PEBB Retiree Enrollment Guide

Your PEBB benefits for
2021

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

HCA 51-0205 (10/20)

Welcome

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

Your benefits include:

- Medical coverage
- Dental coverage
- Retiree Term Life Insurance
- SmartHealth (non-Medicare retirees only)
- Auto and home insurance

Five steps to enroll

1. Submit Form A to enroll in or defer (postpone) PEBB retiree insurance coverage. We must receive your form **no later than 60 days** after your employer-paid, COBRA, or continuation coverage ends (or, for elected or full-time appointed officials, 60 days after you leave public office). If you choose a Medicare Advantage or Medicare Advantage Prescription Drug plan, we must receive Form A no later than the last day of the month before the date PEBB retiree insurance coverage is to begin. If you are a dependent becoming eligible as a survivor, please see page 12 for enrollment timelines. To learn more, see "How to Enroll" on page 13 or "Deferring Your Coverage" on page 23.
2. If you are enrolling dependents, you may need to prove their eligibility by submitting documents. Learn more about this process on page 12.
3. Along with submitting Form A, you must make your first premium payment for PEBB retiree insurance coverage, including applicable premium surcharges, before we can enroll you. To learn more, see "Paying for Coverage" on page 15.
4. If you or your dependents are eligible for Medicare, you must enroll in Medicare Part A and Part B to enroll in PEBB retiree insurance coverage. You will need to submit proof of your Medicare enrollment. To stay enrolled in a PEBB retiree health plan, you must stay enrolled in Medicare Part A and Part B.
5. Get your PEBB Program eligibility and enrollment questions answered. Visit HCA's website at **hca.wa.gov/pebb-retirees** or call PEBB Customer Service at 1-800-200-1004 (TRS: 711).

Good to know!

If you do not enroll in PEBB retiree insurance coverage when you are eligible, as described in chapter 182-12 WAC of PEBB Program rules, you are only eligible to enroll later if you defer (postpone) enrollment and stay continuously enrolled in other qualifying medical coverage. This coverage is described in WAC 182-12-200 and 182-12-205. See important information about deferring PEBB retiree insurance coverage on page 23.

Quick start guide

Need to know if you're eligible?
See page 10.

Ready to enroll in PEBB retiree insurance coverage?
Turn to page 13.

Not sure how to fill out your forms?
Flip to page 67 or check out our self-paced tutorial on HCA's website at **hca.wa.gov/pebb-retirees**.

Paying for PEBB retiree insurance coverage?
Find monthly premiums on page 7. Learn about your payment options on page 15.

Want to know which health plan is best for you?
Turn to page 25.

Curious about how Medicare works with PEBB coverage?
Learn about coordination of benefits on page 17.

Not ready to enroll in PEBB retiree insurance coverage yet?
Don't miss your chance to enroll later. Learn about deferring coverage on page 23.

Interested in Retiree Term Life Insurance?
See page 58.

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

Who to Contact for Help

Contact the health plans for help with:

- Specific benefit questions.
- Checking if your provider contracts with the plan.
- Checking if your medications are covered by the plan.
- Claims.
- ID cards.

Go to HCA's website at hca.wa.gov/pebb-retirees for help with:

- Eligibility and enrollment questions.
- Changes to your account (due to Medicare enrollment, divorce, etc.).
- Changing your name, address, or phone number.
- Enrolling or removing dependents.
- Finding forms.
- Premium surcharge questions.
- Eligibility complaints or appeals.
- You may also call the PEBB Program at 1-800-200-1004 for help.

Good to know!

PEBB Program is saving the green

Help reduce our reliance on paper mailings — and their toll on the environment — by signing up to receive PEBB Program mailings by email. Once you are enrolled in PEBB retiree insurance coverage, you can sign up by visiting PEBB My Account at **hca.wa.gov/my-account**.

Medical plans

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

Kaiser Permanente WA Classic, CDHP, Medicare, SoundChoice, or Value
kp.org/wa/pebb
Non-Medicare members: 1-866-648-1928 (TTY: 711)
Medicare members: 1-206-630-4600 (TTY: 1-800-833-6388)

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

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

UMP Plus–Puget Sound High Value Network
Administered by Regence BlueShield
pugetsoundhighvaluenetwork.org
1-855-776-9503 (TRS: 711)

UMP Plus–UW Medicine Accountable Care Network
Administered by Regence BlueShield
pebb.uwmedicine.org
1-855-520-9500 (TRS: 711)

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

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

Dental plans

DeltaCare
Administered by Delta Dental of Washington
deltadentalwa.com/pebb
1-800-650-1583 (TTY: 1-800-833-6384)

Uniform Dental Plan
Administered by Delta Dental of Washington
deltadentalwa.com/pebb
1-800-537-3406 (TTY: 1-800-833-6384)

Willamette Dental of Washington, Inc.
willamettedental.com/wapebb
1-855-433-6825 (TRS: 711)

Additional contacts

Auto and home insurance: Liberty Mutual Insurance Company
hca.wa.gov/employee-retiree-benefits/retirees/auto-and-home-insurance
1-800-706-5525 (TRS: 711)

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

Retiree Term Life Insurance: Metropolitan Life Insurance Company (MetLife)
metlife.com/wshca-retirees
1-866-548-7139

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

Health reimbursement arrangement (HRA): Voluntary Employees' Beneficiary Association (VEBA)
VEBA Plan or VEBA Medical Expense Plan (MEP): **veba.org**, 1-888-828-4953
HRA VEBA Plan: **hraveba.org**, 1-888-659-8828

