $750/family	$2,000/person • $4,000/family Your deductible, copays, and coinsurance for all covered services apply.	$100/person $300/family (Tier 2 and 3 drugs only)	$2,000/person Your prescription drug deductible and coinsurance for all covered prescription drugs apply.
Kaiser Permanente WA (formerly Group Health) **Value**	$250/person $750/family	$3,000/person • $6,000/family Your deductible, copays, and consurance for all covered services apply.		
Uniform Medical Plan (UMP)[3]				
UMP Classic	$250/person $750/family	$2,000/person • $4,000/family Your deductible, copays, and coinsurance for most covered medical services apply.	$100/person $300/family* (Tier 2 and 3 drugs only)	$2,000/person Your prescription drug deductible and coinsurance for all covered prescription drugs apply.
UMP CDHP	$1,400/person $2,800/family*	$4,200/person • $8,400/family ($6,850 per person in a family) Your deductible and coinsurance for most covered services apply.	Prescription drug costs apply toward medical deductible.	Prescription coinsurance applies to the medical out-of-pocket limit.
UMP Plus–PSHVN	$125/person $375/family	$2,000/person • $4,000/family Your deductible, copays, and coinsurance for most covered medical services apply.	None	$2,000/person Your coinsurance for all covered prescription drugs applies.
UMP Plus–UW Medicine ACN				

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

(continued)

2018 Medical Benefits Comparison

Benefits (You pay)	**Ambulance** Air or ground, per trip	**Diagnostic tests, laboratory, and x-rays**	**Durable medical equipment, supplies, and prosthetics**	**Emergency room** (Copay waived if admitted)	**Hearing**		**Home health**
					Routine annual exam	Hardware	
Kaiser Foundation Health Plan of the Northwest							
Kaiser Permanente NW Classic[2]	15%	$10	20%	15%	$35	You pay any amount over $800 every 36 months for hearing aid and rental/repair combined.	15%
Kaiser Permanente NW CDHP[2]	15%	15%	20%	15%	$30	You pay any amount over $800 every 36 months after deductible has been met for hearing aid and rental/repair combined.	15%
Kaiser Foundation Health Plan of Washington (formerly Group Health)							
Kaiser Permanente WA (formerly Group Health) **Classic**	20%	$0; MRI/CT/PET scan $30	20%	$250	Primary care $15 Specialist $30	You pay any amount over $800 every 36 months for hearing aid and rental/repair combined.	$0
Kaiser Permanente WA (formerly Group Health) **CDHP**	10%	10%	10%	10%	10%		10%
Kaiser Permanente WA (formerly Group Health) **SoundChoice**	20%	15%	15%	$75 + 15%	15%		$0
Kaiser Permanente WA (formerly Group Health) **Value**	20%	$0; MRI/CT/PET scan $40	20%	$300	$20		$0
Uniform Medical Plan (UMP)[3]							
UMP Classic	20%	15%	15%	$75 + 15%	$0	You pay any amount over $800 every three calendar years for hearing aid and rental/repair combined. (CDHP is subject to deductible.)	15%
UMP CDHP	20%	15%	15%	15%	15%		15%
UMP Plus– PSHVN	20%	15%	15%	$75 + 15%	$0		15%
UMP Plus– UW Medicine ACN	20%	15%	15%	$75 + 15%	$0		15%

 Blue ink indicates information only for subscribers who have PEBB dental, life, and long-term disability coverage.

