SCHOOL EMPLOYEE **INITIAL ENROLLMENT GUIDE**

Your 2020 SEBB Program benefits inside.

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

HCA 20-0049 (9/19)

Who to contact for help

Contact the plans directly for help with:

- Benefit questions
- ID cards
- Claims (beginning January 1, 2020)
- Making sure your health care providers are in the plan's network
- Choosing a health care provider
- Making sure your prescriptions are covered

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

- Benefit eligibility and enrollment questions or changes
- Accessing paper forms
- Premium surcharges questions
- Updating your contact information (name, address, phone, etc.)
- Adding or removing dependents
- Payroll deduction information (including pre- or post-tax contributions)

Help with SEBB My Account

October 1 to November 15:
1-855-548-3100
7 a.m. to 9 p.m., Monday through Friday, and 10 a.m. to 4 p.m., Saturday for help with:

- SecureAccess Washington (SAW) registration
- SEBB My Account screen navigation
- Uploading documents

Medical plans

Kaiser Foundation Health Plan of the Northwest
Kaiser Permanente NW 1, 2, 3

my.kp.org/sebb
September 1 to December 31, 2019: 1-800-728-2779
January 1, 2020: 503-813-2000 or
1-800-813-2000 (TRS: 711)

Kaiser Foundation Health Plan of Washington
Kaiser Permanente WA Core 1, 2, 3, SoundChoice
Kaiser Foundation Health Plan of Washington Options, Inc.
Kaiser Permanente WA Options Access PPO 1, 2, 3

kp.org/wa/schools
September 1 to December 31, 2019: 1-800-728-2779
January 1, 2020: 1-888-901-4636
(TTY: 1-800-833-6388 or TRS: 711)

Premera Blue Cross
Premera High PPO, Peak Care EPO, Standard PPO

premera.com/sebb
1-800-807-7310 (TTY: 1-800-842-5357 or TRS: 711)

Uniform Medical Plan (UMP), administered by Regence BlueShield (for medical questions)
UMP Achieve 1, Achieve 2, High Deductible, UMP Plus

regence.com/ump/sebb
1-800-628-3481 (TRS: 711)

UMP Plus—Puget Sound High Value Network
pugetsoundhighvaluenetwork.org
1-877-345-8760

UMP Plus—UW Medicine Accountable Care Network
sebb.uwmedicine.org
1-855-520-9400 (TRS: 711)

Washington State Rx Services (for UMP prescription drug questions)

regence.com/ump/sebb/benefits/prescriptions
1-888-361-1611 (TRS: 711)

Dental plans

DeltaCare, administered by Delta Dental of Washington

deltadentalwa.com/sebb
1-800-650-1583 (TTY: 1-800-833-6384)

Uniform Dental Plan, administered by Delta Dental of Washington

deltadentalwa.com/sebb
1-800-537-3406 (TTY: 1-800-833-6384)

Willamette Dental Group

sebb.willamettedental.com
1-855-433-6825 (TRS: 711)

Vision plans

Davis Vision

davisvision.com/hcasebb
1-877-377-9353 (TTY: 1-800-523-2847)

EyeMed Vision Care

eyemedvisioncare.com/hcasebboe
1-800-699-0993 (TTY: 1-844-230-6498)

Metropolitan Life Insurance Company
MetLife Vision Plan

metlife.com/wshca-sebb
1-855-638-3931 (TTY: 1-800-428-4833)

Additional contacts

HealthEquity
Health savings account for UMP High Deductible

learn.healthequity.com/sebb/hsa
1-844-351-6853 (TRS: 711)

Limeade
SmartHealth wellness program

hca.wa.gov/sebb-smarthealth
1-855-750-8866

Metropolitan Life Insurance Company
MetLife Life and AD&D insurance

metlife.com/wshca-sebb
1-833-854-9624 (TTY: 1-833-854-9624)

Navia Benefit Solutions
Medical Flexible Spending Arrangement and Dependent Care Assistance Program

sebb.naviabenefits.com
1-800-669-3539 or 425-452-3500

The Standard Insurance Company
Long-term disability insurance

standard.com/employee-benefits/washington-state-hca-sebb
1-833-229-4177 (TTY: 1-833-229-4177)

2020 SCHOOL EMPLOYEE INITIAL ENROLLMENT GUIDE

Welcome to the SEBB Program

The School Employees Benefits Board (SEBB) Program was designed with you in mind. Providing you and your eligible dependents with affordable and equitable access to quality health insurance and other benefits is our top priority.

This guide provides SEBB Program eligibility, enrollment, and benefit information for school employees and their dependents. In these pages you'll learn about the quality benefits that the SEBB Program has been building since it was established in the summer of 2017.

What's inside

OCT. 1 First annual open enrollment: October 1 – November 15, 2019

JAN. 1 Benefits begin: January 1, 2020

Sign up for email subscription service

Get the latest news and updates from the SEBB Program by going paperless. When you receive SEBB Program mailings by email, it helps reduce reliance on paper mailings—and their toll on the environment. Go to SEBB My Account at **myaccount.hca.wa.gov** to sign up during the first annual open enrollment or any time after October 1.

YOUR SEBB PROGRAM BENEFITS

The SEBB Program offers a range of health plans and other benefits, beginning January 1, 2020, including:

Employer-paid benefits:

- Medical insurance
- Health savings account (HSA) for those who enroll in UMP High Deductible (administered by Regence BlueShield)
- Wellness programs like SmartHealth and the diabetes prevention program
- Dental insurance
- Vision insurance
- Basic life insurance
- Basic accidental death and dismemberment (AD&D) insurance
- Basic long-term disability (LTD) insurance

Additional benefits available for you to elect (employee-paid benefits):

- Supplemental life insurance
- Supplemental AD&D insurance
- Supplemental LTD insurance
- Medical Flexible Spending Arrangement (FSA)
- Dependent Care Assistance Program (DCAP)

Quick Start Guide

Enrolling in your new SEBB Program benefits is as easy as 1, 2, 3.

1 Find out if you're eligible

Your employer will determine if you are eligible for SEBB benefits based on your specific work circumstances using the criteria described under *Eligibility* on page 12.

Generally, you are eligible for SEBB benefits if you work for a Washington State school district or charter school, or are a represented employee of an educational service district (ESD), and your employer anticipates you will work at least 630 hours during the school year (September 1 through August 31).

Are you enrolling dependents? See *Dependent eligibility* on page 13 for eligibility rules and information. Make sure you have the right documents to prove their eligibility. These are available on page 15.

If you are not eligible as described in the eligibility section, you may be eligible for some SEBB Program benefits if your school district, charter school, or ESD negotiated eligibility as described in WAC 182-30-130. If you are represented, please check with your union or union contract regarding eligibility. Otherwise, your employer's payroll or benefits office will notify you if you are eligible under this provision.

2 Choose your benefits

There's a lot to think about when selecting your benefits. You need to consider things like provider networks, premiums, out-of-pocket costs, drug formularies, and if the plan and its providers are available to you.

You can also consider additional benefits, like the Medical Flexible Spending Arrangement (FSA), Dependent Care Assistance Program (DCAP), supplemental life insurance, supplemental accidental death and dismemberment (AD&D) insurance, and supplemental long-term disability (LTD) insurance.

Use these online tools at **hca.wa.gov/sebb-employee** to explore your options:

Virtual benefits fair
An online benefits fair experience that's available at your convenience. Start out in the virtual exhibition hall to see the available benefits, then visit plan "booths" to watch informative videos and access additional resources to learn more.

ALEX
An interactive, online benefits advisor that provides customized plan suggestions and side-by-side benefits comparisons for your consideration, based on your health care needs.

3 Enroll using SEBB My Account

Once you've decided what benefits and plans you want, head over to **myaccount.hca.wa.gov** to log in and enroll using SEBB My Account, our online enrollment system.

See *Get Started With SEBB My Account* on page 8 for details. You do not need to do anything to enroll in basic life, AD&D, and LTD insurance. You will be automatically enrolled.

Details on how to enroll in the following benefits are included in this enrollment guide.

- Supplemental life and supplemental AD&D: page 55
- Supplemental LTD: page 58
- Medical FSA and DCAP: page 59

What if I have other coverage? You can waive SEBB medical coverage if you are enrolled in other employer-based group medical insurance, a TRICARE plan, or Medicare. However, you must enroll in employer-paid dental and vision coverage, as well as basic life insurance, basic AD&D insurance, and basic LTD insurance. See *Waiving medical coverage* on page 20.

OCT. 1 — First annual open enrollment: October 1 – November 15, 2019

JAN. 1 — Benefits begin: January 1, 2020

SEBB PROGRAM BENEFITS FAIR SCHEDULE 2019

SEPT. 30

Bellingham
4PM–8PM
Bellingham Technical College, Settlemyer Hall
3028 Lindbergh Ave.

Yakima
4PM–8PM
Howard Johnson Yakima Orchard Room
9 N 9th St.

OCT. 1

Mount Vernon
4PM–8PM
Skagit Valley College, Cardinal Center Bldg C-172
2405 E College Way

Spokane
4PM–8PM
Educational Service District #101 (Northeast)
4202 Regal St.

OCT. 2

Olympia
4PM–8PM
South Puget Sound Community College, Student Union Building
2011 Mottman Rd SW

Pasco
3PM–8PM
Columbia Basin College, Gjerde Atrium
2600 N 20th Ave.

OCT. 3

Des Moines
4PM–8PM
Highline College, Mt. Constance/Mt. Olympus rooms
2400 S 240th St.

Wenatchee
4PM–8PM
Confluence Tech Center
285 Technology Center Way

OCT. 7

Shoreline
4:30PM–8PM
Shoreline Community College, Dining room
16101 Greenwood Ave. N

Vancouver
3PM–8PM
Educational Service District #112
2500 NE 65th Ave.

OCT. 8

Seattle
4PM–8PM
Garfield Community Center
2323 E Cherry St.

Tacoma
4:30PM–8PM
UW Tacoma, Phillip Hall
1900 Commerce St.

OCT. 10

Bremerton
4PM–8PM
Sheridan Community Center
680 Lebo Blvd.

OCT. 14

Bellevue
4PM–8PM
Bellevue College, L-Bldg
3000 Landerholm Circle SE

OCT. 17

Port Angeles
4PM–8PM
Peninsula College, J-47
1502 E Lauridsen Blvd.

OCT. 21

Moses Lake
4PM–8PM
Columbia Basin Tech Center, Commons Bldg.
900 Yonezawa Blvd.

OCT. 22

Cheney
4PM–8PM
Eastern Washington University, LA Hall
9th and Elm St.

OCT. 23

Colville
4PM–8PM
AG & Trade Center
317 W Astor Ave.

OCT. 24

Omak
4PM–8PM
Omak High School
20 S Cedar St.

NOV. 7

Pullman
4PM–8PM
Washington State University,
Compton Union Building
115 NW State St.,
Suite 112A

Get Started With SEBB My Account

SEBB My Account is the exclusive online enrollment system for the School Employees Benefits Board (SEBB) Program. Eligible school employees can use SEBB My Account on a computer, tablet, or smartphone to enroll in benefits during the first annual open enrollment, October 1 through November 15, for coverage effective January 1, 2020.

What can I do in SEBB My Account?

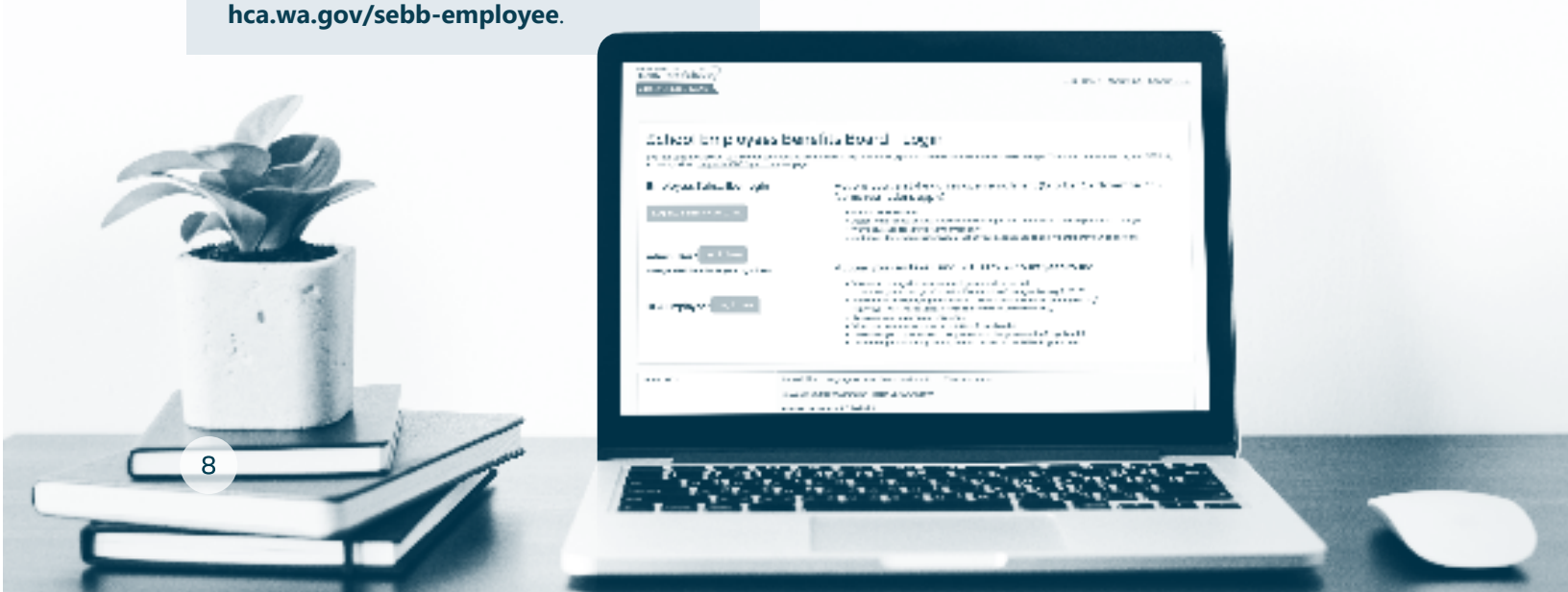
- Enroll in SEBB benefits or waive SEBB medical
- Enroll your eligible dependents in SEBB benefits
- Upload documents to prove dependent eligibility
- Select your medical, dental, and vision plans
- Access vendor websites to enroll in supplemental (employee-paid) life and accidental death and dismemberment insurance, a Medical Flexible Spending Arrangement (FSA), and Dependent Care Assistance Program (DCAP)
- Enroll in supplemental (employee-paid) long-term disability insurance
- Attest to premium surcharges (see the next page for details)
- Request a special open enrollment

Login notes

- Google Chrome is the preferred browser, but Edge, Internet Explorer, Firefox, and Safari will also work.
- Those enrolling in SEBB Continuation Coverage must use the enrollment forms available at **hca.wa.gov/erb** under *Forms & publications*, or in the *SEBB Continuation Coverage Election Notice* mailed to them.
- For more information, check out the SEBB My Account training video series at **hca.wa.gov/sebb-employee**.

Setting up your account

1. Visit **myaccount.hca.wa.gov** and click the green **Login to SEBB My Account** button under **Employee/Subscriber**. You'll be directed to SecureAccess Washington (SAW). See next page to learn about SAW.
2. Click **Sign up** to create a SAW account. (If you already have a SAW account, enter your username and password and skip to step 5.) Enter your name, email address, a username, and password. Remember to save your username and password in a safe place so you don't forget it the next time you log in.
3. Check the box to indicate you're not a robot, click **Submit**, and follow the link to activate your account.
4. Check your email for a message from SAW. Click on the confirmation link, then close the **Account Activated!** browser window that opens, and return to your original window. Follow the instructions on the screen to finish creating your account.
5. You will be redirected back to SEBB My Account. Enter your last name, date of birth, and last four digits of your Social Security number. Click **Verify my information**.
6. Select your security questions and answers. You'll be directed to the SEBB My Account dashboard.



How to enroll

Once you login to SEBB My Account, you can follow the step-by-step tool at the top of the page to guide you through the enrollment process. The four steps are:

1. **Add your dependents.** Enter your dependents' information. If you are not adding dependents, you can skip to step 3.
2. **Verify your dependents.** Your documents must be verified and approved before your dependents can enroll under your coverage. Upload documents from your computer or mobile device to verify your dependents' eligibility. Acceptable documents (like a birth or marriage certificate, or recent tax return) and file types (PDF, JPEG, JPG or PNG) are listed on the page.

   If you are unable to upload documents online, you can submit paper documents to your payroll or benefits office. HCA may audit dependent eligibility determinations. Please make sure to keep the documents you submitted.
3. **Attest to the premium surcharges.** Answer a series of on-screen questions to determine whether you'll be charged the monthly $25-per-account tobacco use premium surcharge and, if applicable, the monthly $50 spouse or state-registered domestic partner coverage premium surcharge.
4. **Select your plans.** You can follow a link to ALEX, the online benefits advisor, to learn more about which plans might be the best fit for you. When you're ready, select your plans in SEBB My Account by checking the box next to the medical, dental, and vision plans you want for you and any dependents you want to enroll.

   If you have other employer-based medical coverage, TRICARE, or Medicare, you can waive SEBB medical coverage.

When can I access SEBB My Account?

You can login to SEBB My Account starting October 1, 2019, which is the first day of the SEBB Program's first annual open enrollment. Open enrollment ends November 15 at 11:59 p.m., but you can log in any time, during or after open enrollment, to check your coverage or request special open enrollment changes.

What information do I need to enroll dependents?

For your spouse, state-registered domestic partner, or any children, you will need:

- Name
- Date of birth
- Social Security number
- Verification documents
  A list of acceptable documents is available in SEBB My Account, as well as at **hca.wa.gov/sebb-employee** and in your enrollment guide.

SecureAccess Washington

SecureAccess Washington (SAW) is the state's secure single sign-on portal for external users. A SAW account will keep your sensitive information secure. You can access multiple government services online with a single user ID and password that you create and manage yourself.

Contents

Eligibility

Who is eligible for SEBB benefits?

This guide provides a summary of employee eligibility for benefits administered by the SEBB Program. Generally, you are eligible for the employer contribution toward SEBB benefits if you work in a school district or charter school, or are a represented employee of an educational service district (ESD), and your employer anticipates you will work at least 630 hours during the school year (September 1 through August 31). Paid holidays do not count toward the required hours, except for certain circumstances when an employee is hired late in the school year.

Your employer will determine if you are eligible for the employer contribution toward SEBB benefits based on your specific work circumstances (see Washington Administrative Code [WAC] 182-31-040). All eligibility determinations are based on rules in chapters 182-30 and 182-31 WAC. If discrepancies arise between WACs and this guide, the WACs take precedence. If you disagree with the eligibility determination, see *Appeals* on page 68.