For help with eligibility and enrollment

- **Visit HCA's website at hca.wa.gov/pebb-retirees** for forms and information updates.
- **Call the PEBB Program** toll-free at 1-800-200-1004 (TRS: 711) Monday through Friday, 8 a.m. to 4:30 p.m. (Other business activities may result in the phones being unavailable at times.)
- **Fax documents to us** at 360-725-0771.
- **Write to us at:**
  Health Care Authority
  PEBB Program
  PO Box 42684
  Olympia, WA 98504-2684
- **Visit our office**:
  Health Care Authority
  626 8th Avenue SE
  Olympia, WA 98501
  Note: Because of recent closures during the COVID-19 pandemic, please call ahead to check whether our office is open before your visit. We see visitors on a first-come, first-served basis. The last visitor will be accepted at 4:30 p.m.
- **Send us a secure message** on HCA's website at **hca.wa.gov/fuze-questions**. You must set up a secure login to use this feature. This helps protect your privacy and sensitive health information.

Good to know!

Due to the COVID-19 pandemic, the PEBB Program has temporarily changed the deadline to enroll in PEBB retiree insurance coverage when first eligible. To learn more about this exception to the timelines listed in this booklet, visit HCA's website at **hca.wa.gov/coronavirus**.

Table of Contents

2021 **PEBB Retiree Monthly Premiums**

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Special requirement for Medicare premiums

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

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

Retiree Medicare medical plan premiums

Effective January 1, 2021

For members enrolled in Medicare Parts A and B	Subscriber	Subscriber & spouse[1]		Subscriber & children		Subscriber, spouse[1] & children		
	1 Medicare eligible	*1 Medicare eligible*	*2 Medicare eligible*	*1 Medicare eligible*	*2 Medicare eligible*	*1 Medicare eligible*	*2 Medicare eligible*	*3 Medicare eligible*
Kaiser Permanente NW Senior Advantage[2]	$174.41	$914.50[3]	$343.27	$729.48[3]	$343.27	$1,469.57[3]	$898.34[3]	$512.11
Kaiser Permanente WA Classic	N/A	$946.93	N/A[4]	$754.47	N/A[4]	$1,524.29	$926.01	N/A[4]
Kaiser Permanente WA Medicare Plan	$177.10	N/A[4]	$348.64	N/A[4]	$348.64	N/A[4]	N/A[4]	$520.18
Kaiser Permanente WA SoundChoice	N/A	$812.96	N/A[4]	$653.99	N/A[4]	$1,289.85	$825.54	N/A[4]
Kaiser Permanente WA Value	N/A	$870.49	N/A[4]	$697.14	N/A[4]	$1,390.53	$868.68	N/A[4]
UMP Classic	$336.30	$1,022.45	$667.04	$850.91	$667.04	$1,537.06	$1,181.65	$997.77
UnitedHealthcare PEBB Balance	$132.93	$819.08[5]	$260.29	$647.54[5]	$260.29	$1,333.68[5]	$774.90[5]	$387.65
UnitedHealthcare PEBB Complete	$156.81	$842.96[5]	$308.05	$671.42[5]	$308.05	$1,357.56[5]	$822.66[5]	$459.29

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

Retiree Premera Blue Cross Medicare Supplement Plan F and Plan G premiums

	Subscriber	Subscriber & spouse[1]			Subscriber & children	Subscriber, spouse[1] & children		
	1 Medicare eligible	*1 Medicare eligible[2]*	*2 Medicare eligible: 1 retired, 1 disabled*	*2 Medicare eligible*	*1 Medicare eligible[2]*	*1 Medicare eligible[2]*	*2 Medicare eligible: 1 retired, 1 disabled[2]*	*2 Medicare eligible[2]*
Plan F Age 65 or older, eligible by age	$116.68	$802.83	$311.45	$227.80	$631.29	$1,317.44	$826.81	$742.41
Plan F Under age 65, eligible by disability	$200.34	$886.49	$311.45	$395.11	$714.95	$1,401.09	$826.81	$909.72
Plan G Age 65 or older, eligible by age	$99.92	$786.07	$260.31	$194.27	$614.53	$1,300.67	$775.67	$708.88
Plan G Under age 65, eligible by disability	$165.96	$852.11	$260.31	$326.36	$680.57	$1,366.72	$775.67	$840.97

Non-Medicare medical plan premiums

For members not eligible for Medicare (or enrolled in Part A only)	Subscriber	Subscriber & spouse[1]	Subscriber & children	Subscriber, spouse[1] & children
Kaiser Permanente NW Classic[3]	$745.66	$1,485.75	$1,300.73	$2,040.82
Kaiser Permanente NW CDHP[3]	$618.76	$1,226.30	$1,089.00	$1,638.21
Kaiser Permanente WA Classic	$775.39	$1,545.22	$1,352.76	$2,122.58
Kaiser Permanente WA CDHP	$619.29	$1,227.86	$1,090.30	$1,640.54
Kaiser Permanente WA SoundChoice	$641.43	$1,277.28	$1,118.32	$1,754.17
Kaiser Permanente WA Value	$698.96	$1,392.34	$1,219.00	$1,912.38
UMP Classic	$691.72	$1,377.86	$1,206.32	$1,892.47
UMP Select	$623.50	$1,241.43	$1,086.95	$1,704.88
UMP CDHP	$618.52	$1,226.31	$1,088.95	$1,638.41
UMP Plus—PSHVN	$658.79	$1,312.02	$1,148.71	$1,801.93
UMP Plus—UW Medicine ACN	$658.79	$1,312.02	$1,148.71	$1,801.93

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

Medical premium surcharges (for non-Medicare subscribers only)

Two premium surcharges may apply in addition to your monthly medical premium. They only apply if you, the subscriber, are not enrolled in Medicare Part A and Part B. You will be charged for them if the conditions described below apply, or if you do not attest to the surcharges.