Benefits (You pay)	Hospital services		Office visit					
	Inpatient	Outpatient	Primary care	Urgent care	Specialist	Mental health	Chemo-therapy	Radiation
Kaiser Foundation Health Plan of the Northwest								
Kaiser Permanente NW Classic[2]	15%	15%	$25	$45	$35	$25	$0	$0
Kaiser Permanente NW CDHP[2]	15%	15%	$20	$40	$30	$20	$0	$0
Kaiser Foundation Health Plan of Washington (formerly Group Health)								
Kaiser Permanente WA (formerly Group Health) **Classic**	$150/day up to $750 maximum/ admission	$150	$15	$15	$30	$15	$15	$30
Kaiser Permanente WA (formerly Group Health) **CDHP**	10%	10%	10%	10%	10%	10%	10%	10%
Kaiser Permanente WA (formerly Group Health) **SoundChoice**	$200/day up to $1,000 maximum/ admission	15%	15%	15%	15%	15%	15%	15%
Kaiser Permanente WA (formerly Group Health) **Value**	$250/day up to $1,250 maximum/ admission	$200	$30	$30	$50	$30	$50	$50
Uniform Medical Plan (UMP)[3]								
UMP Classic	$200/day up to $600 maximum/year per person + 15% professional fees	15%	15%	15%	15%	15%	15%	15%
UMP CDHP	15%	15%	15%	15%	15%	15%	15%	15%
UMP Plus– PSHVN	$200/day up to $600 maximum/year per person + 15% professional fees	15%	$0	15%	15%	15%	15%	15%
UMP Plus– UW Medicine ACN	$200/day up to $600 maximum/year per person + 15% professional fees	15%	$0	15%	15%	15%	15%	15%

(continued)

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

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

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

2018 Medical Benefits Comparison

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

 Blue ink indicates information only for subscribers who have PEBB dental, life, and long-term disability coverage.

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

(continued)

2018 Medical Benefits Comparison

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

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

The information in this document is accurate at the time of printing.
Contact the plans or review the certificate of coverage before making decisions.

Selecting a PEBB Dental Plan

Dental Plan Options

Make sure you confirm with your dentist that he or she accepts the **specific plan network** and **plan group**.

DeltaCare	Managed-care plan	Delta Dental of Washington	DeltaCare PEBB	Group 3100
Willamette Dental Group Plan	Managed-care plan	Willamette Dental of Washington, Inc	Willamette Dental Group, P.C.	WA82
Uniform Dental Plan (UDP)	Preferred-provider plan	Delta Dental of Washington	Delta Dental PPO	Group 3000

How do DeltaCare and Willamette Dental Group plans work?

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

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

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

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

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

How does Uniform Dental Plan (UDP) work?

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

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

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

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

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

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

DeltaCare and Willamette Dental Group are managed-care plans. You must choose a primary dental provider within their networks. If you do not choose a primary dental provider, one will be chosen for you. These plans will not pay claims if you see a provider outside of their network.

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

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

Dental Benefits Comparison

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

Annual Costs	Uniform Dental Plan (UDP) *(Group 3000 Delta Dental PPO)*	DeltaCare *(Group 3100)*	Willamette Dental Group
Deductible	$50/person, $150/family	None	
Plan maximum (See specific benefits maximums below.)	You pay amounts over $1,750	No general plan maximum	

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

 Blue ink indicates information only for subscribers who have PEBB dental, life, and long-term disability coverage.

Group Term Life and AD&D Insurance

Your life insurance benefits allow you to cover yourself, your spouse or state-registered domestic partner, and your children. As an employee, your basic life insurance covers you and pays your designated beneficiaries in the event of your death. The PEBB Program offers basic life insurance and accidental death and dismemberment (AD&D) insurance, which provides extra benefits for certain injuries or death resulting from a covered accident.

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

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

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

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

- **Optional Life Insurance for Employees:** Increments of $10,000 up to $500,000 with no Medical Evidence of Insurability (if elected within 31 days of becoming eligible), to a maximum of $1,000,000 with Medical Evidence of Insurability.
- **Optional Life Insurance for Spouse or State-Registered Domestic Partner:** If you are enrolled in Optional Life Insurance for Employees, you may apply for amounts of optional life Insurance for your spouse or state-registered domestic partner in increments of $5,000 (up to one-half the amount of the Optional Life Insurance for Employees that you get for yourself).
- **Optional Life Insurance for Children:** If you enroll in optional life insurance for yourself, you may apply for child coverage in $5,000 increments up to $20,000.
- **Optional AD&D Insurance for Employees:** You may enroll in optional AD&D coverage in increments of $10,000 up to $250,000. Optional AD&D insurance does not cover death and dismemberment from non-accidental causes. Optional AD&D insurance never requires evidence of insurability, and you can apply at any time.
- **Optional AD&D Insurance for Spouse or State-Registered Domestic Partner:** You can choose to cover your spouse or state-registered domestic partner with AD&D coverage. You may enroll in optional AD&D coverage in increments of $10,000 up to $250,000.
- **Optional AD&D Insurance for Children:** For your children, optional AD&D coverage is available in $5,000 increments up to $25,000.