What if I'm eligible for SEBB benefits both as an employee and as a dependent?

You cannot enroll in medical, dental, or vision under two SEBB accounts. If you are an eligible employee and are also eligible as a dependent under your spouse's, state-registered domestic partner's, or parent's account, you may choose one of these options:

- Waive medical coverage under your own account and instead enroll under your spouse's, state-registered domestic partner's, or parent's account. You must still enroll in dental, vision, basic life insurance, basic AD&D insurance, and basic LTD insurance under your own account.
- Enroll in medical coverage under your own account.

Eligibility based on a revision to your anticipated work pattern or actual hours worked

If you are determined not eligible for the employer contribution toward SEBB benefits at the beginning of the school year, but your work circumstance changes and your employer anticipates at that time that you will work at least 630 hours during the school year, you become eligible on the date your work pattern is revised. Your coverage begins the first day of the following month.

If you are not anticipated to work 630 hours at the beginning of the school year, but you do actually work 630 hours, you become eligible on the day you work your 630th hour. Your coverage begins the first day of the following month.

If you are eligible for the employer contribution toward SEBB benefits at the beginning of the year, but your work pattern is revised so that you are no longer anticipated to work 630 hours during the school year, your eligibility for the employer contribution and coverage end the last day of the month in which the change is effective. See page 66 for information about continuation coverage.

Eligibility based on hours worked the previous two school years

If you worked at least 630 hours in each of the previous two school years and are returning to the same type of position or combination of positions with the same school district, charter school, or educational service district, you are presumed eligible for the employer contribution toward SEBB benefits.

If your employer does not consider you eligible after having worked at least 630 hours the previous two school years, they must notify you, in writing, of the specific reason(s) why you are not anticipated to work at least 630 hours in the current school year. You have the right to appeal the eligibility determination. See *Appeals* on page 68.

Eligibility based on work within one district, charter school, or ESD

All of your hours worked as a school employee within the same school district or charter school, or as a represented employee of the same educational service district (ESD) count in the calculation of hours to determine your eligibility. You cannot "stack" hours from different school districts, charter schools, or ESDs to reach the eligibility level of 630 hours.

For more details on eligibility, refer to Washington Administrative Code (WAC) 182-31-040 at **hca.wa.gov/sebb-rules**.

Returning school employees have uninterrupted coverage

Once you are enrolled in the SEBB Program, you will receive uninterrupted coverage from one school year to the next when you return at the start of the next school year to the same school district, charter school, or as a represented employee of the same ESD, as long as you are still anticipated to work 630 hours in the coming school year.

Eligibility when changing jobs between SEBB organizations

Once enrolled in the SEBB Program, you will have uninterrupted coverage when moving from one SEBB organization to another within the same month or a consecutive month if you are eligible for the employer contribution towards SEBB benefits in the position you are leaving and are anticipated to be eligible for the employer contribution toward SEBB benefits in the new position. SEBB insurance coverage elections also remain the same if you have a break in employment that does not interrupt their employer contribution toward your SEBB insurance coverage. You may make a change if you have a special open enrollment event. See page 63.

When do eligibility and coverage end?

Your eligibility for the employer contribution toward SEBB benefits ends the last day of the school year (August 31). Your eligibility for the employer contribution will end earlier if:

- **Your employer terminates your employment.** Eligibility and coverage ends the last day of the month in which the termination notice is effective.
- **You resign.** Eligibility and coverage ends the last day of the month in which your resignation is effective.
- **Your work pattern is revised** and your employer no longer anticipates you will work 630 hours during the school year. Coverage ends the last day of the month in which the change is effective. See page 66 for information about continuation coverage.

Employees eligible for locally negotiated benefits

If you not eligible as described in this eligibility section, you may be eligible for some SEBB Program benefits if your school district, charter school, or ESD negotiated eligibility as described in WAC 182-30-130. If you are represented, please check with your union or union contract regarding eligibility. Otherwise, your employer's payroll or benefits office will notify you if you are eligible under this provision.

Dependent eligibility

You may enroll the following dependents:

- Your legal spouse
- Your state-registered domestic partner (as defined in WAC 182-30-020)
- Your children (as defined in WAC 182-31-140) through the last day of the month in which they become age 26
- Your extended dependent children who meet specified eligibility criteria (see *Eligible extended dependents* on page 14)
- Your children of any age with a disability (see *Eligible children with disabilities* on page 14)

If you have dependents currently enrolled in medical, dental, or vision under your school district, charter school, or ESD group insurance on December 31, 2019 who are not eligible as dependents, SEBB Program benefits may be available. (See *What are my options when coverage ends?* on page 66 for details.)

Children as defined by WAC 182-31-140

This definition includes:

- Your children, based on establishment of a parent-child relationship as described in RCW 26.26A.100, except when parental rights have been terminated
- Children of your spouse, based on establishment of a parent-child relationship as described in RCW 26.26A.100, except when parental rights have been terminated
- Children for whom you have assumed a legal obligation for total or partial support in anticipation of adoption of the child
- Children of your state-registered domestic partner, based on establishment of a parent-child relationship as described in RCW 26.26A.100, except when parental rights have been terminated
- Children specified in a court order or divorce decree for whom you have a legal obligation to provide support or health care coverage

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Eligible extended dependents

Eligible school employees enrolled in SEBB benefits may enroll a child up to age 26 that is an extended dependent in the legal custody or legal guardianship of the school employee, the school employee's spouse, or the school employee's state-registered domestic partner. The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. An extended dependent child does not include a foster child unless the school employee, the school employee's spouse, or the school employee's state-registered domestic partner has assumed a legal obligation for total or partial support in anticipation of adoption.

Eligible children with disabilities

Eligible children also include children of any age with a developmental or physical disability that renders the child incapable of self-sustaining employment and chiefly dependent upon the employee for support and maintenance, provided the condition occurred before age 26.

The SEBB Program, with input from your medical plan (if applicable), will verify the disability of a child beginning at age 26, but no more frequently than annually after the two-year period following the child's 26th birthday, which will require certification from you and your dependent's provider.

During the SEBB Program's first annual open enrollment, October 1 through November 15:

- If you are a currently enrolled member of the Public Employees Benefits Board (PEBB) Program, you are not required to recertify your child. Your certification will transition to the SEBB Program. Nothing further will be required until the next recertification period.
- If you and your dependent child with a disability are currently enrolled in your SEBB organization's (school district, charter school, or participating educational service district) health plan (and not enrolled in PEBB benefits), your payroll or benefits office is authorized to attest to your dependent child's disability status if the child is enrolled based on eligibility as a dependent child age 26 or older with a disability. The attestation may be based on either of the following:
  - An existing SEBB organization enrollment record, finding the dependent child eligible at age 26 or older based on disability that occurred prior to attainment of age 26.
  - Visual verification of a document from the SEBB organization's current health plan finding the dependent child eligible at age 26 or older based on disability that occurred prior to attainment of age 26.
- For a child with a disability who will turn age 26 on or before December 31, 2019, the SEBB organization can continue to verify and attest through December 31, 2019.

If you are not able to obtain an attestation from your SEBB organization while requesting enrollment of your child, follow the process for initial certification:

- You must submit proof of the disability to the SEBB Program.
- The SEBB Program, with input from your medical plan (if applicable), will verify the disability of a child beginning at age 26, but no more frequently than annually after the two-year period following the child's 26th birthday, which will require recertification from you and your dependent's provider.
- If the SEBB Program does not receive your certification form within the time allowed, the child will no longer be covered. To prevent a gap in coverage you must submit all required documentation within the first annual open enrollment and if your child is turning age 26 in the year of 2020 you must send documentation prior to your child's 26th birthday to prevent a gap in coverage. If your child remains eligible, you can enroll your child if you experience a special open enrollment or during the next annual open enrollment.

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

You must notify the SEBB Program, in writing, no later than 60 days after the date your child is no longer eligible.

Surviving dependent eligibility

If you die, your dependents will lose their eligibility for the employer contribution toward SEBB Program benefits. They may be eligible to enroll in Public Employees Benefits Board (PEBB) Program retiree insurance coverage as a survivor, instead of enrolling

in SEBB Program continuation coverage. See page 66 for more about continuation coverage.

Proving dependent eligibility

When you enroll dependents on your SEBB Program coverage, you are required to provide proof of their eligibility with a document that shows they are dependents, even if you have previously verified their eligibility with your employer. These documents must be approved (verified) by your payroll or benefits office during the first annual open enrollment. You can upload your documents for verification in SEBB My Account (see page 8 to 9), or provide them directly to your employer's payroll or benefits office.

There is an exception for school employees who were previously enrolled in the Public Employees Benefits Board (PEBB) Program. If you are enrolled in PEBB benefits as of December 31, 2019, you do not need to provide dependent verification documents if your enrolled dependents have already been verified by your employer.

Valid dependent verification documents

Birth certificates, adoption decrees, tax returns, and parenting plans are among the types of documents you can use to prove eligibility. All documents must be submitted in English. Documents written in a foreign language must include a translated copy prepared by a professional translator and be notarized.

Documents to enroll a spouse
Provide a copy of (choose one):

- Your most recent year's jointly filed federal tax return that lists the spouse (black out financial information)
- Your and your spouse's most recent year's federal tax returns if filed separately (black out financial information)
- A marriage certificate and evidence that the marriage is still valid (e.g., a utility bill dated within the past two months showing both your and your spouse's names, a bank statement dated within the past two months [black out financial information] showing both your and your spouse's names)
- Petition for dissolution of marriage
- Legal separation notice
- Defense Enrollment Eligibility Reporting System (DEERS) registration
- Valid J-1 or J-2 visa issued by the U.S. government

Documents to enroll a state-registered domestic partner
Provide a copy of (choose one):

- A certificate/card of state registered domestic partnership or legal union and evidence that the partnership is still valid (e.g., utility bill dated within the past two months showing both your and your state-registered domestic partner's names, a bank statement dated within the past two months [black out financial information] showing both your and your partner's names)
- 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 enrolling a state-registered domestic partner, also attach a completed *Declaration of Tax Status* form to indicate whether your state-registered domestic partner qualifies as a dependent for tax purposes under Internal Revenue Code (IRC) Section 152, as modified by IRC Section 105(b).

Documents to enroll children
Provide a copy of (choose one):

- The most recent year's federal tax return that includes the child as a dependent and lists them as a son or daughter (black out financial information). You can submit one copy of your tax return as a verification document for all family members listed who require verification.
- Birth certificate (or hospital certificate with the child's footprints on it) showing the name of the parent who is the subscriber, the subscriber's spouse or state-registered domestic partner.
- 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 or state-registered domestic partner in SEBB insurance coverage.
- Certificate or decree of adoption showing the name of the parent who is the subscriber, the subscriber's spouse or state-registered domestic partner
- Court-ordered parenting plan
- National Medical Support Notice

(continued)

- Defense Enrollment Eligibility Reporting System (DEERS) registration
- Valid J-2 visa issued by the U.S. government

See *Additional required forms* on this page for information regarding requirements for an extended dependent, state-registered domestic partner or their eligible children, or child with a disability.

If you disagree with a specific eligibility decision or denial, you can appeal. See *Appeals* on page 68.

Enrollment

When can I enroll?

If you are eligible for SEBB Program benefits, you must enroll during the SEBB Program's first annual open enrollment, October 1 through November 15, 2019.

How do I enroll?

The easiest way to enroll is online, using SEBB My Account. You can access SEBB My Account using a desktop computer or mobile device. See *Get Started With SEBB My Account* on pages 8 to 9 to learn how to set up your account and enroll online. You cannot access SEBB My Account and enroll online until October 1, 2019. Online enrollment through SEBB My Account must be completed by 11:59 p.m. on November 15, 2019.

If you cannot access the internet, use the *School Employee Enrollment Form*, available from your payroll or benefits office. You cannot submit enrollment forms before October 1, 2019. Your employer's payroll or benefits office must receive any paper forms by November 15, 2019.

When open enrollment begins on October 1, log in to SEBB My Account at **myaccount.hca.wa.gov** to:

- Choose your medical, dental, and vision insurance plans.
- Enroll in (employee-paid) supplemental long-term disability (LTD) insurance
- Access vendor websites to enroll in (employee-paid) supplemental life insurance, supplemental accidental death and dismemberment (AD&D) insurance, Medical Flexible Spending Arrangement (FSA), and Dependent Care Assistance Program (DCAP).
- Enroll your eligible dependents.
- Upload dependent verification documents.
- Make attestations for the tobacco use premium surcharge for yourself and each dependent you want to enroll under your coverage and, if applicable, the spouse or state-registered domestic partner coverage premium surcharge.
- Download a summary of your coverage elections.

You do not need to do anything to enroll in basic life insurance, basic accidental death and dismemberment (AD&D) insurance, and basic long-term disability insurance; you will be automatically enrolled. You will also be automatically enrolled as a participant under the premium payment plan (see *How do I pay for coverage?* on page 22).

Additional required forms

Declaration of Tax Status: Employees must also complete and submit this form when enrolling a state-registered domestic partner or their eligible children regardless of tax status.

Certification of a Child With a Disability: After turning age 26, your child may be eligible for enrollment under your SEBB Program health plan if your child's developmental or physical disability occurred before age 26, and they are incapable of self-sustaining employment and chiefly dependent on you for support and maintenance.

Extended Dependent Certification: To be considered for enrollment in SEBB Program coverage as an extended dependent, all of the following conditions must be met:

- The extended dependent must not be your child through birth, adoption, marriage, or a state-registered domestic partnership.
- You, your spouse, or your state-registered domestic partner are the legal guardian or have legal custody of the child.
- The child's official residence is with the guardian or custodian.
- You have provided the SEBB Program with a valid court order showing that you, your spouse, or your state-registered domestic partner have legal custody or guardianship.
- The child is not a foster child unless you, your spouse, or your state-registered domestic partner has assumed a legal obligation for total or partial support in anticipation of adoption.

If enrolling a:	Also complete this form:
State-registered domestic partner or their eligible children	*Declaration of Tax Status*
Dependent child with a disability (age 26 and older)	*Certification of a Child With a Disability*
Extended (legal) dependent child	*Extended Dependent Certification*

Forms are available at **hca.wa.gov/sebb-employee** under *Forms & publications*.

Am I required to enroll?

Yes. If your employer determines that you are eligible, you are required to enroll. However, you may waive enrollment in SEBB medical coverage if you are enrolled in other employer-based group medical insurance, a TRICARE plan, or Medicare. In order to waive SEBB medical coverage you must actively indicate your intention to do so in SEBB My Account or by submitting an enrollment form to your payroll or benefits office. If you waive SEBB medical insurance, you must still enroll in SEBB dental, vision, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, and basic long-term disability (LTD) insurance.

If you waive medical coverage for yourself, you cannot enroll your eligible dependents in SEBB medical coverage, but you can enroll them in SEBB vision and dental. See *Waiving medical coverage* on page 20 for instructions and timelines.

What if I don't waive or enroll?

If you are eligible for the employer contribution toward SEBB benefits, but do not waive or enroll in SEBB Program medical coverage during the first annual open enrollment, you will be enrolled by default as a single subscriber in UMP Achieve 1 (administered by Regence BlueShield) as your medical plan, Uniform Dental Plan, MetLife vision insurance, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, and basic long-term disability (LTD) insurance. Your dependents will not be enrolled. You will be charged a monthly $33 premium for medical coverage as well as a $25-per-account monthly tobacco use premium surcharge. See *Waiving medical coverage* on page 20.

If you are defaulted, you cannot change plans or enroll your eligible dependents until the next SEBB Program annual open enrollment in fall 2020, unless you have a special open enrollment event that allows the change. You can change your tobacco use attestation at any time through SEBB My Account or by submitting a *2020 SEBB Premium Surcharge Attestation Change Form* to your payroll or benefits office. See *Premium surcharges* on page 23.

Can I enroll in my own account and as a dependent on someone else's SEBB account?

No. A person may be enrolled in only one SEBB medical, dental, and vision plan. You can waive medical coverage for yourself and enroll as a dependent on your spouse's, state-registered domestic partner's, or parent's SEBB medical coverage. However, you must enroll in dental and vision coverage, as well as basic life insurance, basic accidental death and dismemberment insurance, and basic long-term disability insurance under your own account if eligible. See *Waiving medical coverage* on page 20.

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

Yes. If you are enrolled in SEBB Program benefits, and your spouse or state-registered domestic partner or parent is enrolled in Public Employees Benefits Board (PEBB) Program benefits, you can be enrolled in both programs. Your primary coverage would be through the SEBB Program and your secondary coverage would be through the PEBB Program, which is also administered by the Washington State Health Care Authority.

For example, if you are enrolled in the SEBB Program covering yourself as well as your spouse or state-registered domestic partner as a dependent, and your spouse is enrolled in the Public Employees Benefits Board (PEBB) Program and covers you as a dependent, or vice versa, you and your spouse would not incur the monthly $50 spouse or state-registered domestic partner coverage premium surcharge as long as you attest that it does not apply to you. However, if your spouse or state-registered domestic partner waives their PEBB medical coverage and enrolls on your account, you will be charged the monthly $50 spouse or state-registered domestic partner coverage premium surcharge in addition to your monthly medical premium. Alternatively if

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you waive enrollment in SEBB medical and your spouse or state-registered domestic partner enrolls you as a dependent on their PEBB account, they will be charged the monthly $50 spouse or state-registered domestic partner coverage premium surcharge in addition to their monthly medical premium. See *Premium surcharges* on page 23.

What if I am 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. Find contact information for your local office at **ssa.gov/agency/contact**.

For employees and their enrolled spouses age 65 and older, SEBB medical plans provide primary coverage, and Medicare ordinarily provides secondary coverage. You may choose to waive your enrollment in SEBB medical coverage and have Medicare as your medical coverage. However, you will remain enrolled in SEBB dental, vision, basic life insurance, basic AD&D insurance, and basic LTD insurance. See *Waiving medical coverage* on page 20.

Medicare Part B
In most situations, you and your spouse can elect to defer Medicare Part B enrollment, without penalty, as long as you are an active employee enrolled in a group medical plan. Contact your nearest Social Security office for information on deferring or reinstating Medicare Part B. Make sure you understand the Medicare enrollment timelines to avoid late enrollment penalties.

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

Medicare Part D: Annual notice of creditable prescription drug coverage
Medicare Part D is available to people enrolled in Medicare Part A and/or Part B. Part D coverage provides prescription drug benefits through private plans. These plans provide at least a standard level of coverage set by Medicare. All SEBB medical plans provide creditable prescription drug benefits that are as good as or better than Medicare Part D coverage. When you become entitled to Medicare Part A and Part B, you do not have to enroll in Medicare Part D. If you enroll in Medicare Part D, your SEBB medical plan may not coordinate prescription drug benefits with your Medicare Part D plan.