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

For more guidance on whether these premium surcharges apply to you, see the *2021 PEBB Premium Surcharge Attestation Help Sheet* on the HCA website at hca.wa.gov/erb under *Forms & publications*.

Retiree dental plan premiums

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

	Subscriber	Subscriber & spouse1	Subscriber & children	Subscriber, spouse1 & children
DeltaCare[2]	$39.53	$79.06	$79.06	$118.59
Uniform Dental Plan[2]	$48.00	$96.00	$96.00	$144.00
Willamette of Washington	$44.45	$88.90	$88.90	$133.35

1 Or state-registered domestic partner
2 Administered by Delta Dental of Washington

Retiree Eligibility

Who's eligible for PEBB retiree insurance coverage?

This guide provides a general summary of retiree eligibility. The PEBB Program will determine your eligibility based on PEBB Program rules and when we receive your election form.

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

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

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

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

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

You must also be a vested member and meet the eligibility criteria to retire from a Washington State-sponsored retirement plan when your employer-paid coverage, COBRA coverage, or continuation coverage ends. (Different rules apply to elected or full-time appointed officials and employees of an employer group that does not participate in a Washington State-sponsored retirement plan.)

Washington State-sponsored retirement plans include:

- Public Employees' Retirement System (PERS) 1, 2, or 3
- Public Safety Employees' Retirement System (PSERS) 2
- Teachers' Retirement System (TRS) 1, 2, or 3
- Washington Higher Education Retirement Plan (HERP) (for example, TIAA-CREF)
- School Employees' Retirement System (SERS) 2 and 3
- Law Enforcement Officers' and Fire Fighters' Retirement System (LEOFF) 1 or 2
- Washington State Patrol Retirement System (WSPRS) 1 or 2
- State Judges/Judicial Retirement System
- Civil Service Retirement System and Federal Employees' Retirement System (for Washington State University Extension employees covered under PEBB benefits at the time of retirement)

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

- If you receive a lump sum payment, you are only eligible for PEBB retiree insurance coverage if the Department of Retirement Systems offered you the choice between a lump sum actuarially equivalent payment and an ongoing monthly payment.
- If you are an employee retiring or separating under PERS Plan 3, TRS Plan 3, or SERS Plan 3, and you meet the plan's eligibility criteria.
- If you are an employee retiring under a Washington Higher Education Retirement Plan (such as TIAA-CREF) and meet your plan's retirement eligibility criteria, or you are at least age 55 with 10 years of state service.
- If you are an employee retiring from a PEBB employer group, and your employer does not participate in a Washington State-sponsored retirement plan. However, you must meet the same age and years of service requirement as members of PERS Plan 1 (if your date of hire with your employer group was before October 1, 1977) or Plan 2 (if your date of hire with your employer group was on or after October 1, 1977).
- If you are an elected or full-time appointed official as described in WAC 182-12-180.

Dependent Eligibility

You may enroll the following dependents:

- Your legal spouse
- Your state-registered domestic partner, as defined in WAC 182-12-109 and RCW 26.60.020(1). This includes substantially equivalent legal unions from other jurisdictions as defined in RCW 26.60.090. Strict requirements apply to these partnerships, including that one partner is age 62 or older and you live in the same residence.
- Your children, through the last day of the month in which they turn age 26. However, children with a disability may be covered past the age of 26 if they qualify.

How are children defined?

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

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

Extended dependents

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

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

Children with disabilities

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

The PEBB Program, with input from your medical plan (if the child is enrolled in medical coverage), will verify the disability and dependency of the child starting at age 26. The first verification lasts for two years. After that, we will occasionally review their eligibility, but not more than once a year. These verifications may require renewed proof from you. If the PEBB Program does not receive your verification within the time allowed, the child will no longer be covered.

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

Proving dependent eligibility

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

Subscribers who **are not** eligible for Medicare Part A and Part B, or who are enrolling a state-registered domestic partner, must prove their dependents are eligible before we will enroll them. If you are enrolling a dependent, submit the documents with your enrollment forms within PEBB Program timelines.

A few exceptions apply to the dependent verification process:

- Extended dependents are reviewed through a separate process.
- If a subscriber moves from School Employees Benefits Board (SEBB) Program coverage to PEBB Program coverage, and requests to enroll an eligible dependent who has been previously verified under the SEBB Program, we can use the dependent verification data that was submitted to the SEBB Program.

The most common types of documents used to prove dependent eligibility are listed on the next page. To see a full list of documents we will accept, visit HCA's website at **hca.wa.gov/employee-retiree-benefits/retirees/dependent-verification**.

Documents to enroll a spouse

Provide a copy of (choose one):

- The most recent year's federal tax return filed jointly that lists your spouse (black out financial information).
- The most recent year's federal tax return for you and your spouse if filed separately (black out financial information).
- A marriage certificate and evidence that the marriage is still valid. For example: a utility bill or bank statement dated within the past six months showing both your and your spouse's name (black out financial information).

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

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. For example: a utility bill or bank statement dated within the past six months showing both your and your partner's name (black out financial information).
- Petition for dissolution of a state-registered domestic partnership or legal union.