When can I enroll?

You may enroll **no later than 31 days** after becoming eligible for PEBB benefits (generally your first day of employment) for the following coverage, **without providing evidence of insurability:**

- Optional Life Insurance for Employees up to $500,000.
- Optional Life Insurance for Spouse or State-Registered Domestic Partner up to $100,000.
- Optional Life Insurance for Children, all amounts Guaranteed Issue in increments of $5,000 up to $20,000.

Optional AD&D insurance never requires evidence of insurability, and you can apply at any time.

You **must** provide evidence of insurability to MetLife if you:

- Apply for Optional Life Insurance more than 31 days after becoming eligible for PEBB benefits.
- Request more than $500,000 in Optional Employee Life Insurance for yourself.
- Request more than $100,000 in Optional Life Insurance for your spouse or state-registered domestic partner.

MetLife must approve your request for additional levels of coverage.

How do I enroll?

Complete the *MetLife Enrollment/ Change Form* in the back of this book. If you have any questions regarding enrollment please contact MetLife at 1-866-548-7139.

The PEBB Program offers life insurance through Metropolitan Life Insurance Company (Plan number 164995-1-G). This is a summary of benefits only. To see the certificate of coverage, either:

- Go to **www.hca.wa.gov/pebb** under *Forms and publications*.

or

- Contact your employer's personnel, payroll, or benefits office.

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Group Term Life and AD&D Insurance

Premiums

Optional Life Insurance for Employees and Spouse or State-Registered Domestic Partner		
Age	COST PER $1,000 PER MONTH	
	Non-Tobacco User	Tobacco User
Less than 25	$0.028	$0.037
25–29	$0.031	$0.043
30–34	$0.034	$0.057
35–39	$0.043	$0.066
40–44	$0.064	$0.073
45–49	$0.092	$0.111
50–54	$0.143	$0.170
55–59	$0.268	$0.317
60–64	$0.411	$0.482
65–69	$0.758	$0.929
70+	$1.131	$1.510
Cost for your child(ren)	$0.124	$0.124
Your premium rate changes to the next higher rate as you reach each new age bracket.		

Optional Accidental Death and Dismemberment (AD&D) Insurance	
	MONTHLY COST PER $1,000 OF COVERAGE
Employee	$0.019
Dependent Spouse or State-Registered Domestic Partner	$0.019
Dependent Child	$0.016
Premiums shown are guaranteed through December 31, 2018.	

Long-Term Disability Insurance

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

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

What are my PEBB long-term disability insurance options?

LTD coverage has two parts:

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

LTD benefit amounts

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

The LTD benefit for each plan is shown below:

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

Waiting period before benefits become payable

Basic LTD Plan: 90 days or the period of sick leave (excluding shared leave) for which you are eligible under the employer's sick leave plan, whichever is longer.

Optional LTD Plan: 30, 60, 90, 120, 180, 240, 300, or 360 days (depending on your election), or the period of sick leave (excluding shared leave) for which you are eligible under the employer's sick leave plan, whichever is longer.

What is considered a disability?

Being unable to perform with reasonable continuity the duties of your own occupation as a result of sickness, injury, or pregnancy during the benefit waiting period and the first 24 months for which LTD benefits are payable. During this period, you are considered partially disabled if you are working but unable to earn more than 80 percent of your indexed predisability earnings.

After that, as a result of sickness, injury, or pregnancy, being unable to perform with reasonable continuity the material duties of any gainful occupation for which you are reasonably able through education, training, or experience. During this period, you are considered partially disabled if you are working, but unable to earn more than 60 percent of your indexed predisability earnings in that occupation and in all other occupations for which you are reasonably suited.