If you lose or terminate SEBB medical coverage
To avoid paying a higher premium, you should enroll in a Medicare Part D plan within 63 days after your SEBB medical coverage ends. If you don't enroll within the 63-day deadline, your Medicare Part D plan's monthly premium may increase by 1 percent or more for every month you don't have creditable coverage.

If you enroll or terminate (cancel) enrollment in Medicare Part D, you may need a "notice of creditable coverage" to prove to Medicare or the prescription drug plan that you have had continuous prescription drug coverage to reenroll at a later date without penalties. You can call the SEBB Program at 1-800-200-1004 (select menu option 6) to request a notice of creditable coverage.

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

What if I'm thinking about retiring?

The SEBB Program does not offer retiree insurance coverage. Retiree insurance coverage for SEBB members is offered through the Public Employees Benefits Board (PEBB) Program. When you become entitled to Medicare Part A and Part B, you must enroll and maintain enrollment in Medicare Part A and Part B to enroll or remain eligible for PEBB retiree insurance coverage. Be sure you understand the Medicare enrollment timelines, especially if you are leaving employment within a few months of becoming eligible for Medicare or are in your Medicare Initial Enrollment Period (IEP) and want to enroll in PEBB retiree health plan coverage.

When you plan to terminate your employment and want to enroll in PEBB retiree insurance coverage, you can contact the PEBB Program about 90 days prior to terminating employment at 1-800-200-2004 (select menu option 5) to ask general PEBB retiree insurance questions. You can also request a *PEBB Retiree Enrollment Guide* or download it from the link below. You have 60 days from the date your employer-paid SEBB coverage or COBRA coverage ends for the PEBB Program to receive your application for retiree insurance coverage. Once your form is received, PEBB

Program staff will review your form for eligibility and contact you if they have additional questions.

Find information and download forms online at **hca.wa.gov/pebb-retirees**.

When does coverage begin?

When you enroll in benefits during the SEBB Program's first annual open enrollment, your SEBB insurance coverage begins January 1, 2020.

For the first annual open enrollment, the required form(s) and proof of your dependents' eligibility must be received by your employer or in SEBB My Account no later than 11:59 p.m. on November 15, 2019.

When making a change during the SEBB Program's annual open enrollment or when a special open enrollment event occurs, coverage will begin as noted in the table below.

For a special open enrollment, the required form(s) and proof of your dependents' eligibility and/or the event must be **received** by your employer or in SEBB My Account **no later than 60 days** after the special open enrollment event. See *What changes can I make during a special open enrollment?* on page 62 for more information and a list of special open enrollment events.

Event	When coverage begins
SEBB Program's first annual open enrollment	January 1 of the following year
Marriage or registering for a state-registered domestic partnership	The first of the month after the event or the date your payroll or benefits office receives your completed enrollment form with proof of your dependent's eligibility, whichever is later. If that day is the first of the month, coverage begins on that day. You can submit the proof of eligibility later than the online enrollment or form, as long as it is within 60 days of the event.
Birth, adoption, or assumed legal obligation for total or partial support in anticipation of adoption	The date of birth (for a newly born child), the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier (for a newly adopted child). If you enroll yourself in order to enroll a newly born or newly adopted child, medical coverage will begin the first day of the month in which the event occurs. If you enroll your eligible spouse or state-registered domestic partner in your SEBB Program coverage due to your child's birth or adoption, their medical coverage begins the first day of the month in which the birth or adoption occurs. 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 a newly born child begins on the 14th day after birth. You can submit the proof of eligibility later than the online enrollment or form, as long as it is within 60 days of the event.
Child becomes eligible as an extended dependent	The first day of the month following eligibility certification.
Other events that create a special open enrollment See pages 63 to 65.	The first of the month after the date of the event or the date your payroll or benefits office receives your completed online enrollment or form, whichever is later. If that day is the first of the month, coverage begins on that day. You can submit the proof of eligibility later than the online enrollment or form, as long as it is within 60 days of the event.

Waiving medical coverage

You can waive your enrollment in SEBB medical coverage if you are enrolled in other employer-based group medical insurance, a TRICARE plan, or Medicare. If you are eligible for the employer contribution toward SEBB benefits and you waive medical coverage, you must still enroll in dental coverage, vision coverage, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, and basic long-term disability (LTD) insurance for yourself.

If you waive enrollment in SEBB medical coverage:

- You cannot enroll your eligible dependents in SEBB medical coverage, but you can enroll them in SEBB dental and vision coverage.
- The premium surcharges will not apply to you.
- You are still eligible to participate in the SmartHealth wellness program, but you cannot qualify for the wellness incentives.
- You can still enroll in supplemental life insurance, supplemental AD&D insurance, supplemental LTD insurance, the Medical Flexible Spending Arrangement (FSA) and Dependent Care Assistance Program (DCAP).

How do I waive medical coverage?

To waive enrollment in medical coverage, use SEBB My Account by 11:59 p.m. on November 15, 2019. Or, to use the paper enrollment or change form (see your payroll or benefits office for appropriate paper form) your payroll or benefits office must receive the completed form by November 15, 2019.

What happens if I don't enroll in or waive medical coverage?

If you are eligible for the employer contributions toward SEBB benefits but don't either enroll in or waive medical coverage during the first annual open enrollment, you will be enrolled as a single subscriber in UMP Achieve 1 (administered by Regence BlueShield) for medical coverage, Uniform Dental Plan, MetLife vision insurance, basic life insurance, basic AD&D insurance, and basic LTD insurance. Your dependents will not be enrolled. You will be charged a monthly $33 premium for your medical coverage and a monthly $25-per-account tobacco use premium surcharge.

How do I enroll later if I've waived medical coverage?

If you waive medical coverage, you can only enroll during the next annual open enrollment (for coverage effective January 1 the following year). The only exception is if you have a special open enrollment event that allows you to enroll in medical coverage, such as losing eligibility for other coverage, getting married, or having a child. See *What changes can I make during a special open enrollment?* on page 62.

Monthly Medical Plan Premiums

There are no employee premiums for dental, vision, basic life insurance, basic accidental death and dismemberment insurance, and basic long-term disability insurance. There are also no employee premiums to cover dependents on your dental or vision insurance. These premiums are paid by your employer. You only pay the employee share of the monthly medical premium as shown in the table below. Additional premium surcharges may apply (see page 23 for details).

Medical plans	Subscriber	Subscriber and spouse[1]	Subscriber and child(ren)[2]	Subscriber, spouse[1] and child(ren)[2]
Kaiser Permanente NW 1	$28	$56	$49	$84
Kaiser Permanente NW 2	$41	$82	$72	$123
Kaiser Permanente NW 3	$106	$212	$186	$318
Kaiser Permanente WA Core 1	$13	$26	$23	$39
Kaiser Permanente WA Core 2	$19	$38	$33	$57
Kaiser Permanente WA Core 3	$89	$178	$156	$267
Kaiser Permanente WA SoundChoice	$49	$98	$86	$147
Kaiser Permanente WA Options Access PPO 1	$39	$78	$68	$117
Kaiser Permanente WA Options Access PPO 2	$69	$138	$121	$207
Kaiser Permanente WA Options Access PPO 3	$116	$232	$203	$348
Premera High PPO	$70	$140	$123	$210
Premera Peak Care EPO	$31	$62	$54	$93
Premera Standard PPO	$22	$44	$39	$66
Uniform Medical Plan (UMP) Achieve 1	$33	$66	$58	$99
UMP Achieve 2	$98	$196	$172	$294
UMP High Deductible (with a health savings account)	$25	$50	$44	$75
UMP Plus–Puget Sound High Value Network	$68	$136	$119	$204
UMP Plus–UW Medicine Accountable Care Network	$68	$136	$119	$204

[1] Or state-registered domestic partner

[2] You pay the monthly medical premium shown regardless of how many children you enroll.

Paying for benefits

What will I have to pay?

You pay a monthly medical premium for yourself and any enrolled dependents on your account.

In addition to your monthly medical premium, you may be charged a monthly $25-per-account tobacco use premium surcharge and/or a monthly $50 spouse or state-registered domestic partner coverage premium surcharge. See *Premium surcharges* on page 23 for details on whether the premium surcharges apply to you.

You do not pay any premiums for dental, vision, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, or basic long-term disability (LTD) insurance. There are also no employee premiums to cover dependents on your dental or vision insurance. These premiums are paid by your employer.

If you elect to buy supplemental life insurance, supplemental AD&D insurance, or supplemental LTD insurance, you will pay those premiums. See page 55 through 59 for details.

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

You are responsible for paying any out-of-pocket costs for deductibles, coinsurance, or copayments for services under the medical, dental, and vision plans you choose. See the *Medical Benefits Comparison* chart on page 40 for a side-by-side comparison of many common benefits and costs for services for each plan.

How do I pay for coverage?

You will automatically be enrolled as a participant under the premium payment plan, so medical plan premiums and applicable premium surcharges are deducted from your paycheck before taxes, unless you request otherwise. Internal Revenue Code (IRC) Section 125 allows your employer to deduct money from your paycheck before calculating federal withholding, Social Security, and Medicare taxes.

Exception: If you enroll a dependent who does not qualify as an IRC Section 125 dependent (i.e., state-registered domestic partner), your medical premiums associated with the dependent's enrollment and the $50 monthly spouse or state-registered domestic partner coverage premium surcharge (if applicable) will be deducted from your paycheck post-tax.

If you do not want your SEBB medical premiums or applicable premium surcharges paid with pretax earnings, you must complete and submit the *Premium Payment Plan Election/Change* form to your employer's payroll or benefits office during the first annual open enrollment. You cannot do this on SEBB My Account.

Why should I pay my monthly premiums with pretax dollars?

Paying your premiums pretax allows you to take home more in your paycheck because the premium and applicable premium surcharges are deducted before taxes are calculated. This reduces your taxable income, which lowers your taxes and saves you money.

Would it benefit me not to have a pretax deduction?

Deducting your premiums pretax may affect the following benefits:

Social Security
If your base salary is less than the annual federal taxable maximum (find it at **ssa.gov/OACT/COLA/cbb.html**), paying your premiums pretax reduces your Social Security taxes now. However, your lifetime Social Security earnings would be calculated using the lower salary, which lowers your Social Security benefit when you retire.

Unemployment compensation
Paying your premiums pretax also reduces the base salary used to calculate unemployment compensation.

To learn more about IRC Section 125 and its impact on other benefits, talk to a qualified financial planner, tax specialist, or visit your local Social Security office.

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

Yes. You may change your participation under the state's premium payment plan (opt out of, or revoke your election and elect to opt in) during the SEBB Program's first annual open enrollment or if

you have an applicable special open enrollment event as described in WAC 182-30-100. See *What changes can I make during a special open enrollment?* on page 62.

Premium surcharges

Two premium surcharges may apply if you are enrolled in a SEBB Program medical plan:

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

Tobacco use premium surcharge

You will be charged a monthly $25-per-account tobacco use premium surcharge in addition to your monthly medical plan premium if you or a dependent (age 13 or older) enrolled on your SEBB Program medical account has used a tobacco product in the past two months.

The surcharge will not apply if:

- You and/or all enrolled dependents ages 18 and older who use tobacco products are enrolled in a tobacco cessation program through your medical plan, or
- Enrolled dependents ages 13 to 17 who use tobacco products have accessed information and resources aimed at teens at **teen.smokefree.gov**.

Enrolled dependents age 12 and younger are automatically defaulted to non-tobacco users. This means you do not have to attest for dependents age 12 and younger. You do not need to attest when the dependent turns age 13 unless the dependent uses, or starts using, tobacco products.

If a provider finds that ending tobacco use or participating in your medical plan's tobacco cessation program will negatively affect your or your dependent's health, see more information in SEBB Program Administrative Policy 91-1 at **hca.wa.gov/sebb-rules**.

How to attest to this surcharge
To find out if the tobacco use surcharge applies to your account, use the *2020 SEBB Premium Surcharge Attestation Help Sheet* on page 70. You must attest when you enroll either online on SEBB My Account or using the *School Employee Enrollment Form*. If you use the paper form, submit the completed enrollment form to your employer's payroll or benefits office.

You will be charged a monthly $25-per-account tobacco use premium surcharge in addition to your monthly medical premium if you do not attest for all dependents you enroll, or if the attestation results in you incurring the surcharge.

How to report a change in tobacco use

You can report a change in tobacco use status anytime if:

- Any enrolled dependent age 13 and older starts using tobacco products.
- You or your enrolled dependent have not used tobacco products within the past two months.
- You or your enrolled dependent who is 13 years or older and uses tobacco products enrolls in the free tobacco cessation program through your SEBB Program medical plan.
- Your enrolled dependent who is 13 to 17 years old and uses tobacco products accesses the tobacco cessation resources aimed at teens mentioned in the *2020 SEBB Premium Surcharge Attestation Help Sheet*.

Go to **myaccount.hca.wa.gov** to change your attestation, or complete a *2020 SEBB Premium Surcharge Attestation Change Form* (see page 70). Submit the form to your employer's payroll or benefits office.

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

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

Spouse or state-registered domestic partner coverage premium surcharge

If you do not enroll a spouse or state-registered domestic partner on your SEBB medical coverage, this premium surcharge does not apply to you.

You will be charged a monthly $50 spouse or state-registered domestic partner coverage premium surcharge in addition to your monthly medical premium if you have a spouse or state-registered domestic partner enrolled on your SEBB Program medical account, and your spouse or state-registered domestic partner was eligible for,

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but elected not to enroll in, another employer-based group medical insurance where the spouse's or state-registered domestic partner's share of the medical premium is less than 95 percent of the additional cost an employee would be required to pay to enroll a spouse or state-registered domestic partner in the PEBB Program's Uniform Medical Plan (UMP) Classic plan (administered by Regence BlueShield) and the benefits have an actuarial value of at least 95 percent of the actuarial value of the PEBB UMP Classic benefits.

How to attest to this surcharge
If you enroll a spouse or state-registered domestic partner on your SEBB Program medical coverage, use the *2020 SEBB Premium Surcharge Attestation Help Sheet* on page 70 or go to *Spouse or state-registered domestic partner coverage premium surcharges* in SEBB My Account to find out if the spouse or state-registered domestic partner coverage surcharge applies to you. Then, you must attest when you enroll, either online on SEBB My Account or using the *School Employee Enrollment Form*. If you use the paper form, submit the completed enrollment form to your employer's payroll or benefits office.

If you enroll a spouse or state-registered domestic partner on your medical account but do not complete the attestation, or if the attestation results in you incurring the surcharge, you will be charged the spouse or state-registered domestic partner coverage premium surcharge in addition to your monthly medical premium.

Premium surcharge reminders
When you enroll dependents on your SEBB medical coverage, you must attest on your enrollment form or on SEBB My Account to whether the tobacco use premium surcharge applies to all enrolled dependents and, if enrolling a spouse or state-registered domestic partner, whether the spouse or state-registered domestic partner coverage premium surcharge applies. See the *2020 SEBB Premium Surcharge Attestation Help Sheet* on page 70 for details. You may not be charged the premium surcharges, depending on your answers.

Choosing your benefits

The SEBB Program and our benefit plan carriers have a variety of tools to help you choose the plans that are right for you and decide which additional benefits you may want to enroll in. You can access these tools at **hca.wa.gov/sebb-employee**.

Virtual Benefits Fair

The virtual benefits fair is a convenient way to learn about your benefit options through an online experience that's available anytime, day or night, beginning October 1. Use your computer, tablet, or smartphone to visit and explore at your own pace.

The virtual benefits fair includes an exhibit hall where each insurance carrier and plan administrator has a booth that displays information about their plan options. You can get information about medical, dental, and vision plans, as well as life insurance, accidental death and dismemberment insurance, and long-term disability insurance, the Medical Flexible Spending Arrangement (FSA) and Dependent Care Assistance Program (DCAP), and SmartHealth, our wellness program. You'll get links to videos, downloadable content, provider searches, and other information to help you choose the right plans for you and your dependents.

In the virtual benefits fair you'll also be able to learn more about eligibility and enrollment details, access ALEX, our online benefits advisor, and get helpful hints to prepare for enrollment. When you're ready to enroll, you'll be able to head straight to SEBB My Account, our online enrollment system, to start choosing your plans.

ALEX

Our online, interactive benefits advisor, ALEX, will help you understand your benefits and guide you through choosing your medical, dental, and vision plans. ALEX will suggest plans for you to consider. Your responses to ALEX are private and confidential. You'll find links to ALEX on the homepage of the virtual benefits fair and within SEBB My Account. It will be available beginning October 1.

Selecting a medical plan

The SEBB Program is working hard to ensure a seamless and safe transition from your current medical plan to your new SEBB Program medical plan. When choosing your medical plan, be sure to consider how it could influence your overall care. This is especially important if you have a high-risk pregnancy, are currently undergoing treatment, have a chronic condition (such as diabetes, heart disease, depression, or cancer), or are taking a high-cost medication. You should also consider plan eligibility and availability.

Eligibility. Not everyone qualifies to enroll in UMP High Deductible with a health savings account (HSA) (see page 27). If you cover eligible dependents, everyone must enroll in the same medical, dental, and vision plans.

Availability. In most cases, you must live in the medical plan's service area to join the plan. All school employees will be offered a selection of plans based on their county of residence. Some school employees, including employees who live outside Washington State, may have more plan options if they work in a district that crosses county lines or is in a county that borders Idaho or Oregon. See what plans are available to you by county on pages 29 to 34 or by district on pages 35 to 39.

If you move out of your medical plan's service area or change jobs to a different school district, charter school, or educational service district as a represented employee, you may need to change your plan. You must report your new address and any request to change your medical plan to your payroll or benefits office **no later than 60 days** after you move.

How can I compare the medical plans?

All SEBB Program medical plans cover the same basic health care services, but they vary in other ways, such as provider networks, premiums, out-of-pocket costs, and drug formularies. The SEBB Program has a variety of tools and resources to help you choose the plan that's right for you. See *Choosing your benefits* on page 24.

Medical plan differences to consider

When choosing your SEBB Program medical plan, here are some things to keep in mind:

Your provider. If you want to see a specific doctor or health care provider, contact the SEBB medical plan to verify whether they are in the plan's network before you join. Plan contact information is listed at the beginning of this guide. For links to the plans' provider searches, visit **hca.wa.gov/sebb-employee** and search *Find providers*.

Your current care. Discuss with your current providers and care specialists how switching to a new medical plan may impact your care. You'll want to learn how a new plan could affect your or your dependent's ability to continue care with the same medical team, at the same facilities, and with the same prescription medications.