If enrolling a partner of a legal union, you must also submit proof of Washington state residency for both you and your partner (in addition to the dependent verification documents described above). Within one year of the partner's enrollment, additional dependent verification documents will be required to keep them enrolled. For details, read PEBB Program Administrative Policy 33-1.

Documents to enroll children

Provide a copy of (choose one):

- The most recent year's federal tax return that includes children (black out financial information). You can submit one copy of your tax return if it includes all dependents that require verification.
- Birth certificate, or hospital certificate with the child's footprints on it, showing the name of the parent who is the subscriber, the subscriber's spouse, or the subscriber's state-registered domestic partner. If the dependent is the subscriber's stepchild, the subscriber must also verify the spouse or state-registered domestic partner to enroll the child, even if they are not enrolling the spouse or partner in coverage.

Additional required documents

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

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

You must notify the PEBB Program in writing when your dependent is no longer eligible. See "What happens when a dependent loses eligibility?" on page 21 to learn more.

Good to know!

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

If I die, are my surviving dependents eligible?

Your dependents may be eligible to enroll in or defer PEBB retiree insurance coverage as survivors. To do so, they must meet the eligibility and procedural requirements outlined in WAC 182-12-180 or 182-12-265.

The PEBB Program must receive all required forms within the following timelines:

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

For more information about how to continue coverage as a survivor, see "How does a survivor pay for coverage?" on page 16 and "What are my family's options if I pass away?" on page 22. For more information about deferring coverage, see "Required timelines for survivors to defer" on page 24.

When are dependents of emergency service employees eligible?

If you are a surviving spouse, state-registered domestic partner, or dependent child of an emergency service employee who was killed in the line of duty, you may be eligible to enroll in or defer (postpone) PEBB retiree insurance coverage. To be eligible, you must meet both the procedural and eligibility requirements outlined in WAC 182-12-250. To learn more about this coverage, including deadlines to apply, call the PEBB Program at 1-800-200-1004.

How to Enroll

If you are a retiring employee, the PEBB Program must receive your *PEBB Retiree Election Form* (form A) and any other required documents **no later than 60 days** after your employer-paid coverage, COBRA coverage, or continuation coverage ends. If you select a Medicare Advantage or Medicare Advantage Prescription Drug (MAPD) plan, we must receive Form A no later than the last day of the month before the month your employer-paid coverage, COBRA coverage, or continuation coverage ends. Otherwise, you may not select these plans unless you have a special open enrollment. See page 19 to learn more about special open enrollments.

Good to know!

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

If you are an elected or full-time appointed official as described in WAC 182-12-180(1), the PEBB Program must receive your forms **no later than 60 days** after you leave public office. If you select a Medicare Advantage or MAPD plan, we must receive Form A before leaving public office or no later than the last day of the month before the month your PEBB insurance coverage ends. Otherwise, you may not select these plans until a special enrollment period. See page 19 to learn more about special open enrollments.

If you are a dependent becoming eligible as a survivor, please see page 12.

Good to know!

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

You must submit Form A even if you decide to defer (postpone) your enrollment. See "Deferring Your Coverage" on page 23 for more information.

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

You must enroll in medical to enroll in dental. If you choose dental coverage for yourself, you and your dependents must be enrolled in the same dental plan. You must keep dental coverage for at least two years unless you defer or terminate enrollment. You may change dental plans within those two years.

When do I send payment?

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

If you choose to pay by pension deduction and you receive an invoice, you must make the first payment by the deadline on the invoice.

For details, see "Paying for Coverage" starting on page 15. If we do not receive your first payment by the deadline, you will not be enrolled, and you may lose your right to enroll in PEBB retiree insurance coverage.

Can I enroll or defer retroactively due to a disability?

Under some circumstances, yes. If you feel this situation may apply to you, visit HCA's website at **hca.wa.gov/employee-retiree-benefits/retirees/disability-retirement** to learn more.

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

If you and your spouse or state-registered domestic partner are both independently eligible for PEBB insurance coverage, you need to decide which of you will cover yourselves and any eligible children on your PEBB medical or dental plans. A dependent may be enrolled in only one PEBB medical or dental plan. For example, you could defer (postpone) PEBB retiree insurance coverage for yourself (see "Deferring Your Coverage" on page 23) and enroll as a dependent on your spouse's or state-registered domestic partner's PEBB medical.

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

Yes. If you are enrolled in PEBB retiree insurance coverage, and your spouse or state-registered domestic partner is enrolled in School Employees Benefits Board (SEBB) Program benefits, you can enroll in both programs. Your PEBB coverage would be primary, and your SEBB coverage would be secondary. Both programs are administered by the Health Care Authority.

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

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

To defer PEBB retiree insurance coverage, see "Deferring Your Coverage" on page 23. If you are already enrolled and you wish to defer, we must receive your *PEBB Retiree Change Form* (form E) before we defer your coverage. Your deferral is effective from the date we receive Form E and any other required forms. To avoid enrollment in both programs, you should submit your Form E so we receive it on or before the date SEBB health plan coverage begins.

As you make this decision, we suggest that you compare SEBB and PEBB benefits and premiums to decide which option best suits your needs. Visit HCA's website at **hca.wa.gov/pebb-retirees** and **hca.wa.gov/sebb-employee** to get 2021 premiums and benefit information.

What can I expect after I submit my election form?

After you submit your form, we will process it and send you a letter notifying you of next steps. Remember, you must make your first payment of your monthly premiums and applicable premium surcharges by the required deadline before we can enroll you. See "Paying for Coverage" on page 15 for details.