Maximum benefit period

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

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

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

(continued)

Long-Term Disability Insurance

How much does the Optional Plan cost?

Payroll deduction as a percentage of predisability earnings

Benefit waiting period	Higher-education retirement plan employees	TRS, PERS, and other retirement plan employees
30 days	2.60%	2.06%
60 days	1.32%	1.09%
90 days	0.72%	0.60%
120 days	0.42%	0.36%
180 days	0.32%	0.28%
240 days	0.30%	0.27%
300 days	0.28%	0.25%
360 days	0.27%	0.24%

Multiply your monthly base pay (up to $10,000) by the percentage shown above for the desired benefit waiting period to calculate your optional LTD monthly premium.

When can I enroll?

You may enroll in optional LTD coverage **within 31 days** after becoming eligible for PEBB benefits (generally your first day of employment) without providing evidence of insurability.

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

How do I enroll?

If applying within 31 days of initial eligibility for PEBB benefits, complete and submit the *Long Term Disability (LTD) Enrollment/Change Form* (found in the back of this booklet) to your employer's personnel, payroll, or benefits office.

If applying after 31 days, or decreasing the waiting period for optional LTD coverage, you must also complete the *Long Term Disability (LTD) Evidence of Insurability Form* (found at **www.hca.wa.gov/employees/long-term-disability-insurance**) and submit it to Standard Insurance Company.

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

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

- Go to **www.hca.wa.gov/public-employee-benefits/employees/long-term-disability-insurance**.

or

- Contact your employer's personnel, payroll, or benefits office.

Update and Sign

Example #1

If you are a higher-education retirement plan employee with monthly earnings of $1,000, the 60-day benefit waiting period would cost $13.20 per month.

Earnings:	$ 1,000	per month
60-day benefit waiting period:	x 0.0132	(1.32% converts to 0.0132 when multiplying)
Monthly cost:	$ 13.20	

Example #2

If you are a TRS, PERS, or other retirement plan employee with monthly earnings of $1,000, the 60-day benefit waiting period would cost $10.90 per month.

Earnings:	$ 1,000	per month
60-day benefit waiting period:	x 0.0109	(1.09% converts to 0.0109 when multiplying)
Monthly cost:	$ 10.90	

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

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

What is a Medical Flexible Spending Arrangement (FSA)?

A Medical FSA allows you to set aside money from your paycheck on a pre-tax basis to pay for out-of-pocket health care costs for you and your qualified dependents. You can set aside as little as $240 or as much as $2,500 per calendar year. The full amount you elect to set aside for your Medical FSA is available on the first day your benefits become effective.

Note: You **cannot** enroll in both a Medical FSA and a PEBB consumer-directed health plan (CDHP) with a health savings account (HSA).

How does the Medical FSA work?

- Your Medical FSA helps you pay for deductibles, copays, coinsurance, dental, vision, and many other expenses. You can use your Medical FSA for you, your spouse's, or qualified dependent's health care expenses, even if they are not enrolled in your PEBB medical or dental plan.
- To figure out how much you should contribute, estimate your out-of-pocket medical expenses for the calendar year and enroll in a Medical FSA for that amount. The more accurate you are in estimating your expenses, the better this benefit will work for you.The amount you set as your annual election cannot be changed after you enroll (after your initial allowable 31 days of enrollment) unless a special open enrollment event (qualifying event) occurs during the plan year. Common qualifying events include birth, death, adoption, marriage or divorce. Your change in election amount must be consistent with the qualifying event.
- Your election amount is deducted from your pay, divided by the number of paychecks you will receive in the calendar year. Your election amount will be deducted from your paychecks pre-tax (which reduces your taxable income), so you don't pay Federal Insurance Contributions Act (FICA) or federal income taxes on your elected dollars.

What is the Dependent Care Assistance Program (DCAP)?