Preauthorization. If you have received prior authorization for any services under your current plan, it is important that you research which SEBB Program medical plans will honor existing preauthorization and for how long. This information may be available on the medical plan's website, in their certificates of coverage, or in written correspondence sent to you from your plan. Contact the medical plan or website for more information. Plan contact information is listed at the beginning of this guide.

Network adequacy. All health carriers in Washington State are required to maintain mental health and substance abuse treatment provider networks that provide enrollees reasonable access to covered services. They must also provide additional information to consumers on the adequacy of their mental health and substance abuse treatment provider networks. For more information, see Engrossed Substitute House Bill 1099 (Brennan's Law) at **leg.wa.gov**.

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, dental, and/or vision plans directly to ask how they will coordinate benefits. This is especially important for those coordinating benefits between the SEBB and PEBB programs, and those also enrolled in Apple Health (Medicaid). You cannot be enrolled in two SEBB accounts.

All SEBB medical plans coordinate benefit payments with other group medical plans, Medicaid, and Medicare. This coordination ensures

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the highest level of reimbursement for services when a person is covered by more than one plan. Payment will not exceed the benefit amount. If you have other comprehensive group health coverage, you may not enroll in an HDHP with an HSA. Call HealthEquity at 1-877-873-8823 (TRS: 711) to ask about certain exceptions.

Premiums. A premium is the monthly amount the employee or employer pays to the plan to cover the cost of insurance. The premium does not cover copays, coinsurance, or deductibles. Premium amounts vary by medical plan. A higher premium doesn't necessarily mean higher quality of care or better benefits; each plan has the same basic level of benefits. Premiums for all SEBB medical plans are listed on page 21.

Deductibles. All medical plans require you to pay a certain amount of plan costs, such as fees for office visits, before the plan pays for covered services. This is known as the deductible. Medical plans may also have a separate annual deductible for specific prescription drugs. Covered preventive care services are exempt from the medical plan deductible. This means you do not have to pay your deductible before the plan pays for the covered preventive service.

If you enroll in a high-deductible health plan (HDHP), keep in mind:

- If you cover one or more dependents, you must pay the entire family deductible before the plan begins paying benefits (except for covered preventive care).
- HDHPs have a combined medical and prescription drug deductible that must be met before the plan begins to pay for benefits. This means you will pay the full cost of your medical claims and prescription drugs until you meet your deductible.

Coinsurance or copays. Some medical plans require you to pay a fixed amount when you receive care, called a copay. Other medical plans require you to pay a percentage of an allowed fee, called coinsurance. These amounts vary by plan and are based on the type of care received.

Out-of-pocket limit. The annual out-of-pocket limit is the most you pay in a calendar year for covered benefits. Some plans have a separate out-of-pocket limit for prescription drugs. Once you have reached the out-of-pocket limit, the plan pays 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) may count toward your out-of-pocket limit.

There are a few costs that do not apply toward your out-of-pocket limit (see the plans' certificates of coverage for specifics):

- Monthly premiums and applicable surcharges
- Charges that exceed the plan's allowed amount of billed charges
- Charges for services or treatments the plan doesn't cover
- Coinsurance for non-network providers

Referral procedures. Some medical 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 network providers for women's health-care services.

Paperwork. In general, SEBB medical plans don't require you to file claims. However, Uniform Medical Plan (UMP) members may need to file a claim if they receive services from an out-of-network provider. UMP High Deductible members also should keep paperwork received from their provider or for qualified health care expenses to verify eligible payments or reimbursements from their HSA.

What type of plan should I select?

The SEBB Program offers several types of medical plans: managed-care plans, preferred provider organization (PPO) plans, and a high-deductible health plan (HDHP). In addition, some plans are also considered value-based plans.

Value-based plans. 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 specific criteria about the quality of care they provide. This means your providers are dedicated to ensuring you get the right care at the right time, which usually results in lower out-of-pocket costs for you.

Managed-care plans. Managed-care plans may require you to select a primary care provider within the medical plan's network to fulfill or coordinate all of your health needs. Some outpatient specialty services are available in network participating medical offices without a referral.

This type of plan may not pay benefits if you see a non-contracted provider for non-emergency services. The following SEBB medical plans are managed-care plans:

- Kaiser Permanente NW 1*
- Kaiser Permanente NW 2*
- Kaiser Permanente NW 3*
- Kaiser Permanente WA Core 1*
- Kaiser Permanente WA Core 2*
- Kaiser Permanente WA Core 3*
- Kaiser Permanente WA SoundChoice*

** Value-based plan*

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

- Kaiser Permanente WA Options Access PPO 1
- Kaiser Permanente WA Options Access PPO 2
- Kaiser Permanente WA Options Access PPO 3
- Premera High PPO
- Premera Peak Care EPO*
- Premera Standard PPO
- UMP Achieve 1 (administered by Regence BlueShield)
- UMP Achieve 2 (administered by Regence BlueShield)
- UMP Plus—Puget Sound High Value Network (administered by Regence BlueShield)*
- UMP Plus—UW Medicine Accountable Care Network (administered by Regence BlueShield)*

** Value-based plan*

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

- UMP High Deductible (administered by Regence BlueShield)

UMP High Deductible with a health savings account (HSA)

The SEBB Program's UMP High Deductible plan is combined with a health savings account (HSA). When you enroll in UMP High Deductible, you can enroll in a tax-free HSA through HealthEquity that you can use to pay for IRS-qualified out-of-pocket medical expenses (such as deductibles, copays, and coinsurance), including some expenses and services that your health plans may not cover. (See *IRS Publication 969 Health Savings Accounts and Other Tax Favored Health Plans* at **irs.gov** for details.)

The HSA is administered by HealthEquity, Inc. You can use your HSA funds to pay for or reimburse your costs for qualified medical expenses.

Employer contributions
You must establish an HSA with HealthEquity to receive any employer contributions. If you are eligible, HCA, on behalf of your employer, may contribute the following amounts to your HSA:

- $31.25 each month for an individual subscriber, up to $375 for the 2020 calendar year; or
- $62.50 each month for a subscriber with one or more enrolled dependents, up to $750 for the 2020 calendar year.
- $50 if you qualify for the SmartHealth wellness incentive in 2019.

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 you are eligible and 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 two ways. Contact your payroll or benefits office to set up pretax payroll deductions or contact HealthEquity to set up direct deposits to your HSA. 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 2020, the annual HSA contribution limit is $3,550 (subscriber only) and $7,100 (you and one or more dependents). 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.

(continued)

Who is eligible for UMP High Deductible with an HSA?

You cannot enroll in UMP High Deductible if:

- You are enrolled in Apple Health (Medicaid).
- You are enrolled in Medicare Part A or Part B.
- You are enrolled in another health plan that is not an IRS-qualified high-deductible health plan (HDHP)—for example, on a spouse's or state-registered domestic partner's plan—unless the health plan coverage is limited coverage, such as 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 health reimbursement account (HRA) coverage.
- You have a TRICARE plan.
- You enrolled in a Medical Flexible Spending Arrangement (FSA). This also applies if your spouse has a Medical FSA, even if you are not covering your spouse on your HDHP. This does not apply if your spouse's Medical FSA or HSA is a limited purpose account, or a post-deductible Medical FSA. If you try to enroll in both a Medical FSA and UMP High Deductible, you will only be in the UMP High Deductible with an HSA.
- 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 **learn.healthequity.com/sebb/hsa** under *Documents*, or *IRS Publication 969—Health Savings Accounts and Other Tax-Favored Health Plans* at **irs.gov**, contact your tax advisor, or call HealthEquity toll-free at 1-887-873-8823 (TRS: 711).

Are there special considerations if I enroll in UMP High Deductible mid-year?

Yes. Enrolling in UMP High Deductible 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.

Other features of UMP High Deductible with an HSA

- If you cover one or more dependents, you must pay the entire family deductible before the plan begins paying benefits.
- Your prescription drug costs count toward the annual deductible and out-of-pocket maximum.
- 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.

What happens to my health savings account when I leave UMP High Deductible?

If you later choose a medical plan that is not UMP High Deductible, 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 SEBB Program, and other individuals can no longer contribute to your HSA. 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.

How do I find Summaries of Benefits and Coverage (SBC)?

The Affordable Care Act requires the SEBB Program and medical plans to provide a standardized comparison of medical plan benefits, terms, and conditions, called the *Summary of Benefits and Coverage (SBC)*. The SBC allows you 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 SEBB Program and medical plans must provide an SBC (or explain how to get one) at different times throughout the year, such as when someone applies for coverage, upon plan renewal, and when requested. The SBC is available upon request in your preferred language.

You can get SBCs online at **hca.wa.gov/sebb-employee** under *Forms & publications* (enter SBC in the search field), or from the medical plans' websites. You can also call the plan's customer service or the SEBB Program at 1-800-200-1004 to request a paper copy at no charge. Medical plan websites and customer service phone numbers are listed at the front of this guide.

Medical Plan Premiums and Deductibles Available by County

All school employees will be offered a selection of plans based on their county of residence. Some school employees, including those who live outside Washington State, may have more plan options if they work in a district that crosses county lines or is in a county that borders Idaho or Oregon (see *Medical Plans Available by School District* on page 35 for more information). Be sure to call the medical plan(s) you are interested in to ask about provider availability.

Adams, Asotin, Chelan, Clallam, Ferry, Garfield, Grant, Lincoln, Okanogan, Pend Oreille, Skamania, Stevens, Wahkiakum

	Employee monthly premium				Annual medical deductible
Plan	Subscriber (employee only)	Subscriber & spouse[1]	Subscriber & children[2]	Subscriber, spouse[1] & children[2]	Employee/ family
Premera High PPO	$70	$140	$123	$210	$750/$1,875
Premera Standard PPO	$22	$44	$39	$66	$1,250/$3,125
UMP Achieve 1[3]	$33	$66	$58	$99	$750/$2,250
UMP Achieve 2[3]	$98	$196	$172	$294	$250/$750
UMP High Deductible[3]	$25	$50	$44	$75	$1,400/$2,800

Benton, Columbia, Franklin, Walla Walla, Whitman

Kaiser Permanente WA Core 1	$13	$26	$23	$39	$1,250/$3,750
Kaiser Permanente WA Core 2	$19	$38	$33	$57	$750/$2,250
Kaiser Permanente WA Core 3	$89	$178	$156	$267	$250/$750
Premera High PPO	$70	$140	$123	$210	$750/$1,875
Premera Standard PPO	$22	$44	$39	$66	$1,250/$3,125
UMP Achieve 1[2]	$33	$66	$58	$99	$750/$2,250
UMP Achieve 2[2]	$98	$196	$172	$294	$250/$750
UMP High Deductible[2]	$25	$50	$44	$75	$1,400/$2,800

Clark

Kaiser Permanente NW 1	$28	$56	$49	$84	$1,250/$2,500
Kaiser Permanente NW 2	$41	$82	$72	$123	$750/$1,500
Kaiser Permanente NW 3	$106	$212	$186	$318	$125/$250
UMP Achieve 1[2]	$33	$66	$58	$99	$750/$2,250
UMP Achieve 2[2]	$98	$196	$172	$294	$250/$750
UMP High Deductible[2]	$25	$50	$44	$75	$1,400/$2,800

[1] Or state-registered domestic partner
[2] You pay the monthly medical premium shown regardless of how many children you enroll.
[3] Administered by Regence BlueShield

(continued)

Cowlitz					
	Employee monthly premium				Annual medical deductible
Plan	Subscriber (employee only)	Subscriber & spouse[1]	Subscriber & children[2]	Subscriber, spouse[1] & children[2]	Employee/ family
Kaiser Permanente NW 1	$28	$56	$49	$84	$1,250/$2,500
Kaiser Permanente NW 2	$41	$82	$72	$123	$750/$1,500
Kaiser Permanente NW 3	$106	$212	$186	$318	$125/$250
Premera High PPO	$70	$140	$123	$210	$750/$1,875
Premera Standard PPO	$22	$44	$39	$66	$1,250/$3,125
UMP Achieve 1[3]	$33	$66	$58	$99	$750/$2,250
UMP Achieve 2[3]	$98	$196	$172	$294	$250/$750
UMP High Deductible[3]	$25	$50	$44	$75	$1,400/$2,800
Douglas, Klickitat, San Juan					
UMP Achieve 1[3]	$33	$66	$58	$99	$750/$2,250
UMP Achieve 2[3]	$98	$196	$172	$294	$250/$750
UMP High Deductible[3]	$25	$50	$44	$75	$1,400/$2,800
Grays Harbor, Jefferson, Pacific					
Premera Standard PPO	$22	$44	$39	$66	$1,250/$3,125
UMP Achieve 1[3]	$33	$66	$58	$99	$750/$2,250
UMP Achieve 2[3]	$98	$196	$172	$294	$250/$750
UMP High Deductible[3]	$25	$50	$44	$75	$1,400/$2,800
Island					
Kaiser Permanente WA Core 1	$13	$26	$23	$39	$1,250/$3,750
Kaiser Permanente WA Core 2	$19	$38	$33	$57	$750/$2,250
Kaiser Permanente WA Core 3	$89	$178	$156	$267	$250/$750
Kaiser Permanente WA Options Access PPO 1	$39	$78	$68	$117	$1,250/$3,750
Kaiser Permanente WA Options Access PPO 2	$69	$138	$121	$207	$750/$2,250
Kaiser Permanente WA Options Access PPO 3	$116	$232	$203	$348	$250/$750
UMP Achieve 1[3]	$33	$66	$58	$99	$750/$2,250
UMP Achieve 2[3]	$98	$196	$172	$294	$250/$750
UMP High Deductible[3]	$25	$50	$44	$75	$1,400/$2,800

[1] Or state-registered domestic partner
[2] You pay the monthly medical premium shown regardless of how many children you enroll.
[3] Administered by Regence BlueShield

King, Kitsap

	Employee monthly premium				Annual medical deductible
Plan	Subscriber (employee only)	Subscriber & spouse[1]	Subscriber & children[2]	Subscriber, spouse[1] & children[2]	Employee/ family
Kaiser Permanente WA Core 1	$13	$26	$23	$39	$1,250/$3,750
Kaiser Permanente WA Core 2	$19	$38	$33	$57	$750/$2,250
Kaiser Permanente WA SoundChoice	$49	$98	$86	$147	$125/$375
Kaiser Permanente WA Options Access PPO 1	$39	$78	$68	$117	$1,250/$3,750
Kaiser Permanente WA Options Access PPO 2	$69	$138	$121	$207	$750/$2,250
Kaiser Permanente WA Options Access PPO 3	$116	$232	$203	$348	$250/$750
Premera High PPO	$70	$140	$123	$210	$750/$1,875
Premera Standard PPO	$22	$44	$39	$66	$1,250/$3,125
UMP Achieve 1[3]	$33	$66	$58	$99	$750/$2,250
UMP Achieve 2[3]	$98	$196	$172	$294	$250/$750
UMP High Deductible[3]	$25	$50	$44	$75	$1,400/$2,800
UMP Plus–PSHVN[3]	$68	$136	$119	$204	$125/$375
UMP Plus–UW Medicine ACN[3]	$68	$136	$119	$204	$125/$375

Kittitas

Kaiser Permanente WA Core 1	$13	$26	$23	$39	$1,250/$3,750
Kaiser Permanente WA Core 2	$19	$38	$33	$57	$750/$2,250
Kaiser Permanente WA Core 3	$89	$178	$156	$267	$250/$750
UMP Achieve 1[3]	$33	$66	$58	$99	$750/$2,250
UMP Achieve 2[3]	$98	$196	$172	$294	$250/$750
UMP High Deductible[3]	$25	$50	$44	$75	$1,400/$2,800

[1] Or state-registered domestic partner
[2] You pay the monthly medical premium shown regardless of how many children you enroll.
[3] Administered by Regence BlueShield

(continued)

Lewis, Mason, Whatcom

	Employee monthly premium				Annual medical deductible
Plan	Subscriber (employee only)	Subscriber & spouse[1]	Subscriber & children[2]	Subscriber, spouse & children[2]	Employee/ family
Kaiser Permanente WA Core 1	$13	$26	$23	$39	$1,250/$3,750
Kaiser Permanente WA Core 2	$19	$38	$33	$57	$750/$2,250
Kaiser Permanente WA Core 3	$89	$178	$156	$267	$250/$750
Kaiser Permanente WA Options Access PPO 1	$39	$78	$68	$117	$1,250/$3,750
Kaiser Permanente WA Options Access PPO 2	$69	$138	$121	$207	$750/$2,250
Kaiser Permanente WA Options Access PPO 3	$116	$232	$203	$348	$250/$750
Premera High PPO	$70	$140	$123	$210	$750/$1,875
Premera Standard PPO	$22	$44	$39	$66	$1,250/$3,125
UMP Achieve 1[3]	$33	$66	$58	$99	$750/$2,250
UMP Achieve 2[3]	$98	$196	$172	$294	$250/$750
UMP High Deductible[3]	$25	$50	$44	$75	$1,400/$2,800

Pierce, Thurston

Kaiser Permanente WA Core 1	$13	$26	$23	$39	$1,250/$3,750
Kaiser Permanente WA Core 2	$19	$38	$33	$57	$750/$2,250
Kaiser Permanente WA SoundChoice	$49	$98	$86	$147	$125/$375
Kaiser Permanente WA Options Access PPO 1	$39	$78	$68	$117	$1,250/$3,750
Kaiser Permanente WA Options Access PPO 2	$69	$138	$121	$207	$750/$2,250
Kaiser Permanente WA Options Access PPO 3	$116	$232	$203	$348	$250/$750
Premera High PPO	$70	$140	$123	$210	$750/$1,875
Premera Peak Care EPO	$31	$62	$54	$93	$750/$1,875
Premera Standard PPO	$22	$44	$39	$66	$1,250/$3,125
UMP Achieve 1[3]	$33	$66	$58	$99	$750/$2,250
UMP Achieve 2[3]	$98	$196	$172	$294	$250/$750
UMP High Deductible[3]	$25	$50	$44	$75	$1,400/$2,800
UMP Plus–PSHVN[3]	$68	$136	$119	$204	$125/$375
UMP Plus–UW Medicine ACN[3]	$68	$136	$119	$204	$125/$375

[1] Or state-registered domestic partner
[2] You pay the monthly medical premium shown regardless of how many children you enroll.
[3] Administered by Regence BlueShield