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

If you chose to defer your coverage, see "Deferring Your Coverage" on page 23.

When does coverage begin?

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

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

Paying for Coverage

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

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

How much will my monthly premiums be?

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

What are the premium surcharges?

Non-Medicare subscribers must attest to two premium surcharges:

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

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

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

Tobacco use premium surcharge

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

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

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

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

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

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

Spouse or state-registered domestic partner coverage premium surcharge

This $50 premium surcharge will apply in addition to your monthly medical premium if you enroll your spouse or state-registered domestic partner and they have chosen not to enroll in another employer-based group medical insurance that is comparable to Uniform Medical Plan (UMP) Classic. Find out more on HCA's website at **hca.wa.gov/pebb-retirees** under *Surcharges*.

How do I pay for coverage?

You have three options to pay for PEBB retiree insurance coverage. In most cases, you must make your first payment by check before we can enroll you.

Pension deduction

Your payments are taken from your end-of-the-month pension through the Department of Retirement Systems (DRS). For example, if your coverage takes effect January 1, your January 31 pension will show your deductions for January. Due to timing issues with DRS, you may receive an invoice for any premiums and applicable premium surcharges not deducted from your pension when you first enrolled. We will send you an invoice if a first payment is needed. If you receive an invoice, your payment is due by the deadline listed on it.

Electronic debit service (EDS)

You can pay through automatic bank account withdrawals. To choose this option, you must submit the *PEBB Electronic Debit Service Agreement*, available in the back of this booklet. You **cannot** make your first payment through EDS because approval takes six to eight weeks. In the meantime, please make payments as invoiced until you receive a letter from us with your EDS start date. Send your first payment to HCA **no later than 45 days** after your 60-day election period ends.

Monthly invoice

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

If we do not receive your first payment **no later than 45 days** after your 60-day election period ends, you will not be enrolled, and you may lose your right to enroll in PEBB retiree insurance coverage.

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

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

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

How does a survivor pay for coverage?

When you become eligible as a survivor, you will move from being a dependent to having your own account. You cannot have a gap in coverage between these accounts. As a result, you may receive two invoices and must pay both:

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

If premiums and applicable premium surcharges were deducted from the subscriber's pension through the Department of Retirement Systems (DRS), this will stop. You may be eligible for a survivor's pension from DRS. To find out, call DRS at 1-800-547-6657.

If the first invoice listed above remains unpaid, your PEBB retiree health plan coverage will be terminated back to the last day of the month in which you paid. This may cause a gap in coverage, which means that any claims paid from the month the subscriber passed away to the current month would be your financial responsibility. If your coverage is terminated, you may not be able to enroll again unless you regain eligibility in the future.

What happens if I miss a payment?

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

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

If either of these events occur and the payment stays unpaid for 60 days from the original due date, the PEBB Program will terminate your PEBB retiree health plan coverage back to the last day of the month for which the monthly premium and applicable premium surcharges were paid. We will also terminate coverage for any enrolled dependents.

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

Can I use a VEBA account?

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

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

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

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

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

Medicare Enrollment

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

Because the Social Security Administration and the PEBB Program have different timelines for Medicare enrollment, we encourage you to apply for Medicare three months before turning age 65. Doing so will make sure that you enroll (or meet the requirements to stay enrolled) in PEBB retiree insurance coverage within our timelines. To enroll in Medicare, call the Social Security Administration at 1-800-772-1213 (TTY: 1-800-325-0778) or visit their website at **socialsecurity.gov**. To learn more about Medicare benefits, call Medicare at 1-800-633-4227 or go to the Medicare website at **medicare.gov**.

Once you or your dependent enrolls in Medicare Part A and Part B, you must send us proof of the enrollment. If you are enrolling in PEBB retiree insurance coverage for the first time, submit the proof with Form A. If you or your Medicare-eligible dependent are already enrolled, send us one of the following documents **30 days before turning age 65**, so we can properly adjust your premium. (If Medicare coverage is delayed, send us the document **no later than 60 days** after turning age 65.)

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

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

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

Fax: 360-725-0771

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

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

Enrolling in Medicare is a special open enrollment event that allows you to change your medical plan. For details, see "What is a special open enrollment?" on page 19.

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

No. If you are enrolled in a consumer-directed health plan (CDHP) with a health savings account (HSA), UMP Select, or a UMP Plus plan, you must change medical plans when someone on your account enrolls in Medicare Part A or Part B. The PEBB Program must receive your change form **no later than 60 days** after the Medicare enrollment date.

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

The effective date of the plan change will be the first of the month after the date the medical plan becomes unavailable, or the date we receive your form, whichever is later. If that day is the first of the month, the change in the medical plan begins on that day.

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

Here is what you must do, depending on which member is enrolled in Medicare Part A and Part B:

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

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

All PEBB medical plans (except Medicare Supplement plans) have prescription drug coverage that is "creditable coverage." That means it is as good as or better than the standard Medicare prescription drug coverage (Medicare Part D).

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

If you decide to enroll in a standalone Part D plan, the only PEBB medical plan you can choose is Premera Blue Cross Medicare Supplement Plan G. If you are enrolled in any other PEBB medical plan when you enroll in a Part D plan, you must switch to Medicare Supplement Plan G. If you fail to change plans or send us proof of your Medicare Part D cancellation, you or your dependent may lose PEBB retiree health plan coverage.