Child or elder care can be one of the largest expenses for a family. The DCAP allows you to set aside money from your paycheck on a pre-tax basis to help pay for qualifying child care or elder care expenses while you and your spouse attend school full-time, work, or look for work. A qualifying dependent must live with you and must be 12 years old or younger. A dependent age 13 or older qualifies only if he or she is physically or mentally incapable of self-care and regularly spends at least eight hours each day in your household. The care must be provided during the hours the parent(s) work, look for work, or attend school. You can set aside as much as $5,000 annually (single person or married couple filing joint income tax return) or $2,500 annually (married filing separate income tax return).

The total amount of your contribution cannot be more than either your earned income or your spouse's earned income, whichever is less. Earned income means wages, salaries, tips, and other employee compensation plus net earnings from self-employment.

How does the DCAP work?

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

When can I enroll?

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

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

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

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

How can I enroll?

You can download and print the *Medical Flexible Spending Arrangement (FSA) and Dependent Care Assistance Program (DCAP) Enrollment Form* at **pebb.naviabenefits.com**.
Exception: University of Washington employees must enroll through Workday.

When can I change my Medical FSA or DCAP election?

Once you enroll in a Medical FSA or DCAP, you can change your election only if you experience a special open enrollment event (qualifying event). (See WAC 182-08-199 for details.) The requested change must correspond to and be consistent with the qualifying event.

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

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

Navia Benefits Solutions, Inc. administers the Medical FSA and DCAP

For details and forms, visit Navia Benefits Solutions at **pebb.naviabenefits.com** or call 1-800-669-3539.

Email questions to **customerservice@naviabenefits.com**

SmartHealth

SmartHealth is the state's voluntary wellness program designed to help you take steps to improve your health by participating in fun and engaging SmartHealth activities. As you progress on your wellness journey, you can qualify for the SmartHealth financial wellness incentives.

Who is eligible to participate?

Subscribers and their spouses or state-registered domestic partners enrolled in PEBB medical coverage can participate in SmartHealth through the SmartHealth website; however, only the subscriber can quality for the financial wellness incentives, and other SmartHealth promotions.

What are the financial wellness incentives?

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

- A $25 Amazon.com gift card* wellness incentive, and
- Either a $125 reduction in the subscriber's 2019 PEBB medical deductible, **or** a one-time deposit of $125 into the subscriber's health savings account (if enrolled in a PEBB consumer-directed health plan in 2019).

How do I qualify for the financial wellness incentives?

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

- Not be enrolled in both Medicare Part A and Part B as their primary insurance, and
- Complete the SmartHealth Well-being Assessment and claim the $25 Amazon.com gift card* by December 31, 2018.

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

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

To receive the $125 wellness incentive in 2019, the subscriber must still be enrolled in a PEBB medical plan in 2019.

The PEBB Program will work with a subscriber who cannot complete a wellness incentive requirement in order to provide an alternative requirement that will allow the subscriber to qualify for the wellness incentive or waive the requirement.

If a subscriber qualifies for the $125 wellness incentive in 2018, then becomes a retiree, COBRA subscriber, or PEBB Continuation Coverage subscriber enrolled in Medicare Part A and Part B while enrolled in a PEBB medical plan after January 1, 2019, he or she will still receive the SmartHealth incentive in 2019.

How do I get started?

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

1. Go to **www.smarthealth.hca.wa.gov** and select *Get started* to walk through the activation process.
2. Take the SmartHealth Well-being Assessment (**required** to qualify for the wellness incentives). After completing the Well-being Assessment, you earn the $25 gift card wellness incentive. You do not earn SmartHealth points for completing your PEBB medical plan's health assessment.

   Note: If you don't have internet access, call SmartHealth Customer Service toll-free at 1-855-750-8866 (Monday through Friday, 7 a.m. to 7 p.m. Pacific Time) to complete the Well-being Assessment by phone.
3. Complete other activities on SmartHealth's website to earn 2,000 total points by the applicable deadline to qualify for the $125 wellness incentive.

Deadline requirements

When is the deadline to meet the requirements for the $25 gift card wellness incentive?

The deadline to qualify for and claim the $25 Amazon.com gift card* wellness incentive is December 31, 2018.