Skagit

	Employee monthly premium				Annual medical deductible
Plan	Subscriber (employee only)	Subscriber & spouse[1]	Subscriber & children[2]	Subscriber, spouse[1] & children[2]	Employee/ family
Kaiser Permanente WA Core 1	$13	$26	$23	$39	$1,250/$3,750
Kaiser Permanente WA Core 2	$19	$38	$33	$57	$750/$2,250
Kaiser Permanente WA Core 3	$89	$178	$156	$267	$250/$750
Kaiser Permanente WA Options Access PPO 1	$39	$78	$68	$117	$1,250/$3,750
Kaiser Permanente WA Options Access PPO 2	$69	$138	$121	$207	$750/$2,250
Kaiser Permanente WA Options Access PPO 3	$116	$232	$203	$348	$250/$750
Premera High PPO	$70	$140	$123	$210	$750/$1,875
Premera Standard PPO	$22	$44	$39	$66	$1,250/$3,125
UMP Achieve 1[3]	$33	$66	$58	$99	$750/$2,250
UMP Achieve 2[3]	$98	$196	$172	$294	$250/$750
UMP High Deductible[3]	$25	$50	$44	$75	$1,400/$2,800
UMP Plus–UW Medicine ACN[3]	$68	$136	$119	$204	$125/$375

Snohomish

Kaiser Permanente WA Core 1	$13	$26	$23	$39	$1,250/$3,750
Kaiser Permanente WA Core 2	$19	$38	$33	$57	$750/$2,250
Kaiser Permanente WA SoundChoice	$49	$98	$86	$147	$125/$375
Kaiser Permanente WA Options Access PPO 1	$39	$78	$68	$117	$1,250/$3,750
Kaiser Permanente WA Options Access PPO 2	$69	$138	$121	$207	$750/$2,250
Kaiser Permanente WA Options Access PPO 3	$116	$232	$203	$348	$250/$750
Premera Standard PPO	$22	$44	$39	$66	$1,250/$3,125
UMP Achieve 1[3]	$33	$66	$58	$99	$750/$2,250
UMP Achieve 2[3]	$98	$196	$172	$294	$250/$750
UMP High Deductible[3]	$25	$50	$44	$75	$1,400/$2,800
UMP Plus–PSHVN[3]	$68	$136	$119	$204	$125/$375
UMP Plus–UW Medicine ACN[3]	$68	$136	$119	$204	$125/$375

[1] Or state-registered domestic partner
[2] You pay the monthly medical premium shown regardless of how many children you enroll.
[3] Administered by Regence BlueShield

(continued)

Spokane					
	Employee monthly premium				Annual medical deductible
Plan	Subscriber (employee only)	Subscriber & spouse[1]	Subscriber & children[2]	Subscriber, spouse[1] & children[2]	Employee/ family
Kaiser Permanente WA Core 1	$13	$26	$23	$39	$1,250/$3,750
Kaiser Permanente WA Core 2	$19	$38	$33	$57	$750/$2,250
Kaiser Permanente WA SoundChoice	$49	$98	$86	$147	$125/$375
Kaiser Permanente WA Options Access PPO 1	$39	$78	$68	$117	$1,250/$3,750
Kaiser Permanente WA Options Access PPO 2	$69	$138	$121	$207	$750/$2,250
Kaiser Permanente WA Options Access PPO 3	$116	$232	$203	$348	$250/$750
Premera High PPO	$70	$140	$123	$210	$750/$1,875
Premera Peak Care EPO	$31	$62	$54	$93	$750/$1,875
Premera Standard PPO	$22	$44	$39	$66	$1,250/$3,125
UMP Achieve 1[3]	$33	$66	$58	$99	$750/$2,250
UMP Achieve 2[3]	$98	$196	$172	$294	$250/$750
UMP High Deductible[3]	$25	$50	$44	$75	$1,400/$2,800
UMP Plus–UW Medicine ACN[3]	$68	$136	$119	$204	$125/$375
Yakima					
Kaiser Permanente WA Core 1	$13	$26	$23	$39	$1,250/$3,750
Kaiser Permanente WA Core 2	$19	$38	$33	$57	$750/$2,250
Kaiser Permanente WA Core 3	$89	$178	$156	$267	$250/$750
Premera High PPO	$70	$140	$123	$210	$750/$1,875
Premera Standard PPO	$22	$44	$39	$66	$1,250/$3,125
UMP Achieve 1[3]	$33	$66	$58	$99	$750/$2,250
UMP Achieve 2[3]	$98	$196	$172	$294	$250/$750
UMP High Deductible[3]	$25	$50	$44	$75	$1,400/$2,800
UMP Plus–PSHVN[3]	$68	$136	$119	$204	$125/$375

[1] Or state-registered domestic partner
[2] You pay the monthly medical premium shown regardless of how many children you enroll.
[3] Administered by Regence BlueShield

If you move out of the medical plan's service area or change jobs to a different district, charter school, or educational service district (represented employees only), you may need to change plans. You must report your new address and any request to change your health plan to your payroll or benefits office **no later than 60 days** after your move.

Medical Plans Available by School District

If you work in a school district that crosses county lines, or is in a county that borders Idaho or Oregon, you may have access to more School Employees Benefits Board (SEBB) Program medical plans than what is available in your county of residence. Those school districts are listed in the chart below. **Available medical plans for each district are marked by blue boxes.**

If your school district is not listed below, see *Medical Plan Premiums and Deductibles Available by County* on page 29 to learn more about your available medical plans.

	Kaiser NW			Kaiser WA				Kaiser WA Options			Premera			Uniform Medical Plan*		
School district	KP NW 1	KP NW 2	KP NW 3	Core 1	Core 2	Core 3	SoundChoice	Access PPO 1	Access PPO 2	Access PPO 3	High PPO	Peak Care EPO	Standard PPO	Achieve 1	Achieve 2	High Deductible
Almira											■		■	■	■	■
Asotin-Anatone											■		■	■	■	■
Auburn				■	■		■	■	■	■	■	■	■	■	■	■
Battle Ground	■	■	■											■	■	■
Bickleton				■	■	■					■		■	■	■	■
Brewster											■		■	■	■	■
Bridgeport											■		■	■	■	■
Camas	■	■	■											■	■	■
Castle Rock	■	■	■	■	■	■		■	■	■	■		■	■	■	■
Centerville														■	■	■
Central Valley				■	■		■	■	■	■	■	■	■	■	■	■
Centralia				■	■	■		■	■	■	■	■	■	■	■	■
Cheney				■	■		■	■	■	■	■	■	■	■	■	■
Clarkston				■	■	■					■		■	■	■	■
Colfax				■	■	■					■		■	■	■	■
College Place				■	■	■					■		■	■	■	■
Colton				■	■	■					■		■	■	■	■
Columbia (Walla Walla)				■	■	■					■		■	■	■	■

*Administered by Regence BlueShield

(continued)

	Kaiser NW			Kaiser WA				Kaiser WA Options			Premera			Uniform Medical Plan*		
School district	KP NW 1	KP NW 2	KP NW 3	Core 1	Core 2	Core 3	SoundChoice	Access PPO 1	Access PPO 2	Access PPO 3	High PPO	Peak Care EPO	Standard PPO	Achieve 1	Achieve 2	High Deductible
Concrete				■	■	■		■	■	■	■		■	■	■	■
Coulee-Hartline											■		■	■	■	■
Curlew											■		■	■	■	■
Cusick											■		■	■	■	■
Darrington				■	■	■		■	■	■	■		■	■	■	■
Dayton				■	■	■					■		■	■	■	■
Deer Park				■	■		■	■	■	■	■	■	■	■	■	■
Dixie				■	■	■					■		■	■	■	■
East Valley (Spokane)				■	■		■	■	■	■	■	■	■	■	■	■
Eatonville				■	■		■	■	■	■	■	■	■	■	■	■
Elma				■	■	■		■	■	■	■		■	■	■	■
Endicott				■	■	■					■		■	■	■	■
Ephrata											■		■	■	■	■
Evergreen (Clark)	■	■	■											■	■	■
Fife				■	■		■	■	■	■	■	■	■	■	■	■
Finley				■	■	■					■		■	■	■	■
Freeman				■	■		■	■	■	■	■	■	■	■	■	■
Garfield				■	■	■					■		■	■	■	■
Glenwood														■	■	■
Goldendale														■	■	■
Grand Coulee Dam											■		■	■	■	■
Grandview				■	■	■					■		■	■	■	■
Great Northern				■	■		■	■	■	■	■	■	■	■	■	■
Green Mountain	■	■	■											■	■	■
Hockinson	■	■	■											■	■	■
Kalama	■	■	■								■		■	■	■	■
Kelso	■	■	■								■		■	■	■	■

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	Kaiser NW			Kaiser WA				Kaiser WA Options			Premera			Uniform Medical Plan*		
School district	KP NW 1	KP NW 2	KP NW 3	Core 1	Core 2	Core 3	SoundChoice	Access PPO 1	Access PPO 2	Access PPO 3	High PPO	Peak Care EPO	Standard PPO	Achieve 1	Achieve 2	High Deductible
Kennewick				■	■	■					■		■	■	■	■
Kettle Falls											■		■	■	■	■
Kiona-Benton City				■	■	■					■		■	■	■	■
Klickitat														■	■	■
La Center	■	■	■											■	■	■
LaCrosse				■	■	■					■		■	■	■	■
Lake Chelan											■		■	■	■	■
Lamont				■	■	■					■		■	■	■	■
Liberty				■	■		■	■	■	■	■	■	■	■	■	■
Longview	■	■	■								■		■	■	■	■
Loon Lake											■		■	■	■	■
Lyle														■	■	■
Mary M. Knight				■	■	■		■	■	■	■		■	■	■	■
McCleary				■	■	■		■	■	■	■		■	■	■	■
Mead				■	■		■	■	■	■	■	■	■	■	■	■
Medical Lake				■	■		■	■	■	■	■	■	■	■	■	■
Mill A											■		■	■	■	■
Mount Pleasant	■	■	■								■		■	■	■	■
Naches Valley				■	■	■					■		■	■	■	■
Naselle-Grays River Valley											■		■	■	■	■
Newport				■	■		■	■	■	■	■	■	■	■	■	■
Nine Mile Falls				■	■		■	■	■	■	■	■	■	■	■	■
North Franklin				■	■	■					■		■	■	■	■
North Mason				■	■		■	■	■	■	■		■	■	■	■
North River													■	■	■	■
Northshore				■	■		■	■	■	■	■		■	■	■	■
Oakesdale				■	■	■					■		■	■	■	■
Oakville				■	■	■		■	■	■	■		■	■	■	■

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(continued)

	Kaiser NW			Kaiser WA				Kaiser WA Options			Premera			Uniform Medical Plan*		
School district	KP NW 1	KP NW 2	KP NW 3	Core 1	Core 2	Core 3	SoundChoice	Access PPO 1	Access PPO 2	Access PPO 3	High PPO	Peak Care EPO	Standard PPO	Achieve 1	Achieve 2	High Deductible
Ocean Beach													■	■	■	■
Ocosta													■	■	■	■
Odessa											■		■	■	■	■
Orchard Prairie				■	■		■	■	■	■	■	■	■	■	■	■
Orient											■		■	■	■	■
Othello				■	■	■					■		■	■	■	■
Palouse				■	■	■					■		■	■	■	■
Pateros											■		■	■	■	■
Paterson				■	■	■					■		■	■	■	■
Pe Ell				■	■	■		■	■	■	■		■	■	■	■
Pomeroy				■	■	■					■		■	■	■	■
Prescott				■	■	■					■		■	■	■	■
Prosser				■	■	■					■		■	■	■	■
Pullman				■	■	■					■		■	■	■	■
Quillayute Valley											■		■	■	■	■
Quincy											■		■	■	■	■
Raymond													■	■	■	■
Reardan-Edwall				■	■		■	■	■	■	■	■	■	■	■	■
Republic											■		■	■	■	■
Richland				■	■	■					■		■	■	■	■
Ridgefield	■	■	■											■	■	■
Ritzville											■		■	■	■	■
Riverside				■	■		■	■	■	■	■	■	■	■	■	■
Rochester				■	■		■	■	■	■	■	■	■	■	■	■
Roosevelt														■	■	■
Rosalia				■	■	■		■	■	■	■	■	■	■	■	■

*Administered by Regence BlueShield

	Kaiser NW			Kaiser WA				Kaiser WA Options			Premera			Uniform Medical Plan*		
School district	KP NW 1	KP NW 2	KP NW 3	Core 1	Core 2	Core 3	SoundChoice	Access PPO 1	Access PPO 2	Access PPO 3	High PPO	Peak Care EPO	Standard PPO	Achieve 1	Achieve 2	High Deductible
Sedro-Woolley				■	■	■		■	■	■	■		■	■	■	■
Selah				■	■	■					■		■	■	■	■
Selkirk											■		■	■	■	■
Sequim											■		■	■	■	■
Skamania											■		■	■	■	■
South Bend													■	■	■	■
Spokane				■	■		■	■	■	■	■	■	■	■	■	■
Sprague											■		■	■	■	■
St. John				■	■	■		■	■	■	■	■	■	■	■	■
Stanwood-Camano				■	■		■	■	■	■			■	■	■	■
Starbuck				■	■	■					■		■	■	■	■
Steptoe				■	■	■					■		■	■	■	■
Stevenson-Carson											■		■	■	■	■
Tekoa				■	■	■		■	■	■	■	■	■	■	■	■
Touchet				■	■	■					■		■	■	■	■
Toutle Lake	■	■	■								■		■	■	■	■
Trout Lake														■	■	■
Vancouver	■	■	■											■	■	■
Wahkiakum											■		■	■	■	■
Wahluke				■	■	■					■		■	■	■	■
Waitsburg				■	■	■					■		■	■	■	■
Walla Walla				■	■	■					■		■	■	■	■
Warden											■		■	■	■	■
Washougal	■	■	■								■		■	■	■	■
Washtucna				■	■	■					■		■	■	■	■
West Valley (Spokane)				■	■		■	■	■	■	■	■	■	■	■	■
White Salmon Valley											■		■	■	■	■
Willapa Valley													■	■	■	■
Wilson Creek											■		■	■	■	■
Wishram														■	■	■
Woodland	■	■	■								■		■	■	■	■
Yelm				■	■		■	■	■	■	■	■	■	■	■	■

*Administered by Regence BlueShield

Medical Benefits Comparison

The chart below briefly compares the medical deductibles and per-visit out-of-pocket costs of some in-network benefits for SEBB medical plans. Copays and coinsurances may apply; some copays and coinsurance do not apply until after you have paid your annual deductibles. Call the plans directly for more information on specific benefits, including preauthorization requirements and exclusions. If anything in these charts conflicts with the plan's Certificate of Coverage (COC), the COC takes precedence and prevails.

Annual costs (what you pay)	Medical deductible (applies to medical out-of-pocket limit)	Medical out-of-pocket limit (see separate prescription drug out-of-pocket limit for some plans)
Kaiser Foundation Health Plan of the Northwest		
Kaiser Permanente NW 1	$1,250/person $2,500/family	$4,000/person $8,000/family
Kaiser Permanente NW 2	$750/person $1,500/family	$3,500/person $7,000/family
Kaiser Permanente NW 3	$125/person $250/family	$2,000/person $4,000/family
Kaiser Foundation Health Plan of Washington		
Kaiser Permanente WA Core 1	$1,250/person $3,750/family	$4,000/person $8,000/family
Kaiser Permanente WA Core 2	$750/person $2,250/family	$3,000/person $6,000/family
Kaiser Permanente WA Core 3	$250/person $750/family	$2,000/person $4,000/family
Kaiser Permanente WA SoundChoice	$125/person $375/family	$2,000/person $4,000/family
Kaiser Foundation Health Plan of Washington Options, Inc.		
Kaiser Permanente WA Options Access PPO 1	$1,250/person $3,750/family	$4,500/person $9,000/family
Kaiser Permanente WA Options Access PPO 2	$750/person $2,250/family	$3,500/person $7,000/family
Kaiser Permanente WA Options Access PPO 3	$250/person $750/family	$2,500/person $5,000/family
Premera Blue Cross		
Premera High PPO	$750/person $1,875/family	$3,500/person $7,000/family
Premera Peak Care EPO	$750/person $1,875/family	$3,500/person $7,000/family
Premera Standard PPO	$1,250/person $3,125/family	$5,000/person $10,000/family
Uniform Medical Plan		
UMP Achieve 1	$750/person $2,250/family	$3,500/person $7,000/family
UMP Achieve 2	$250/person $750/family	$2,000/person $4,000/family
UMP High Deductible	$1,400/person $2,800/family[2]	$4,200/person $8,400/family[3]
UMP Plus (both PSHVN & UW Medicine ACN)	$125 person $375/family	$2,000/person $4,000/family

[1] Waived for preferred generic prescription drugs
[2] Combined medical and prescription drug deductible
[3] Out-of-pocket expenses for a single family member are not to exceed $6,900

Prescription drug deductible	Prescription drug out-of-pocket limit
None	Applies to medical out-of-pocket limit
None	Applies to medical out-of-pocket limit
None	Applies to medical out-of-pocket limit
None	Applies to medical out-of-pocket limit
None	Applies to medical out-of-pocket limit
None	Applies to medical out-of-pocket limit
None	Applies to medical out-of-pocket limit
None	Applies to medical out-of-pocket limit
None	Applies to medical out-of-pocket limit
None	Applies to medical out-of-pocket limit
$125/person $312/family[1]	Applies to medical out-of-pocket limit
$125/person $312/family[1]	Applies to medical out-of-pocket limit
$250/person $750/family[1]	Applies to medical out-of-pocket limit
Tier 2 and specialty; $250/person $750/family (applies to prescription out-of-pocket limit)	$2,000/person $4,000/family
Tier 2 and specialty; $100/person $300/family (applies to prescription out-of-pocket limit)	$2,000/person $4,000/family
Combined (medical and prescription) deductible	Combined (medical and prescription) out-of-pocket limit
None	$2,000/person $4,000/family

(continued)

Benefits (what you pay)	Ambulance (air or ground) per trip	Diagnostic tests, laboratory, and x-rays	Durable medical equipment, supplies, and prosthetics
Kaiser Foundation Health Plan of the Northwest			
Kaiser Permanente NW 1	20%	$30	20%
Kaiser Permanente NW 2	20%	$25	20%
Kaiser Permanente NW 3	20%	$20	20%
Kaiser Foundation Health Plan of Washington			
Kaiser Permanente WA Core 1	20%	20% over $500	20% ($300 allowance/ year for orthotic devices)
Kaiser Permanente WA Core 2	20%	20% over $500	20% ($300 allowance/ year for orthotic devices)
Kaiser Permanente WA Core 3	20%	20%	20% ($300 allowance/ year for orthotic devices)
Kaiser Permanente WA SoundChoice	20%	15%	15% ($300 allowance/ year for orthotic devices)
Kaiser Foundation Health Plan of Washington Options, Inc.			
Kaiser Permanente WA Options Access PPO 1	20%	20% over $500	20% ($300 allowance/ year for orthotic devices)
Kaiser Permanente WA Options Access PPO 2	20%	20% over $500	20% ($300 allowance/ year for orthotic devices)
Kaiser Permanente WA Options Access PPO 3	20%	20%	20% ($300 allowance/ year for orthotic devices)
Premera Blue Cross			
Premera High PPO	25%	25%	25%
Premera Peak Care EPO	25%	25%	25%
Premera Standard PPO	20%	20%	20%
Uniform Medical Plan			
UMP Achieve 1	20%	20%	20%
UMP Achieve 2	20%	15%	15%
UMP High Deductible	20%	15%	15%
UMP Plus (both PSHVN & UW Medicine ACN)	20%	15%	15%

* Enhanced benefit: Enhanced in-network cost shares apply when a member uses designated integrated providers and pharmacies (Kaiser Permanente Medical Centers and providers, or other designated providers as identified in the provider directory). These providers offer services at the lowest cost share.