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

You can keep your PEBB medical plan and not pay a late enrollment penalty if you decide to enroll in a standalone Medicare Part D plan later.

Making Changes in Coverage

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

What changes can I make anytime?

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

- Change your or your dependent's tobacco use premium surcharge attestation. Use the *PEBB Premium Surcharge Attestation Change Form* or log in to PEBB My Account at **hca.wa.gov/my-account**.
- Change your name or address. To do so, mail the PEBB Program a written request with your new name or address, or send a fax to 360-725-0771. Write your full name and the last four digits of your Social Security number on the copy so we can identify your account. You can also call 1-800-200-1004 to report the change.
- Terminate or defer (postpone) your PEBB retiree insurance coverage. (See "How do I terminate coverage?" on page 21 or "Deferring Your Coverage," starting on page 23.)
- Remove a dependent from your PEBB retiree health plan coverage. See "When Does PEBB Insurance Coverage End?" on page 22.
- Change your retiree term life insurance beneficiary information. Visit MetLife's website at **mybenefits.metlife.com/wapebb** or call 1-866-548-7139. (See "Retiree Term Life Insurance" on page 58.)
- Apply for, terminate, or change auto or home insurance coverage. (See "Auto and Home Insurance" on page 63.)
- Start, stop, or change your contributions to your health savings account (HSA). To do this, contact HealthEquity. UMP members, call 1-844-351-6853 (TRS: 711). Kaiser Permanente members, call 1-877-873-8823 (TRS: 711).
- Change your HSA beneficiary information. Use the HealthEquity *Beneficiary Designation Form* available at **learn.healthequity.com/pebb/hsa/documents**.

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

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

During the annual open enrollment, you can:

- Change your medical or dental plan.
- Add dental coverage.
- Enroll an eligible dependent.
- Remove a dependent.
- Terminate or defer (postpone) your PEBB retiree insurance coverage.
- Enroll in a PEBB retiree health plan if you deferred coverage in the past. You will need to provide proof of continuous enrollment in other qualifying coverage. (See "Deferring Your Coverage," starting on page 23.)

What is a special open enrollment?

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

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

If you are changing your medical plan to Premera Blue Cross Medicare Supplement Plan G, the PEBB Program must receive Form E and the *Group Medicare Supplement Enrollment Application* (form B) **no later than six months** after you or your dependent enroll in Medicare Part B.

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

before the month you or your dependent enrolls in the Medicare Advantage or MAPD plan.

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

In most cases, the change will occur the first of the month after the event date, or the date we receive your forms, whichever is later. If that day is the first of the month, the change in enrollment begins on that day. One exception is PEBB Medicare Advantage or MAPD plans, which start the first of the month after the PEBB Program receives your forms, per federal rules. Another exception is the arrival of a child (a newborn, adopted child, or a child you are legally required to support ahead of adoption), in which case PEBB benefits will start or end as follows:

- For a newborn child, PEBB health plan coverage will start on the date of birth.
- For a newly adopted child, PEBB health plan coverage will start on the date of placement or the date you assume legal responsibility for their support ahead of adoption, whichever is earlier.
- For a spouse or state-registered domestic partner due to birth or adoption, PEBB health plan coverage will start the first day of the month in which the event occurs. The spouse or partner will be removed from health plan coverage the last day of the month in which the event occurred.
- If the special open enrollment is due to a child becoming eligible as an extended dependent or a dependent child with a disability, PEBB health plan coverage will start the first day of the month following either the event date or the date we confirm their eligibility, whichever is later.

Good to know!

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

Events that create special open enrollments

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

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

The following events allow you to enroll dependents:

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

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

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

The following event allows you to change your medical plan:

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

What happens when a dependent loses eligibility?

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

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

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

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

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

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

How do I terminate coverage?

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

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

Fax: 360-725-0771

Secure online message to **hca.wa.gov/fuze-questions**. You must register for an account to use this feature. Doing so helps protect your privacy. Attach your written request to the secure message. We cannot terminate your coverage in response to a secure message alone.

Your health plan coverage will terminate on the last day of the month in which we receive your written request (or a future date, if you asked for one). If we receive your request on the first day of the month, coverage will terminate on the last day of the previous month, with two exceptions:

- To terminate only dental coverage, you must have been enrolled for at least two years. Any dependents will also lose dental coverage.
- If you are terminating medical coverage and you or a covered dependent is enrolled in a PEBB Medicare Advantage plan, you must also submit a *PEBB Medicare Advantage Plan Disenrollment Form* (form D). Coverage will terminate on the last day of the month in which we receive Form D.

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

When Does PEBB Insurance Coverage End?

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

- When you or a dependent loses eligibility for PEBB retiree insurance coverage, coverage ends on the last day of the month in which eligibility ends.
- Coverage for you and your enrolled dependents ends on the last day of the month for which the monthly premium and applicable premium surcharges were paid.
- Coverage for you or an enrolled dependent ends if you fail to respond to a request from the PEBB Program for information about Medicare Part A and Part B enrollment or an action required due to enrolling in Medicare Part D.

If you or a dependent lose eligibility for PEBB retiree insurance coverage, you and your dependents may be eligible to continue PEBB health plan coverage under PEBB Continuation Coverage (COBRA). If you enroll, you must pay the full premiums — with no employer contribution — and any applicable premium surcharges. We will mail you a *PEBB Continuation Coverage Election Notice* when your coverage ends with more information about this option. This notice explains eligibility and deadlines, and it contains the form you need to enroll.