When is the deadline to meet the requirements for the $125 wellness incentive?

- If you are continuing enrollment in PEBB medical or are a new subscriber with a PEBB medical effective date in January through June, your deadline to qualify for the financial incentive is **September 30, 2018**.
- If your PEBB medical effective date is in July or August, your deadline is **120 days** from your medical effective date. **Example:** *Sam is new to state employment and his PEBB medical effective date is July 1, 2018. Sam's deadline to complete his SmartHealth Activities and earn his financial wellness incentive is October 29, 2018.*
- If your PEBB medical effective date is in September through December, your deadline is **December 31, 2018**.

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

Auto and Home Insurance

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

What does Liberty Mutual offer?

PEBB Program members may receive a group discount of up to 12 percent off Liberty Mutual's auto insurance rates and up to 5 percent off Liberty Mutual's home insurance rates. In addition to the discounts, Liberty Mutual also offers:

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

When can I enroll?

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

How do I enroll?

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

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

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

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

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

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

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

Spokane **1-800-208-3044**
16201 East Indiana Ave., Suite 2280
Spokane, WA 99216

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

Tumwater **1-800-319-6523**
1550 Irving Street SW, Suite 202
Tumwater, WA 98512

Enrollment Forms

The following forms are available online:

2018 Employee Enrollment/Change

www.hca.wa.gov/assets/pebb/50-400-2018.pdf

2018 Employee Enrollment/Change for Medical Only Groups

www.hca.wa.gov/assets/pebb/52-030-2018.pdf

2018 Enrollment/Change MetLife

https://www.hca.wa.gov/assets/pebb/metlife-employee-enrollment.doc

Long Term Disability (LTD) Enrollment/Change Form

www.standard.com/eforms/7533d_377661.pdf

2018 Premium Surcharge Help Sheet

www.hca.wa.gov/assets/pebb/50-226-2018.pdf

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

PEBB Program Nondiscrimination Notice and Language Access Services

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

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

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

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

If you believe this organization has failed to provide language access services or discriminated in another way…	**You can file a grievance with:**
PEBB Program *You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the HCA Compliance Officer is available to help you.*	Health Care Authority Division of Legal Services, Attn: HCA Compliance Officer PO Box 42704 Olympia, WA 98504-2704 1-855-682-0787 (TRS: 711) | Fax 360-586-9551 **compliance@hca.wa.gov**
PEBB MEDICAL PLANS	
Kaiser Foundation Health Plan of the Northwest	Kaiser Foundation Health Plan of the Northwest Attn: Member Relations – Kaiser Civil Rights Coordinator 500 NE Multnomah, Suite 100 Portland, OR 97232 1-800-813-2000 or 503-813-2000 (TTY: 711)
Kaiser Foundation Health Plan of Washington (formerly Group Health Cooperative) **Kaiser Foundation Health Plan of Washington Options, Inc. (formerly Group Health Options, Inc.)**	Kaiser Foundation Health Plan of Washington Civil Rights Coordinator Quality GNE-D1E-07 PO Box 9812 Renton, WA 98057 1-888-901-4636 or 206-630-4636 (TTY: 711) | Fax 206-901-6205 **csforms@ghc.org**
Washington State Rx Services (for discrimination concerns about prescription-drug benefits for Uniform Medical Plan [UMP])	Washington State Rx Services Attn: Appeals Unit PO Box 40168 Portland, OR 97204-0168 1-888-361-1611 (TDD/TTY: 711) | Fax 1-866-923-0412 **compliance@modahealth.com**
Premera Blue Cross (for discrimination concerns about Medicare Supplement Plan F and the Center of Excellence Program for UMP Classic and UMP CDHP members)	Premera Blue Cross Attn: Civil Rights Coordinator - Complaints and Appeals PO Box 91102 Seattle, WA 98111 1-855-332-4535 (TTY: 1-800-842-5357) | Fax 425-918-5592 **AppealsDepartmentInquiries@Premera.com**

(continued)