	Emergency room (copay waived if admitted)	Routine annual hearing exam	Hearing hardware	Home health	Therapy: Physical, occupational, speech, and neurodevelopmental (per-visit cost for annual covered visits)
	20%	$40	$400 max benefit every 36 months	20% for 130 days/year	$40 (60 combined/year)
	20%	$35	$400 max benefit every 36 months	20% for 130 days/year	$35 (60 combined/year)
	20%	$30	$400 max benefit every 36 months	20% for 130 days/year	$30 (60 combined/year)
	$150+20%	$30	$400 max benefit every 36 months	20% for 130 days/year	$40 (60/year)
	$150+20%	$25	$400 max benefit every 36 month	20% for 130 days/year	$35 (60/year)
	$150+20%	$20	$400 max benefit every 36 month	20% for 130 days/year	$30 (60 combined/year)
	$150+15%	$0	$400 max benefit every 36 month	15% for 130 days/year	$30 (60 combined/year)
	$150+20%	$30 ($20*)	$400 max benefit every 36 months	20% for 130 days/year	$40 ($30*, 60 combined/year)
	$150+20%	$25 ($15*)	$400 max benefit every 36 months	20% for 130 days/year	$35 ($25*, 60 combined/year)
	$150+20%	$20 ($10*)	$400 max benefit every 36 months	20% for 130 days/year	$30 ($20*, 60 combined/year)
	$150+25%	$0	$1,000 max benefit every 3 years	25%	$40 (45 combined/year)
	$150+25%	$0	$1,000 max benefit every 3 years	25%	$40 (45 combined/year)
	$150+20%	$0	$1,000 max benefit every 3 years	20%	$40 (45 combined/year)
	$75+20%	$0	$800 max benefit every 3 years	20%	20% (80 combined/year)
	$75+15%	$0	$800 max benefit every 3 years	15%	15% (80 combined/year)
	15%	15%	$800 max benefit every 3 years	15%	15% (80 combined/year)
	$75+15%	$0	$800 max benefit every 3 years	15%	15% (60 combined/year)

(continued)

Benefits (what you pay)	Hospital services: Inpatient	Hospital services: Outpatient	Office visit: Primary care
Kaiser Foundation Health Plan of the Northwest			
Kaiser Permanente NW 1	20%	20%	$30
Kaiser Permanente NW 2	20%	20%	$25
Kaiser Permanente NW 3	20%	20%	$20
Kaiser Foundation Health Plan of Washington			
Kaiser Permanente WA Core 1	20%	20%	$30
Kaiser Permanente WA Core 2	20%	20%	$25
Kaiser Permanente WA Core 3	20%	20%	$20
Kaiser Permanente WA SoundChoice	15%	15%	$0
Kaiser Foundation Health Plan of Washington Options, Inc.			
Kaiser Permanente WA Options Access PPO 1	20%	20%	$30 ($20*)
Kaiser Permanente WA Options Access PPO 2	20%	20%	$25 ($15*)
Kaiser Permanente WA Options Access PPO 3	20%	20%	$20 ($10*)
Premera Blue Cross			
Premera High PPO	25%	25%	$20
Premera Peak Care EPO	25%	25%	$20
Premera Standard PPO	20%	20%	$20
Uniform Medical Plan			
UMP Achieve 1	$200/day up to $600 for facility+20% for professional services	20%	20%
UMP Achieve 2	$200/day up to $600 for facility+15% for professional services	15%	15%
UMP High Deductible	15%	15%	15%
UMP Plus (both PSHVN & UW Medicine ACN)	$200/day up to $600 for facility+15% for professional services	15%	$0 plus 15% for related services

* Enhanced benefit: Enhanced in-network cost shares apply when a member uses designated integrated providers and pharmacies (Kaiser Permanente Medical Centers and providers, or other designated providers as identified in the provider directory). These providers offer services at the lowest cost share.

Office visit: Urgent care	Office visit: Specialist	Office visit: Mental health	Number of visits covered per year:		
			Chiropractic	Acupuncture	Massage therapy
$50	$40	$30	No limit	20	20
$45	$35	$25	No limit	20	20
$40	$30	$20	No limit	20	20
$30	$40	$30	20	20	20
$25	$35	$25	20	20	20
$20	$30	$20	20	20	20
$0	$30	$0	20	20	20
$30 ($20*)	$40 ($30*)	$30 ($20*)	20	20	20
$25 ($15*)	$35 ($25*)	$25 ($15*)	20	20	20
$20 ($10*)	$30 ($20*)	$20 ($10*)	20	20	20
25%	$40	$20	12	12	12
25%	$40	$20	12	12	12
20%	$40	$20	12	12	12
20%	20%	20%	16	16	16
15%	15%	15%	16	16	16
15%	15%	15%	16	16	16
15%	15%	15%	10	16	16

(continued)

Benefits (what you pay) Prescription drugs: Retail pharmacy (up to a 30-day supply)	Value Tier (specific high-value prescription drugs used to treat certain chronic conditions)	Tier 1 (primarily low-cost generic drugs)
Kaiser Foundation Health Plan of the Northwest		
Kaiser Permanente NW 1	N/A	$20
Kaiser Permanente NW 2	N/A	$15
Kaiser Permanente NW 3	N/A	$10
Kaiser Foundation Health Plan of Washington		
Kaiser Permanente WA Core 1	N/A	$5
Kaiser Permanente WA Core 2	N/A	$10
Kaiser Permanente WA Core 3	N/A	$10
Kaiser Permanente WA SoundChoice	N/A	$10
Kaiser Foundation Health Plan of Washington Options, Inc.		
Kaiser Permanente WA Options Access PPO 1	N/A	$10 ($5*)
Kaiser Permanente WA Options Access PPO 2	N/A	$10 ($5*)
Kaiser Permanente WA Options Access PPO 3	N/A	$10 ($5*)
Premera Blue Cross		
Premera High PPO	N/A	$7
Premera Peak Care EPO	N/A	$7
Premera Standard PPO	N/A	$7
Uniform Medical Plan		
UMP Achieve 1	5% up to $10	10% up to $25
UMP Achieve 2	5% up to $10	10% up to $25
UMP High Deductible	15% after combined (medical and prescription) deductible	15% after combined (medical and prescription) deductible
UMP Plus (both PSHVN & UW Medicine ACN)	5% up to $10	10% up to $25

* Enhanced benefit: Enhanced in-network cost shares apply when a member uses designated integrated providers and pharmacies (Kaiser Permanente Medical Centers and providers, or other designated providers as identified in the provider directory). These providers offer services at the lowest cost share.

Tier 2 (preferred brand-name drugs, high-cost generic drugs, and specialty drugs for UMP)	Tier 3 (nonpreferred brand-name drugs and nonpreferred generic drugs[4])	Tier 4 (specialty and certain high cost generic drugs)
$40	50% up to $100	50% up to $150
$30	50% up to $100	50% up to $150
$20	50% up to $100	50% up to $150
$25	$50	50% up to $150
$25	$50	50% up to $150
$25	$50	50% up to $150
$25	$50	50% up to $150
$50 ($40*)	50% up to $125	50% up to $150
$50 ($40*)	50% up to $125	50% up to $150
$50 ($40*)	50% up to $125	50% up to $150
$30	30%	$50
$30	30%	$50
30%	50%	40%
30% up to 75%	N/A	N/A
30% up to 75%	N/A	N/A
15% after combined (medical and prescription) deductible	N/A	N/A
30% up to $75	N/A	N/A

[4] Includes nonpreferred generic drugs for Kaiser Permanente WA, Kaiser Permanente WA Options, and Premera plans.

All plans pay 100% for covered preventive prescription drugs, with no deductible. Exception: On the UMP High Deductible plan, male condoms and male spermicides are paid at 100% after you meet the plan deductible.

(continued)

Benefits (what you pay) Prescription drugs: Mail order (up to a 90-day supply)	Value Tier (specific high-value prescription drugs used to treat certain chronic conditions)	Tier 1 (primarily low-cost generic drugs)
Kaiser Foundation Health Plan of the Northwest (deductibles do not apply)		
Kaiser Permanente NW 1	N/A	$40
Kaiser Permanente NW 2	N/A	$30
Kaiser Permanente NW 3	N/A	$20
Kaiser Foundation Health Plan of Washington (deductibles do not apply)		
Kaiser Permanente WA Core 1	N/A	$10
Kaiser Permanente WA Core 2	N/A	$20
Kaiser Permanente WA Core 3	N/A	$20
Kaiser Permanente WA SoundChoice	N/A	$20
Kaiser Foundation Health Plan of Washington Options, Inc. (deductibles do not apply)		
Kaiser Permanente WA Options Access PPO 1	N/A	$20 ($10*)
Kaiser Permanente WA Options Access PPO 2	N/A	$20 ($10*)
Kaiser Permanente WA Options Access PPO 3	N/A	$20 ($10*)
Premera Blue Cross		
Premera High PPO	N/A	$14 (deductible waived)
Premera Peak Care EPO	N/A	$14 (deductible waived)
Premera Standard PPO	N/A	$14 (deductible waived)
Uniform Medical Plan		
UMP Achieve 1	5% up to $30	10% up to $75
UMP Achieve 2	5% up to $30	10% up to $75
UMP High Deductible	15% after combined (medical and prescription) deductible	15% after combined (medical and prescription) deductible
UMP Plus (both PSHVN & UW Medicine ACN)	5% up to $30	10% up to $75

* Enhanced benefit: Enhanced in-network cost shares apply when a member uses designated integrated providers and pharmacies (Kaiser Permanente Medical Centers and providers, or other designated providers as identified in the provider directory). These providers offer services at the lowest cost share.

Tier 2 (preferred brand-name drugs)	Tier 3 (nonpreferred brand-name drugs and nonpreferred generic drugs[4])
$80	50% up to $200
$60	50% up to $200
$40	50% up to $200
$50	$100
$50	$100
$50	$100
$50	$100
$100 ($80*)	50% up to $250
$100 ($80*)	50% up to $250
$100 ($80*)	50% up to $250
$60	deductible, then 30%
$60	deductible, then 30%
30%	50%
30% up to $225	N/A
30% up to $225	N/A
15% after combined (medical and prescription) deductible	N/A
30% up to $225	N/A

[4] Includes nonpreferred generic drugs for Kaiser Permanente WA, Kaiser Permanente WA Options, and Premera plans.

! All plans pay 100% for covered preventive prescription drugs, with no deductible. Exception: On the UMP High Deductible plan, male condoms and male spermicides are paid at 100% after you meet the plan deductible.

Selecting a dental plan

If you are eligible for SEBB Program benefits, dental coverage is included for you and your eligible dependents; your employer pays the premium. You and any enrolled dependents must enroll in the same SEBB dental plan.

There are three SEBB Program dental plans to choose from—two managed care plans and one preferred-provider plan. Make sure you check with the plan to see if the dentist you want is in the plan's network. The dental benefit comparison chart is available on page 51.

Things to keep in mind before you select a dental plan or provider

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.

Uniform Dental Plan (UDP) is a preferred provider organization (PPO) 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 below). This is especially important because DeltaCare and UDP are both administered by Delta Dental of Washington. You can call the dental plan's customer service (listed in the beginning of this guide), or use the dental plan network's online directory. Carefully review your selection before enrolling in SEBB My Account or submitting your paper enrollment form.

How do the DeltaCare and Willamette Dental Group plans work?

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.

DeltaCare is administered by Delta Dental of Washington. Its network is DeltaCare SEBB (Group 09601).

Willamette Dental Group is underwritten by Willamette Dental of Washington, Inc. Its network is Willamette Dental Group, P.C., with dental offices in Washington, Oregon, and Idaho. Willamette Dental Group administers its own dental network (WA 733).

Dental plan options

Plan name	Plan type	Plan administrator	Plan network	Plan group number
DeltaCare	Managed-care plan	Delta Dental of Washington	DeltaCare SEBB	Group 09601
Willamette Dental Group Plan	Managed-care plan	Willamette Dental of Washington, Inc.	Willamette Dental Group, P.C.	WA 733
Uniform Dental Plan (UDP)	Preferred-provider plan	Delta Dental of Washington	Delta Dental PPO	Group 09600

How does the Uniform Dental Plan (UDP) work?

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

When you see a network 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 dependent, including preventive visits.

UDP is administered by Delta Dental of Washington. Its network is Delta Dental PPO (Group 09600).

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). If anything in these charts conflicts with the plan's Certificate of Coverage (COC), the COC takes precedence and prevails.

Annual costs	**PPO**	**Managed-care plans**	
	Uniform Dental Plan (Group 09600)	DeltaCare (Group 09601)	Willamette Dental Group (Group WA 733)
Deductible	$50 individual/ up to $150 family	None	None
Plan maximum (see specific benefit maximums below)	$1,750	No general plan maximum	No general plan maximum
Benefits	**PPO**	**Managed-care plans**	
	Uniform Dental Plan (Group 09600)	DeltaCare (Group 09601)	Williamette Dental (Group WA 733)
	You pay after deductible:	**You pay:**	
Dentures	50% PPO and out of state; 60% non-PPO	$140 for complete upper or lower	$140 for complete upper or lower
Root canals (endodontics)	20% PPO and out of state; 30% non-PPO	$100 to $150	$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	30% of costs, then any amount after plan has paid $1,000 per year, then any amount over $5,000 in member's lifetime	Any amount 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	$10 to $50 to extract erupted teeth

(continued)

Benefits	PPO	Managed-care plans	
	Uniform Dental Plan (Group 09600 PPO)	DeltaCare (Group 09601)	Williamette Dental (Group WA733)
	You pay after deductible:	You pay:	
Orthodontia	50% of costs until the plan has paid a maximum of $1,750 for member's lifetime (separate from the annual maximum of $1,750)	Up to $1,500 copay per case	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 the lesser of the maximum allowable or the fees actually charged; then any amount over $5,000 in member's lifetime	30%, 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	$15 to $100
Preventive/ diagnostic (deductible doesn't apply)	$0 PPO; 10% out of state; 20% non-PPO	$0	$0
Restorative fillings	20% PPO and out of state; 30% non-PPO	$10 to $50	$10 to $50
Restorative crowns	50% PPO and out of state; 60% non-PPO	$100 to $175	$100 to $175

Selecting a vision plan

If you are eligible for SEBB Program benefits, vision coverage is included for you and your eligible dependents; your employer pays the premium. You and any enrolled dependents must enroll in the same SEBB vision plan. The vision benefit comparison chart is available on page 53.

Vision plan options

There are three SEBB Program vision plans to choose from.

- Davis Vision
- EyeMed Vision Care
- MetLife Vision

Routine eye exams are covered at 100 percent under any of the three plans. In general, frames are covered up to $150 every 24 months, and then 80 percent of the balance over $150.

Before you select a vision plan, check with the plan to see if your vision provider is in the plan's network. You can call the vision plan's customer service (listed in the beginning of this guide), or use the vision plan network's online directory. Some vision plans have their own clinics, where you get the plan's best price for services and hardware.

Vision Benefits Comparison

For information on specific benefits and exclusions, refer to the vision plan's certificate of coverage or contact the plan directly. The figures listed below show what you pay for in-network coverage, with the amount up to which you would be reimbursed for out-of-network services in parentheses. If anything in these charts conflicts with the plan's Certificate of Coverage (COC), the COC takes precedence and prevails.

Adults (19 and older)

Vision care service	Davis Vision	EyeMed	MetLife
Routine eye exam (once per calendar year, starting January 1)	$0 ($40)	$0 ($84)	$0 ($45)
Frames (once every 24 months starting January 1 in even years)	$0 up to $150, then 80% of balance over $150; or, $0 at Visionworks; or, $0 for any of the Exclusive Frame Collection ($50)	$0 up to $150, then 80% of balance over $150 ($75)	$0 up to $150, then 80% of balance over $150 ($70)
Lenses (once every 24 months starting January 1 in even years)	$0 (Single, $40; bifocal, $60; trifocal, $80; lenticular, $100)	$0 (Single, $25; bifocal, $40; trifocal, $55; lenticular, $55)	$0 (Single, $30; bifocal, $50; trifocal, $65; lenticular, $100)
Progressive lenses (once every 24 months starting January 1 in even years)	$50-$140 ($60)	$55-$175 ($55)	$0-$175 ($50)

Lens enhancements	Davis Vision	EyeMed	MetLife
Anti-reflective coating	$35–$60	$45–$85 ($5)	$41–$85[1]
Scratch-resistant	$0	$0 ($5)	$17–$33[1]
Polycarbonate	$30	$40[2]	$31–$35[1]
Photochromic/transitions	$65	$75[2]	$47-$82[1]
Polarized	$75	80% of retail price[2]	80% of retail price[1]
Tinting	$0	$15[2]	$17–$44[1]
UV treatment	$12	$15[2]	$0[1]

[1] Reimbursement for out-of-network lens enhancements is applied to the out-of-network reimbursement amount for each lens (single, $30; bifocal, $50; trifocal, $65; lenticular, $100; progressive, $50).
[2] No out-of-network lens enhancement reimbursement is available.

Contact lenses (in lieu of glasses)	Davis Vision	EyeMed	MetLife
Conventional*	$0 up to $150, then 85% of balance over $150; or, four boxes from Collection lenses ($105)	$0 up to $150, then 85% of balance over $150 ($150)	$0 up to $150, then 100% of balance over $150 ($105)
Disposable*	$0 up to $150, then 85% of balance over $150; or eight boxes from Collection lenses ($105)	$0 up to $150, then 100% of balance over $150 ($150)	$0 up to $150, then 100% of balance over $150 ($105)
Medically necessary	$0 ($225)	$0 ($300)	$0 ($210)

* Conventional lenses, with proper care and cleaning, can be used for longer periods of time, from one month to up to one year. Disposable contact lenses are single-use lenses and are removed and discarded after a determined period of time, typically at the end of each day or week.