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

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

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

Deferring Your Coverage

Deferring means postponing your PEBB retiree insurance coverage so you keep your eligibility to enroll later. To defer, you must meet the eligibility requirements under PEBB Program rules for PEBB retiree insurance coverage and be enrolled in other qualified medical coverage. You may choose to defer when you first become eligible for PEBB retiree insurance coverage or after you enroll.

Why would I defer?

You may want to defer if you have other qualified medical coverage available. For example, if you are retiring but your spouse or state-registered domestic partner is still working, you may want to use their employer's health coverage. Later, when your spouse or partner retires or separates from employment, you can apply to enroll yourself and any eligible dependents in a PEBB retiree health plan.

Good to know!

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

How do I defer?

To defer your enrollment, you must:

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

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

You may defer enrollment in a PEBB retiree health plan:

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

You must provide proof of continuous enrollment in one or more qualifying medical plan coverages to return to a PEBB retiree health plan after deferral. We encourage you to collect proof of coverage annually and keep a file to provide to the PEBB Program in the event you want to return in the future.

Required timelines for retirees to defer

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

- If you are an eligible retiring employee (or in some cases, a separating employee), the PEBB Program must receive the *PEBB Retiree Election Form* (form A) **no later than 60 days** after your employer-paid coverage, COBRA coverage, or continuation coverage ends. The PEBB Program will defer your enrollment the first of the month after the date your employer-paid coverage, COBRA coverage, or continuation coverage ends.
- If you are an employee found eligible for disability retirement, see "Can I enroll retroactively due to a disability?" on page 13 for more information.
- If you are an eligible elected or full-time appointed official leaving public office, we must receive the *PEBB Retiree Election Form* (form A) **no later than 60 days** after you leave office. We will defer your enrollment the first of the month after the date you leave office.
- If you are already enrolled in PEBB retiree insurance coverage, we must receive the *PEBB Retiree Change Form* (form E) and any other required forms before you defer coverage. Enrollment will be deferred effective the first of the month after we receive all the required forms. If we receive the forms on the first day of the month, enrollment

will be deferred that day. When a member is enrolled in a PEBB Medicare Advantage Plan, enrollment will be deferred effective the first of the month after the date we receive the *PEBB Medicare Advantage Plan Disenrollment Form* (form D).

- If you enrolled as a dependent in a Washington State educational service district-sponsored, PEBB-sponsored, or SEBB-sponsored medical plan (including COBRA or continuation coverage), and then lose coverage, you will have 60 days to enroll in a PEBB retiree health plan. To continue in a deferred status, the subscriber must defer enrollment as described in WAC 182-12-205.

Required timelines for survivors to defer

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

- In the event of an employee's death, the PEBB Program must receive the form **no later than 60 days** after the date of the employee's death, or the date the survivor's PEBB, educational service district, or SEBB insurance coverage ends, whichever is later.
- In the event of an elected or full-time appointed official's death, the PEBB Program must receive the form **no later than 60 days** after the date of the official's death, or the date the survivor's PEBB insurance coverage ends, whichever is later.
- In the event of a retiree's death, the PEBB Program must receive the form **no later than 60 days** after the death.
- If a survivor enrolls in PEBB retiree insurance coverage and becomes eligible to defer coverage, they must submit the *PEBB Retiree Change Form* (form E) and any other required forms. Enrollment will be deferred as of the first of the month after the date we receive the forms. If we receive them on the first day of the month, enrollment will be deferred that day. When a member is enrolled in a PEBB Medicare Advantage Plan, coverage will be deferred as of the first of the month after the date we receive the *PEBB Medicare Advantage Plan Disenrollment Form* (form D).
- In the event of the death of emergency service personnel killed in the line of duty, we must receive the form **no later than 180 days** after the later of:
  - The death of the emergency service worker.
  - The date on the eligibility letter from the Washington State Department of Retirement Systems or the board for volunteer firefighters and reserve officers.
  - The last day the survivor was covered under any health plan (including COBRA coverage) through the emergency service worker's employer.

How do I enroll after deferring?

If you deferred enrollment in PEBB retiree insurance coverage, you may enroll in a PEBB retiree health plan under the following circumstances. You must have been continuously enrolled in one or more qualifying medical coverages during your deferral.

- **During any PEBB Program annual open enrollment.** We must receive the *PEBB Retiree Open Enrollment Election/Change* form (form A-OE) and proof of continuous enrollment in one or more qualified medical coverages no later than the last day of open enrollment. Your enrollment will begin January 1 of the next year.
- **When other qualifying medical coverage ends.** We must receive the *PEBB Retiree Election Form* (form A) **no later than 60 days** after the date your other qualifying medical coverage ends. Enrollment will begin the first day of the month after the other coverage ends. Although you have 60 days to enroll, you must pay premiums and applicable premium surcharges back to when your other coverage ended. Proof of continuous enrollment in one or more qualifying medical coverages must list the dates the coverage began and ended. **Exception:** If you select a Medicare Advantage or Medicare Advantage Prescription Drug (MAPD) plan, we must receive your form no later than the last day of the month before the month your other qualifying medical coverage ends. Otherwise, you may not select a Medicare Advantage or MAPD plan until a special open enrollment.

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

You have a one-time opportunity to enroll in a PEBB retiree health plan if you deferred PEBB retiree insurance coverage for CHAMPVA, a TRICARE plan, the Federal Employees Health Benefits Program, or coverage through a health benefit exchange established under the Affordable Care Act.