If you believe this organization has failed to provide language access services or discriminated in another way…	You can file a grievance with:
Regence BlueShield **(for discrimination concerns about UMP Classic, UMP Consumer-Directed Health Plan [CDHP], and UMP Plus)**	Regence BlueShield Civil Rights Coordinator MS: CS B32B, PO Box 1271 Portland, OR 97207-1271 1-888-344-6347 (TTY: 711) **CS@regence.com**
Regence BlueShield **(for discrimination concerns about UMP Classic for Medicare members)**	Regence BlueShield Civil Rights Coordinator MS: B32AG, PO Box 1827 Medford, OR 97501 1-866-749-0355 (TTY: 711) | Fax 1-888-309-8784 **medicareappeals@regence.com**
PEBB DENTAL PLANS	
Delta Dental **(for discrimination concerns about DeltaCare and the Uniform Dental Plan)**	Delta Dental Attn: Isaac Lenox, Compliance/Privacy Officer PO Box 75983 Seattle, WA 98175 1-800-554-1907 (TTY: 1-800-833-6384) | Fax 206-729-5512 **Compliance@DeltaDentalWA.com**
Willamette Dental *HCA will process discrimination complaints pertaining to Willamette Dental Group.*	Health Care Authority Division of Legal Services, Attn: HCA Compliance Officer PO Box 42704 Olympia, WA 98504-2704 1-855-682-0787 (TRS: 711) | Fax 360-586-9551 **compliance@hca.wa.gov**

You can also file a civil rights complaint with:

U.S. Department of Health and Human Services, Office for Civil Rights
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019 (TDD: 1-800-537-7697)
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf (to submit complaints electronically)
http://www.hhs.gov/ocr/office/file/index.html (to find complaint forms online)

Washington State Health Care Authority

PUBLIC EMPLOYEES BENEFITS BOARD

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

[Amharic] የቋንቋ እገዛ አገልግሎት፣ አስተርጓሚ እና የሰነዶችን ትርጉም ጨምሮ በነጻ ይገኛል። ተቀጣሪዎች፡ የቀጣሪዎትን ሰራተኛ፣ የደሞዝ ወይም ጥቅማ-ጥቅም ክፍያ ጽ/ቤትን በቀጥታ ያነጋግሩ። ጡረታ የወጡ፣ COBRA እና ቀጣይነት ያለው ሽፋን አባላት ብቻ፡ የ PEB መምሪያ ጥቅማ-ጥቅም አገልግሎትን በ1-800-200-1004. (TRS: 711) ያነጋግሩ።

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

[Burmese] ဘာသာပြန်ဆိုသူများနှင့် ထုတ်ပြန်ထားသည့် စာရွက်စာတမ်းများဘာသာပြန်ခြင်းအပါအဝင် ဘာသာစကားအထောက်အကူဝန်ဆောင်မှုများကို အခမဲ့ရနိုင်ပါသည်။ အလုပ်သမားများ- သင့်အလုပ်ရှင်၏ကိုယ်ရေးအရာရှိ၊ လစာ သို့မဟုတ် အကျိုးခံစားခွင့်ဆိုင်ရာ ရုံးသို့ တိုက်ရိုက်ဆက်သွယ်ပါ။ ပင်စင်ယူသူများ၊ COBRA နှင့် ဆက်လက်ပြီးအကျုံးဝင်သည့် အဖွဲ့ဝင်များသာလျှင်- PEB ဌာနခွဲ အကျိုးခံစားခွင့်ဝန်ဆောင်မှုများသို့ 1-800-200-1004. (TRS: 711) ကိုဖုန်းခေါ်ဆိုပါ။