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Additional member savings	Davis Vision	EyeMed	MetLife
Additional glasses	30% off	Up to 40% off	20% off
LASIK surgery	40-50% off national average	15% off retail price; or, 5% off a promotional offer	15% off retail price; or, 5% off a promotional offer

Children (under age 19) – what your pay for in-network services

Vision care service (once per calendar year)	Davis Vision	EyeMed	MetLife
Routine eye exam	$0	$0	$0
Frames	$150 allowance; 80% off balance above $150	$150 allowance; 80% off balance above $150	$150 allowance; 80% off balance above $150
Lenses	$0	$0	$0
Progressive lenses	$50-$140	$0-$175	$0-$175
Lens enhancements	**Davis Vision**	**EyeMed**	**MetLife**
Anti-reflective coating	$35-$60	$45-$85	$41–$85
Scratch-resistant	$0	$0	$0
Polycarbonate	$0	$0	$0
Photochromic/transitions	$65	$75	$47–$82
High Index	$0	$0	$0
Tinting	$0	$15	$17–$44
UV treatment	$0	$15	$0
Contact lenses (in lieu of glasses)	**Davis Vision**	**EyeMed**	**MetLife**
Conventional*	$0 up to 4 boxes annually	Any amount over $300	Any amount over $300
Disposable*	$0 up to 8 boxes annually	Any amount over $300	Any amount over $300
Medically necessary	$0	Any amount over $300	$0

* Conventional lenses, with proper care and cleaning, can be used for longer periods of time, from one month to up to one year. Disposable contact lenses are single-use lenses and are removed and discarded after a determined period of time, typically at the end of each day or week.

Additional member savings	Davis Vision	EyeMed	MetLife
Additional glasses	50% off at Visionworks; 30% off at other providers	40% off	20% off
LASIK surgery	40%-50%	15% off retail price, or 5% off promotional price	15% off retail price, or 5% off promotional price

Life and AD&D insurance

The SEBB Program provides basic life insurance and basic accidental death and dismemberment (AD&D) insurance at no cost to school employees who are eligible for the employer contribution toward SEBB benefits. If eligible, you will automatically be enrolled in basic coverage, even if you waive medical coverage.

You can buy supplemental life insurance and supplemental AD&D insurance for yourself and your eligible dependents. Supplemental life and AD&D insurance is not available to employees whose eligibility was locally negotiated under Washington Administrative Code (WAC) 182-30-130 (see *Eligibility* on page 12).

These benefits are provided through Metropolitan Life Insurance Company (plan number 219743). The information below is a summary of benefits only; if anything conflicts with the certificate of coverage (COC), the COC takes precedence and prevails. To see the COC, visit **hca.wa.gov/sebb-employee** under *Forms & publications* or contact MetLife directly at 1-833-854-9624.

What are (employer-paid) basic life insurance and basic AD&D insurance?

As an employee, your basic life insurance covers you and pays your designated beneficiaries in the event of your death. Accidental death and dismemberment (AD&D) insurance provides benefits for certain injuries or death resulting from a covered accident. These benefits are paid for by your employer, and you do not have to provide evidence of insurability (proof of good health).

The SEBB Program's benefits package includes basic life insurance and basic AD&D insurance for all school employees who are eligible for the employer contribution toward SEBB benefits. It provides:

- $35,000 for death from any cause.
- Up to $5,000 in case of accidental death or dismemberment (AD&D).

What are (employee-paid) supplemental life and AD&D insurance?

If you enroll in supplemental life insurance and supplemental AD&D insurance for yourself, you may also buy supplemental life and supplemental AD&D insurance for your eligible dependents.

Following are the kinds of supplemental life and AD&D insurance you can buy.

Supplemental life insurance for employees
You may enroll in supplemental life insurance for yourself in increments of $10,000 up to $500,000 with no evidence of insurability (if elected during the first annual open enrollment). You can buy supplemental life insurance coverage up to a maximum of $1,000,000 with evidence of insurability.

Supplemental life insurance for spouse or state-registered domestic partner
If you are enrolled in supplemental life insurance, you may buy supplemental life insurance for your spouse or state-registered domestic partner in increments of $5,000 up to $500,000, not to exceed one-half the supplemental amount you get for yourself as an employee. You can buy up to $100,000 of coverage with no evidence of insurability (if elected during the first annual open enrollment). Evidence of insurability is always required above $100,000, up to a maximum of $500,000.

Supplemental life insurance for children
If you enroll in supplemental life insurance for yourself, you may buy coverage for your children in $5,000 increments up to $20,000. One premium covers all your enrolled children. Evidence of insurability is not required for children.

Supplemental AD&D insurance for employees
You may enroll in supplemental AD&D coverage in increments of $10,000 up to $250,000. Supplemental AD&D insurance does not cover death and dismemberment from non-accidental causes and never requires evidence of insurability.

Supplemental 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 in increments of $10,000 up to $250,000. Evidence of insurability is not required.

Supplemental AD&D insurance for children
For your children, supplemental AD&D coverage is available in $5,000 increments up to $25,000. One premium covers all your enrolled children. Evidence of insurability is not required.

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What do supplemental life and AD&D insurance cost?

The table below shows the monthly cost per $1,000 of coverage, based on your (the subscriber's) age as of December 31, 2019, and tobacco use by the person being insured.

Supplemental life insurance monthly rates for employees and spouse or state-registered domestic partner, and children

Age	Non-tobacco user	Tobacco user
Less than 25	$0.038	$0.050
25–29	$0.042	$0.060
30–34	$0.046	$0.080
35–39	$0.058	$0.090
40–44	$0.088	$0.100
45–49	$0.128	$0.150
50–54	$0.188	$0.230
55–59	$0.346	$0.400
60–64	$0.534	$0.630
65–69	$0.962	$1.220
70+	$1.438	$1.988
Cost for children	$0.124	$0.124

Sample calculation—supplemental life insurance
To cover yourself, the monthly rate for one person age 40–44 who is a non-tobacco-user is $0.088 per $1,000 coverage. For $10,000 of supplemental life insurance coverage, the monthly cost is $0.88.

$10,000 coverage:	10
40–44 age rate:	x 0.088
Monthly cost:	$0.88

Supplemental AD&D insurance monthly rates
The table below shows the monthly cost per $1,000 of coverage.

Employee	$0.019
Spouse or state-registered domestic partner	$0.019
All dependent children	$0.016

Sample calculation—supplemental AD&D insurance
To cover yourself, the monthly rate is $0.019 per $1,000 coverage. For $10,000 of supplemental (AD&D) insurance coverage, the monthly cost is $0.19.

$10,000 coverage:	10
40–44 age rate:	x 0.019
Monthly cost:	$0.19

When can I enroll in supplemental life insurance?

You may enroll for the following supplemental coverage without providing evidence of insurability during the first annual open enrollment, or **no later than 31 days** after becoming eligible for the employer contribution toward SEBB benefits:

- Supplemental life insurance for employees up to $500,000
- Supplemental life insurance for a spouse or state-registered domestic partner up to $100,000
- Supplemental life insurance for children, in increments of $5,000 up to $25,000

MetLife must approve your request for additional levels of coverage. You must provide evidence of insurability to MetLife if you apply for:

- Any amount of supplemental life Insurance for yourself, spouse or state-registered domestic partner, or children after the first annual open enrollment, or after 31 days from becoming eligible for SEBB benefits.
- More than $500,000 in supplemental employee life insurance for yourself.
- More than $100,000 in supplemental life insurance for your spouse or state-registered domestic partner.

When can I enroll in supplemental AD&D insurance?

You can enroll in supplemental AD&D at any time. Supplemental AD&D insurance never requires evidence of insurability.

How do I enroll in supplemental life and supplemental AD&D insurance?

Enroll online using MetLife's MyBenefits portal at **mybenefits.metlife.com/wasebb**. It can take up to 30 days to process the MetLife enrollment/

change form. If you have any questions about enrollment or need to request paper forms, please contact MetLife at 1-833-854-9624.

How do I create an online account with MetLife?

1. Visit MetLife's MyBenefits portal at **mybenefits.metlife.com/wasebb**. A *Welcome to MyBenefits* screen will appear.
2. You should see *WA State Health Care Authority SEBB* in the *Account Sign in* box. If you see *Enter your company name*, type *SEBB* into the field and a dropdown of options should appear. Select *WA State Health Care Authority SEBB*.
3. Click the *Submit* button. This will take you to a *Welcome to MyBenefits* screen that has *Life Insurance* and *Tools & Resources* boxes in the center of the screen and a *Not Registered?* box on the right.

   If you have visited MyBenefits before and completed steps 2 and 3, you will see the *Welcome to MyBenefits* screen that has *Life Insurance* and *Tools & Resources* boxes when you click the MetLife MyBenefits portal link above.
4. In the *Not Registered?* box on the right, click the *Register Now!* button.
5. Complete the registration form.
6. Click the *Register* button.
7. On the next screen, click the *Continue* button.

You will receive a thank you email from MetLife that includes a link back to the MyBenefits page. If you have questions regarding enrollment or the MetLife website, please contact MetLife at 1-833-854-9624, Monday through Friday, 5 a.m. to 8 p.m. Pacific Time (except for major holidays).

If I leave employment, can I continue life insurance coverage?

If you're eligible for portability or conversion due to termination or other reasons, MetLife will send you information and an application. Complete and mail the application to the address on the form.

Portability Provision
Under the Portability Provision of your SEBB Program employee life insurance, you can apply to continue your employee basic life and supplemental life insurance until age 100 if certain conditions are met. You must be actively enrolled (or within 60 days from when your coverage ended) to have the opportunity to continue all or part of your coverage through portability.

You may also apply to continue your terminated dependent basic life insurance and your spouse or state-registered domestic partner supplemental life insurance at the same time you apply to continue your own life insurance coverage under the Portability Provision. Dependent and spouse or state-registered domestic partner life insurance may be continued even if you choose not to continue your life insurance.

To continue life insurance under the Portability Provision, you must apply to MetLife within 60 days after the date your SEBB Program employee life insurance ends.

Any amount of life insurance not ported may be converted.

Conversion of Life Insurance Provision
You may convert your basic life, supplemental life, spouse or state-registered domestic partner, or dependent life insurance to an individual policy. The amount of the individual policy will be equal to (or if you choose, less than) the amount of life insurance you or your insured dependents had on the termination date of the policy you are converting.

You must apply to continue your coverage under the Conversion of Life Insurance Provision. You have 60 days to apply for conversion coverage after your employee life insurance ends.

Contact MetLife directly at 1-833-854-9624 with any questions.

Long-term disability insurance

LTD insurance helps 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.

The SEBB Program provides (employer-paid) basic long-term disability (LTD) insurance at no cost to school employees who are eligible for the employer contribution toward SEBB benefits. If eligible, you will automatically be enrolled in basic LTD insurance coverage, even if you waive SEBB medical coverage. You may also buy (employee-paid) supplemental LTD insurance.

Basic and supplemental LTD insurance are not available to employees whose eligibility was locally negotiated under WAC 182-30-130 (see *Eligibility* on page 12).

These benefits are provided through The Standard Insurance Company. The information below is a summary; if anything conflicts with the LTD plan booklet, the plan booklet takes precedence and prevails. To see the LTD plan booklet or to get a form, go to **hca.wa.gov/sebb-employee** under *Additional benefits* or contact your employer's payroll or benefits office.

What is basic LTD insurance?

The SEBB Program's basic LTD insurance provides:

- **Benefit**: 60 percent of the first $667 of your predisability earnings (your monthly gross pay), reduced by any deductible income
- **Minimum**: $100/month
- **Maximum**: $400/month

Benefits start after the benefit-waiting period, which is the longer of:

- 90 days
- The period of sick leave (excluding shared leave) for which you are eligible under your employer's sick leave, paid time off (PTO), or other salaried continuation plan (excluding vacation leave)
- The period of Washington Paid Family and Medical Leave for which you are receiving benefits.

Benefits continue during disability up to the maximum benefit period. The maximum benefit period is determined by your age when disability begins. See *What is the maximum benefit period?* on page 59.

What is (employee-paid) supplemental LTD insurance?

If you are eligible for basic LTD, you can buy supplemental LTD to cover yourself.

Supplemental LTD provides:

- **Benefit**: 60 percent of the first $16,667 of your predisability earnings, reduced by any deductible income
- **Minimum**: Greater of $100/month or 10 percent of LTD benefit before reduction by deductible income
- **Maximum**: $10,000/month

Supplemental LTD benefits start and continue in the same manner as basic LTD.

What does supplemental LTD insurance cost?

Your monthly supplemental LTD premium is based on your current age and your predisability earnings (your monthly gross pay before you became disabled). To calculate your premium, multiply your monthly gross pay (up to $16,667) by the appropriate age-banded rate (your age on January 1, 2020) shown below.

Supplemental LTD rates based on your age on January 1, 2020.

Age	Rate
<30	0.0014
30–34	0.0019
35–39	0.0029
40–44	0.0041
45–49	0.0056
50–54	0.0077
55–59	0.0093
60–64	0.0096
65+	0.0098

Sample calculation—LTD insurance
If your monthly earnings are $1,000, the 40–44 age rate is $4.10 per month.

Earnings:	$1,000 per month
40–44 age rate:	x 0.041
Monthly cost:	$4.10

How do I enroll in supplemental LTD insurance?

During the first annual open enrollment, you can enroll online using SEBB My Account. If you are unable to enroll online and are using paper enrollment forms, complete the *Long-term Disability Enrollment/Change Form* and submit it to your employer's payroll or benefits office.

If applying after the first annual open enrollment, do not use SEBB My Account. Complete the *Long-term Disability Enrollment/Change Form*. For questions about enrollment, contact your employer's payroll or benefits office. If you have a specific question about a claim, contact The Standard Insurance Company at 1-833-229-4177. Claim services will be available beginning January 1, 2020.

When can I enroll in supplemental LTD insurance?

You may enroll in supplemental LTD coverage without providing evidence of insurability during the first annual open enrollment, or after becoming eligible for SEBB benefits during the 2020 plan year.

What is considered a disability?

Disability is defined as 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 long-term disability 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 the first 24 months, disability as a result of sickness, injury, or pregnancy means 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.

What is the maximum benefit period?

For both basic LTD and supplemental LTD insurance, the "maximum benefit period" means the benefit duration, which 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 longer
62	To SSNRA* or 42 months, whichever is longer
63	To SSNRA* or 36 months, whichever is longer
64	To SSNRA* or 30 months, whichever is longer
65	24 months
66	21 months
67	18 months
68	15 months
69 or older	12 months

** SSNRA is your Social Security normal retirement age*

Medical FSA and DCAP

Both the Medical Flexible Spending Arrangement (FSA) and Dependent Care Assistance Program (DCAP) are available to school employees eligible for the employer contribution toward for SEBB benefits. These benefits are not available to employees whose eligibility was locally negotiated under WAC 182-30-130 (see *Eligibility* on page 12).

What is a Medical Flexible Spending Arrangement (FSA)?

A Medical FSA allows you to set aside money from your paycheck on a pretax basis to pay for qualifying out-of-pocket health care costs for you and your qualified tax dependents. You can set aside as little as $240 or as much as $2,700 per

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calendar year. The full amount you elect to set aside for your Medical FSA is available on the first day your benefits become effective.

You cannot enroll in both a Medical FSA and UMP High Deductible with a health savings account (HSA). If you try to enroll in both, you will only be enrolled in the UMP High Deductible with a starting date of January 1, 2020.

How does the Medical FSA work?

Your Medical FSA helps you pay for deductibles, copays, coinsurance, and many other expenses. You can use your Medical FSA for your health care expenses or those of your spouse or qualified tax dependent, even if they are not enrolled in your SEBB medical, dental, or vision plan.

To figure out how much you may want to contribute, estimate your out-of-pocket health care 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 (i.e., after the first annual open enrollment ends or your initial allowable 31 days of enrollment if you're newly eligible) unless a special open enrollment event (also called a qualifying event) occurs during the plan year. Common special open enrollment events include birth, death, adoption, marriage, and divorce. Your change in election amount must be consistent with the qualifying event.

Your election amount will be deducted from your pay, divided by the number of paychecks you will receive in the calendar year. Your election amount will be deducted pretax, which reduces your taxable income, so you won't pay federal taxes on your elected Medical FSA dollars.

What is the Dependent Care Assistance Program (DCAP)?

The Dependent Care Assistance Program (DCAP) allows you to set aside money from your paycheck on a pretax 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 they are physically or mentally incapable of self-care and regularly spend 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 (for a single person or married couple filing a joint income tax return) or $2,500 annually (for a married person filing a 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, as well as net earnings from self-employment.

When can I enroll in Medical FSA and DCAP?

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

- During the SEBB Program's first annual open enrollment
- **No later than 31 days** after the date you become newly eligible for the employer contribution toward SEBB benefits
- **No later than 60 days** after you or an eligible dependent experiences a qualifying event that creates a special open enrollment

How do I enroll in Medical FSA and DCAP?

The Medical FSA and DCAP are administered by Navia Benefit Solutions, Inc. For details, visit **sebb.naviabenefits.com**.

To enroll in these benefits, log in to SEBB My Account and click on *Supplemental coverage* to access the Medical FSA and DCAP enrollment websites.

If you are unable to access SEBB My Account or Navia Benefit Solutions' portal, you can download and print the *Medical Flexible Spending Arrangement (FSA) and Dependent Care Assistance Program (DCAP) Enrollment Form* at **sebb.naviabenefits.com** or call 1-800-669-3539. Navia Benefit Solutions must receive your form by November 15, 2019. Email questions to **customerservice@naviabene its.com**.

If you enroll in UMP High Deductible with a health savings account (HSA) you cannot also enroll in a Medical FSA in the same plan year. You are eligible to enroll in DCAP.

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 (i.e., qualifying event). The requested change must correspond to and be consistent with the qualifying event. For details, see *SEBB Policy Addendum 42-2A* at **hca.wa.gov/sebb-employee** and click on *Rules & policies*.

If you have a qualifying event and want to change your elections, your payroll or benefits office must receive your completed *Navia Benefit Solutions Change of Status* form and evidence of the qualifying event that created the special open enrollment **no later than 60 days** after the date of the event.

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

SmartHealth

SmartHealth is included in your benefits and is a voluntary wellness program that supports you on your journey toward living well.

The secure, easy-to-use, mobile-friendly website offers fun activities to help you reach your wellness goals, such as sleeping better, eating healthier, and planning for retirement. As you progress on your wellness journey, you can qualify for the SmartHealth wellness incentive.

Who is eligible for SmartHealth?