[Cambodian] សេវាជំនួយភាសា រួមមានទាំងអ្នកបកប្រែផ្ទាល់មាត់ និង ការបកប្រែឯកសារបោះពុម្ព គឺអាចរកបានដោយឥតគិតថ្លៃ។ ហៅទូរស័ព្ទទៅលេខ 1-800-562-3022 (TRS: 711)។ និយោជិក ៖ សូមទាក់ទងការិយាល័យបុគ្គលិកនិយោជករបស់អ្នក ការិយាល័យបញ្ជីប្រាក់ខែ ការិយាល័យអត្ថប្រយោជន៍ដោយផ្ទាល់។ អ្នកចូលនិវត្តន៍, COBRA, និងសមាជិក Continuation Coverage ប៉ុណ្ណោះ ៖ សូមទាក់ទងសេវាអត្ថប្រយោជន៍ នៃនាយកដ្ឋាន PEB តាមលេខ 1-800-200-1004. (TRS: 711)។

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

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

[Laotian] ການບໍລິການດ້ານພາສາ, ລວມທັງນາຍແປພາສາ ແລະ ການ ແປເອກະສານຕີພິມ, ມີໄວ້ໃຫ້ຟຣີໂດຍບໍ່ຄິດຄ່າ. ພະນັກງານ: ຕິດຕໍ່ ຫາພະແນກຊັບພະຍາກອນມະນຸດ, ພະແນກບັນຊີເງິນເດືອນ, ຫລື ຫ້ອງການສະວັດດີການໂດຍກົງ. ຜູ້ອອກບໍານານ, COBRA, ແລະ ການຄຸ້ມຄອງການສະວັດດີການ PEB ໄດ້ທີ່ເລກ 1-800-200-1004 (TRS: 711).

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

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

[Punjabi] ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ—ਦੁਭਾਸ਼ੀਏ ਅਤੇ ਪ੍ਰਿੰਟ ਕੀਤੀ ਹੋਈ ਸਮੱਗਰੀ ਦੇ ਅਨੁਵਾਦ ਸਮੇਤ—ਮੁਫ਼ਤ ਉਪਲੱਬਧ ਹਨ। ਮੁਲਾਜ਼ਮ: ਆਪਣੇ ਰੁਜ਼ਗਾਰਦਾਤਾ ਦੇ ਮੁਲਾਜ਼ਮ, ਪੇਅਰੋਲ, ਜਾਂ ਲਾਭਾਂ ਵਾਲੇ ਦਫ਼ਤਰ ਨਾਲ ਸਿੱਧਾ ਸੰਪਰਕ ਕਰਨ। ਸੇਵਾ-ਮੁਕਤ ਮੁਲਾਜ਼ਮ, COBRA (ਕੋਬਰਾ), ਅਤੇ ਸਿਰਫ਼ ਕੰਟੀਨਿਊਏਸ਼ਨ ਕਵਰੇਜ ਮੈਂਬਰ: 1-800-200-1004. (TRS: 711) ਉੱਤੇ PEB (ਪੀਈਬੀ) ਡਿਵੀਜ਼ਨ ਲਾਭ ਸੇਵਾਵਾਂ ਨਾਲ ਸੰਪਰਕ ਕਰਨ।

[Romanian] Serviciile de asistenţă lingvistică, inclusiv cele de interpretariat şi de traducere a materialelor imprimate, sunt disponibile gratuit. Angajaţi: Contactaţi biroul pentru personal, salarii sau beneficii al angajatorului dvs. în mod direct. Numai pentru pensionari, membri COBRA sau Continuation Coverage: Contactaţi Serviciile de beneficii de la Divizia PEB la 1-800-200-1004. (TRS: 711).

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

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

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

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

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

[Tigrigna] ተርጎምትን ናይ ዝተፅሓፉ ማተርያላት ትርጉምን ሓዊሱ ናይ ቋንቋ ሓገዝ ግልጋሎት፤ ብዘይ ምንም ክፍሊት ይርከቡ። ሰራሕተኛታት፡ ንናይ መስርሒ ዉልቃዊ ዝርዝር ደሞዝ ወይ ቤት ጽሕፈት ጥቅምታት ብቐጥታ ርኸቡ። ጡረተኛታት፣ COBRA፣ ኣባላት መቐጸልታ ሽፋን ጥራሕ፡ ንናይ PEB ክፋል ጥቅምታት ግልጋሎት ብ1-800-200-1004 ርኸቡ (TRS: 711) ።

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

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