You (the subscriber) and your spouse or state-registered domestic partner enrolled in SEBB medical coverage can participate in SmartHealth. Only subscribers enrolled in SEBB medical coverage can qualify for the SmartHealth wellness incentive.

Are you waiving SEBB medical coverage? You can still access SmartHealth, but you won't be eligible to qualify for the SmartHealth wellness incentive.

What is the wellness incentive?

Subscribers can qualify for a SmartHealth wellness incentive each year. A $50 incentive is applied in January 2020 if you qualify. A $125 incentive is applied in January 2021 if you qualify.

To get the incentive, you must complete program requirements one year and still be enrolled in SEBB medical coverage as a subscriber the following year. How the incentive applies depends on what type of SEBB medical plan you choose.

- **High-deductible health plans:** A one-time deposit into the subscriber's health savings account (HSA).
- **All other plans:** A reduction to the subscriber's SEBB medical plan deductible.

How do I qualify during the first annual open enrollment?

1. Starting October 1, 2019, use SEBB My Account to enroll in SEBB benefits.
2. Go to **smarthealth.hca.wa.gov** and click *Get Started*.
3. Complete the SmartHealth Well-being Assessment by November 15, 2019 to qualify for a $50 wellness incentive (applied in January 2020).
   - Only takes 15 minutes
   - Works on computers, laptops, tablets, and smartphones
   - Learn your top strengths and areas to improve

How do I qualify starting in January 2020?

1. Go to **smarthealth.hca.wa.gov**.
   - If you registered during the first annual open enrollment, just sign in. If you did not register, click *Get Started*.
2. Complete the SmartHealth Well-being Assessment (WBA).
   - If you completed the WBA during the first annual open enrollment, you do not have to complete it again in 2020 to qualify.
3. Join and track fun activities to earn at least 2,000 points by November 30, 2020 to qualify for a $125 wellness incentive (applied in January 2021).

What if I don't have internet access?

Contact SmartHealth Customer Service to participate in SmartHealth by phone.

SmartHealth contacts

About: **hca.wa.gov/sebb-smarthealth**
Website: **smarthealth.hca.wa.gov**
Customer Service: 1-855-750-8866
Toll-free Monday through Friday,
7 a.m. to 7 p.m. Pacific Time

Making changes in coverage

How do I make changes in my health plan coverage?

You can make changes to your enrollment or health plan elections in one of these ways:

- Log in to SEBB My Account during the first annual open enrollment period, October 1 through November 15, 2019, and change your selections.
- Submit the required form(s) to your employer's payroll or benefits office during the first annual open enrollment period.
- Log in to SEBB My Account or submit the required form(s) to your payroll or benefits office when a special open enrollment event occurs, within the SEBB Program's timelines.

What changes can I make at any time?

You can make some changes outside of annual open enrollment without a special open enrollment event.

- Change your name and/or address by notifying your payroll or benefits office. You cannot change this through SEBB My Account.
- Apply for, terminate (cancel), change coverage amounts, and update beneficiary information for supplemental life insurance, supplemental accidental death and dismemberment (AD&D) insurance, and supplemental long-term disability insurance with evidence of insurability. (See *Life and AD&D insurance* on page 55 and *Long-term disability insurance* on page 58.)
- Remove dependent(s) from coverage due to loss of eligibility (this is required). You must make this change in SEBB My Account or submit the completed S*chool Employee Change Form* to your employer's payroll or benefits office **no later than 60 days** after the event. You may also need to provide proof of the event before the dependent can be removed.
- Enroll in, or cancel supplemental long-term disability coverage. You can do this on SEBB My Account during the first annual open enrollment period or with the *Long-Term Disability Enrollment/Change Form* after the first annual open enrollment period.
- 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 **hca.wa.gov/sebb-employee** under *Forms & publications*.
- Change your HSA beneficiary information. Use the *Health Savings Account Beneficiary Designation* form available at **learn.healthequity.com/sebb/hsa**.
- Make changes to your tobacco use surcharge attestation. You can do this on SEBB My Account or use the *SEBB Premium Surcharge Change Form* at **hca.wa.gov/sebb-employee** under *Forms & publications*.

What changes can I make only during the SEBB Program annual open enrollment?

During the annual open enrollment you can:

- Change your medical, dental, and vision plans.
- Enroll your eligible dependents.
- Waive medical coverage or enroll after waiving.
- Enroll in a Medical Flexible Spending Arrangement (FSA).
- Enroll in the Dependent Care Assistance Program (DCAP).
- Attest to the spouse or state-registered domestic partner coverage premium surcharge.

What changes can I make during a special open enrollment?

Certain events let you make account changes (like changing plans or enrolling a dependent) outside of annual open enrollment. We call these special open enrollment events.

You must provide evidence of the event that created the special open enrollment (for example, a marriage or birth certificate) along with the required enrollment/change forms to your payroll or benefits office, or in SEBB My Account, **no later than 60 days** after the event.

In many instances, the date your change is received affects the effective date of the change in enrollment. *(Continued on page 65.)*

If this event happens	Add dependent	Remove dependent	Change SEBB medical, dental, or vision plan	Waive SEBB medical coverage	Enroll after waiving SEBB medical coverage
Marriage, registering a domestic partner, birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption	Yes[1]	Yes[2]	Yes	Yes	Yes
Child becomes eligible as an extended dependent through legal custody or legal guardianship	Yes	No	Yes	No	Yes
Employee or dependent loses eligibility for other coverage under a group health plan or through health insurance, as defined by the Health Insurance Portability and Accountability Act (HIPAA)	Yes	No	Yes	No	Yes
Employee has a change in employment status that affects the employee's eligibility for their employer contribution toward their employer-based group health plan	Yes	Yes	Yes	Yes	Yes
Employee's dependent has a change in their employment status that affects their eligibility for the employer contribution under their employer-based group health plan	Yes	Yes	Yes	Yes	Yes
Employee has a change in employment from a SEBB organization to a school district that straddles county lines or is in a county that borders Idaho or Oregon, which results in having different medical plans available	No	No	Yes	No	No
Employee or dependent has a change in enrollment under another employer-based group health plan during its annual open enrollment that does not align with the SEBB Program's annual open enrollment	Yes	Yes	No	Yes	Yes

[1] Subscriber may add only the new spouse, state-registered domestic partner, or children of the spouse or partner. Existing dependents may not be added.

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

(continued)

If this event happens	Add dependent	Remove dependent	Change SEBB medical, dental, or vision plan	Waive SEBB medical coverage	Enroll after waiving SEBB medical coverage
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
Employee or dependent has a change in residence that affects health plan availability	No	No	Yes	No	No
A court order 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 dependent becomes entitled to or loses eligibility for Apple Health (Medicaid) or a state Children's Health Insurance Program (CHIP)	Yes	Yes	Yes	Yes	Yes
Employee or dependent becomes eligible for a state premium assistance subsidy for SEBB health plan from Apple Health (Medicaid) or a state CHIP	Yes	No	Yes	No	Yes
Employee or dependent becomes entitled to coverage under Medicare, or the employee or dependent loses eligibility for coverage under Medicare	No	No	Yes	Yes	Yes
Employee's or 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 dependent experiences a disruption of care that could function as a reduction in benefits for the employee or their dependent for a specific condition or ongoing course of treatment (requires approval by the SEBB Program).	No	No	Yes, if approved by SEBB Program	No	No

[1] Subscriber may add only the new spouse, state-registered domestic partner, or children of the spouse or partner. Existing dependents may not be added.

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

If this event happens	Add dependent	Remove dependent	Change SEBB medical, dental, or vision plan	Waive SEBB medical coverage	Enroll after waiving SEBB medical coverage
Employee or dependent becomes eligible and enrolls in a TRICARE plan, or loses eligibility for a TRICARE plan	No	No	No	Yes	Yes

[1] Subscriber may add only the new spouse, state-registered domestic partner, or children of the spouse or partner. Existing dependents may not be added.

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

(Continued from page 62.)
The changes shown on pages 63 to 65 may be allowed as a special open enrollment.

In addition, subscribers can make changes to supplemental life and AD&D insurance, Medical Flexible Spending Arrangements (FSA), and Dependent Care Assistance Program (DCAP) during a special open enrollment.

What happens when my dependent loses eligibility?

You must remove an ineligible dependent **no later than 60 days** after the date they no longer meet SEBB Program eligibility. Remove the dependent from your account in SEBB My Account, or submit your completed *School Employee Change Form* to your payroll or benefits office. The form must be received **no later than 60 days** after the date the dependent no longer meets SEBB eligibility criteria. Your dependent will be removed from coverage on the last day of the month they no longer meet the eligibility criteria.

Consequences for not submitting the change within 60 days of the last day of the month your dependent loses eligibility are explained in WAC 182-31-150. The consequences 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 66.
- 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 to my dependent's coverage if they die?

If your covered dependent dies, you must use SEBB My Account or submit a *School Employee Change Form* to your employer's payroll or benefits office to remove the deceased dependent **no later than 60 days** after the event. By submitting this change, 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 SEBB Program collects premiums for the entire calendar month and will not prorate them for any reason, including when a member dies before the end of the month. The deceased dependent's coverage will end the last day of the month in which the dependent dies. Any change to your premium will be effective the first day of the following month.

If you have life insurance coverage for your dependent, or are unsure if you elected supplemental life insurance for the dependent, contact MetLife at 1-833-854-9624. Also consider reviewing and updating any beneficiary designations for benefits such as your life insurance beneficiaries, Department of Retirement Systems administered pension benefits, or other administered deferred compensation program accounts.

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What happens when I am required to provide health plan coverage for a dependent?

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 their health plan coverage as directed by the NMSN. You must make the change in SEBB My Account and upload the NMSN, or complete and submit a *School Employee Change Form* and a copy of the NMSN to your payroll and benefits office.

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

The following options are allowed:

- The child will be enrolled under the subscriber's SEBB Program coverage as directed by the NMSN.
- If you have previously waived SEBB medical coverage, you will be enrolled in medical coverage as directed by the NMSN in order to enroll the child.
- The subscriber's selected health plan will be changed if directed by the NMSN.
- If the child is already enrolled under another SEBB subscriber, the child will be removed from the other health plan coverage and enrolled as directed by the NMSN.
- If the subscriber is eligible for and elects COBRA or other continuation coverage, the NMSN will be enforced and the dependent must be covered in accordance with the NMSN.
- When an NMSN requires someone else to provide health plan coverage for your enrolled dependent child, and that coverage is in fact provided, you may remove the child from your coverage. 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.

When SEBB Program coverage ends

SEBB insurance coverage ends as described below.

- When the SEBB organization terminates the employment relationship. Eligibility for the employer contribution ends the last day of the month in which the employer-initiated termination notice is effective.
- When the school employee terminates the employment relationship. Eligibility for the employer contribution ends the last day of the month in which the school employee's resignation is effective.
- When the school employee's work pattern is revised such that the school employee is no longer anticipated to work 630 hours during the school year. Eligibility for the employer contribution ends as of the last day of the month in which the change is effective.

In the event you lose eligibility, your employer will notify you and give you the opportunity to appeal the decision. You can find information on how to appeal on page 68.

If your dependent loses eligibility, you must remove the ineligible dependent **no later than 60 days** after the date they are no longer eligible. See *What happens when my dependent loses eligibility?* on page 65.

The SEBB Program collects premiums for the entire calendar month and will not prorate them for any reason.

What are my options when coverage ends?

If you have dependents currently on continuation coverage through your SEBB organization on December 31, 2019 who are not eligible as dependents under the SEBB Program, continuation coverage options may be available. They may choose to self-pay to continue their coverage for up to 18 months.

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

You can also enroll on your spouse's or state-registered domestic partner's employer-paid SEBB coverage as a dependent. Options for continuing coverage vary based on the reason eligibility is lost.

The SEBB Program will mail a *SEBB 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 SEBB Program **no later than 60 days** from the date SEBB health plan coverage ended or from the postmark date on the S*EBB Continuation Coverage Election Notice*, whichever is later. If the election notice is not received by the deadline, you will lose all rights to continue SEBB insurance coverage.

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

- SEBB Continuation Coverage (COBRA)
- SEBB Continuation Coverage (Unpaid Leave)
- PEBB retiree insurance coverage

The first two options temporarily extend SEBB health plan coverage when your or your dependent's SEBB health plan coverage ends due to a qualifying event.

PEBB retiree insurance is only available to PEBB-eligible retirees who meet eligibility and procedural requirements. When you plan to terminate your employment and want to enroll in PEBB retiree health plan coverage, you should contact the PEBB Program about 90 days prior to terminating employment at 1-800-200-1004 to discuss your PEBB retiree health plan enrollment and request a *Retiree Enrollment Guide*. You have **60 days** from the date your employer-paid SEBB coverage or COBRA coverage ends for the PEBB Program to receive your application for retiree insurance coverage. You can also find information online at **hca.wa.gov/erb**.

COBRA eligibility is defined in federal law and governed by federal rules. If you qualify for both SEBB Continuation Coverage options, you may choose to enroll in only one of the options.

SEBB Continuation Coverage (COBRA) includes eligibility and administrative requirements under federal law and also includes coverage for some enrollees who are not qualified beneficiaries under federal COBRA continuation coverage.

SEBB Continuation Coverage (Unpaid Leave) is an alternative created by the SEBB Program with wider eligibility criteria and qualifying event types, such as a layoff, approved leave of absence, or when called to active duty in the uniformed services. This option also allows you to continue life insurance. If an employee does not elect this coverage, their dependents do not have independent election right to SEBB Continuation Coverage (Unpaid Leave).

The SEBB Program administers all continuation coverage options. For information about your rights and obligations under SEBB rules and federal law, refer to the S*EBB Initial Notice of COBRA and Continuation Coverage Rights* (mailed to you after you enroll in SEBB insurance coverage), or the *SEBB Continuation Coverage Election Notice,* at **hca.wa.gov/sebb-employee** under *Forms & publications*.

What happens to my Medical FSA funds when coverage ends?

When your SEBB 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 Flexible Spending Arrangement. Eligibility ends on the last day of the month of loss of coverage or unapproved leave. You will be able to claim expenses incurred while employed, up to your remaining benefit, unless you are eligible to continue your Medical FSA coverage under SEBB Continuation Coverage (COBRA) or SEBB Continuation Coverage (Unpaid Leave), through Navia Benefit Solutions. 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.

What happens to my DCAP funds when coverage ends?

If you terminate employment and have unspent Dependent Care Assistance Program 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

(continued)

continuation coverage rights for the DCAP.

For more information on when coverage ends, see the *Medical FSA Enrollment Guide* or *DCAP Enrollment Guide* at **sebb.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 health savings account (HSA) when coverage ends?

If you enroll in UMP High Deductible (HDHP) with an HSA, then later 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 SEBB 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 medical plan* on page 25 to learn more about the UMP High Deductible with an HSA.

What happens to my life insurance when coverage ends?

If your SEBB Program life insurance ends as an employee, you may have an opportunity to continue all or part of your coverage through a portability or conversion option. If you are eligible for these options, MetLife will send you information and an application. For more information, see *Life and AD&D insurance* on page 55 or contact MetLife at 1-833-854-9624.

Appeals

How do I appeal a decision made by a plan?

If you are seeking a review of a decision by a SEBB Program health plan or insurance carrier, contact the plan to request information on how to appeal its decision. For example, you would contact your health plan to appeal a denial of a medical claim. Plan contact information is listed at the beginning of this guide.

How do I appeal a decision from my employer or the SEBB Program?

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 WAC 182-32 and at **hca.wa.gov/sebb-appeals** or see the table on page 69.

How do I appeal a decision made by a SEBB Appeals presiding officer?

You can appeal the SEBB Appeals Unit's presiding officer's initial order by filing a written request for review or by making an oral request for review. Information detailing your right to request review is included in the SEBB Appeals Unit's presiding officer's initial order. Once your request for review is received by the Appeals Unit, a final order will generally be mailed within 20 days.

Mail your written request to:
Health Care Authority
SEBB Appeals
PO Box 45504
Olympia, WA 98504-5504
By Fax: 360-586-9080

Request an oral review by calling 1-800-351-6827.

Deadline: The SEBB Appeals Unit must **receive** your request for review **no later than 21 calendar days** after the service date of the initial order.

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

You must provide the SEBB Program with a completed *Authorization for Release of Information* form or a copy of a valid power of attorney naming your representative and authorizing them to access your medical records and/or SEBB Program account information and exercise your rights under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rule. The form is available at **hca.wa.gov**. If you have questions please call the PEBB Appeals unit at 1-800-351-6827.

If your situation is:	Follow these instructions and submission deadlines:

You disagree with **a decision made by your employer and you are requesting your employer's review about:**
• Premium surcharges
• Eligibility for or enrollment in:
  • Medical coverage
  • Dental coverage
  • Vision coverage
  • Life insurance
  • Long-term disability insurance
  • Medical Flexible Spending Arrangement (FSA)
  • Dependent Care Assistance Program (DCAP)
	Instructions: Submit the *Employee Request for Review/Notice of Appeal* form (available at **hca.wa.gov/sebb-employee** under *Forms & publications*) to your employer.
	
	Deadline: Your employer must **receive** the form **no later than 30 calendar days** after the date of the initial denial notice or decision you are appealing.

You disagree with a review decision made by your employer, or agree that further review is needed because your employer did not grant you the relief you requested, and are now **requesting the SEBB Program's review of your employer's decision.**	Instructions: Submit the *SEBB Employee Request for Review/Notice of Appeal* form to the SEBB Appeals Unit as directed on the form, or follow the appeal rules as outlined in WAC 182-32-2070. Deadline: The SEBB Appeals Unit must **receive** the form **no later than 30 calendar days** after the date of your employer's review decision.

Your appeal concerns **a decision from the SEBB Program about:**
• Eligibility for or enrollment in:
  • Premium payment plan
  • Medical Flexible Spending Arrangement (FSA)
  • Dependent Care Assistance Program (DCAP)
  • Life insurance
• Eligibility to participate in SmartHealth or receive a wellness incentive
• Dependent, extended dependent, or disabled dependent eligibility
• Premium surcharges
• Premium payments
	Instructions: Submit the *SEBB Employee Request for Review/Notice of Appeal* form to the SEBB Appeals Unit as directed on the form, or follow the appeal rules as outlined in WAC 182-32-2070.
	
	Deadline: The SEBB Appeals Unit must **receive** the form **no later than 30 calendar days** after the date of the denial notice or decision you are appealing.

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

PO Box 42720
Olympia, WA
98504-2720
Return Service Requested

FIRST ANNUAL OPEN ENROLLMENT:

OCTOBER 1 – NOVEMBER 15, 2019

BENEFITS BEGIN:

JANUARY 1, 2020