Choosing a PEBB Medical Plan

Your medical plan options are based on eligibility and where you live. If you cover dependents, everyone must enroll in the same medical plan (with some exceptions, based on eligibility for Medicare Part A and Part B).

- **Eligibility.** You must be enrolled in Medicare Part A and Part B to enroll in a PEBB Medicare Advantage, Medicare Advantage Prescription Drug, or PEBB Medicare Supplement plan. Also, not everyone qualifies to enroll in a consumer-directed health plan (CDHP) with a health savings account (HSA) or a UMP Plus plan. See "What do I need to know about the consumer-directed health plans?" on page 27 or "What is a value-based plan, and why should I choose one?" below to learn more.
- **Where you live.** In most cases, you must live in the plan's service area to join the plan. (See "2021 PEBB Medical Plans Available by County" starting on page 30.) Be sure to contact the plans you're interested in to ask about provider availability in your county. If you move out of your plan's service area, you may need to change your plan. Otherwise, you may have limited access to network providers and covered services. You must report your new address to the PEBB Program **no later than 60 days** after your move.

In general, the type of plan you choose depends on whether you are eligible for Medicare Part A and Part B, and whether you qualify to enroll in a CDHP with an HSA. The PEBB Program offers three types of medical plans:

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

Good to know!

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

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

How can I compare the plans?

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

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

Deductibles. Most medical plans require you to pay an annual deductible before the plan pays for covered services. For some services, like covered preventive care, you do not have to pay your deductible before the plan covers the service.

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

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

Referral procedures. Some plans allow you to self-refer to network providers for specialty care. Others require you to have a referral from your primary care provider.

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

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

Paperwork. In general, PEBB plans don't require you to file claims. However, Uniform Medical Plan (UMP) members may need to file a claim if they receive services from a non-network provider. CDHP members also should keep paperwork from providers and from qualified health care expenses to verify eligible payments from their health savings account.

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

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

One exception to coordination of benefits: PEBB medical plans that cover prescription drugs **will not** coordinate prescription-drug coverage with Medicare Part D. (All PEBB medical plans cover prescription drugs except Premera Blue Cross Medicare Supplement Plan G.) If you enroll in a standalone Medicare Part D plan, you must enroll in Plan G or lose your PEBB retiree health plan coverage. Keep in mind that the UnitedHealthcare Medicare Advantage Prescription Drug plans include Medicare Part D coverage. You can compare some of the medical plans' benefits in this booklet on pages 34–47 and on HCA's website at **hca.wa.gov/pebb-retirees**.

Behavioral Health Coverage

Ensuring timely access to care

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

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

All carriers must provide information on their websites for mental health and substance abuse treatment providers' ability to ensure timely access to care. For more information, see Engrossed Substitute House Bill 1099 (Brennen's Law) on the Washington State Legislature's website at **leg.wa.gov**.

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

Compare coverage by plan

When you need information about what mental health and substance use disorders are covered, you can read the PEBB medical plans' certificates of coverage, which are on the *Medical plans and benefits* webpage at **hca.wa.gov/pebb-retirees**.

Key words to look for in these documents are: inpatient and outpatient coverage, mental health, chemical dependency, residential treatment facility, and substance use disorder. The "Medical Benefits Comparison" on page 34 and the "Medicare Plan Benefits Comparison" on page 44 include high-level summaries of coverage by plan.

Crisis information

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

For immediate help:

Call 911 or go to the nearest emergency care facility for a life-threatening emergency.

For suicide prevention:

Call the National Suicide Prevention Lifeline at 1-800-273-8255 (TTY: 1-800-799-4889).

For additional support from county-based crisis support assistance options:

Visit the HCA website at **hca.wa.gov/mental-health-crisis-lines**.

Washington Recovery Help Line

Call 1-866-789-1511 anytime, day or night. This anonymous and confidential help line provides crisis intervention and referral services for individuals in Washington State experiencing substance use disorder, problem gambling, or a mental health challenge. Professionally trained volunteers and staff are available to provide emotional support 24 hours a day, seven days a week. In addition, they can suggest local treatment resources for substance use, problem gambling, and mental health, as well as other community services.

Medicare options

For members enrolled in Medicare Part A and Part B (see plan benefit comparisons starting on page 44). Value-based plans noted in bold.

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

Non-Medicare options

For members not eligible for Medicare or enrolled in Part A only (see plan benefit comparisons starting on page 34). Value-based plans noted in bold.

Consumer-directed health plans (CDHPs)

Not available if any member is enrolled in Medicare

- **Kaiser Permanente NW[1] CDHP**
- **Kaiser Permanente WA CDHP**
- UMP CDHP, administered by Regence BlueShield

Managed-care plans

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

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

Preferred-provider plans

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

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

A consumer-directed health plan (CDHP) is a high-deductible health plan (HDHP) with a health savings account (HSA). They generally have lower premiums with higher out-of-pocket costs than other types of medical plans.

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

When you enroll in a CDHP, you are automatically enrolled in a tax-free HSA that you can use to pay for IRS-qualified out-of-pocket medical expenses (like deductibles, copays, and coinsurance), including some that your health plans may not cover. See *IRS Publication 969 Health Savings Accounts and Other Tax Favored Health Plans* on the IRS website at **irs.gov** for details. Your HSA balance can grow over the years, earn interest, and build savings that you can use to pay for health care as needed or pay for Medicare Part B premiums.

The HSA is set up by your health plan with HealthEquity, Inc., the HSA trustee for all PEBB CDHPs.

Who is eligible?

You cannot enroll in a CDHP with an HSA if:

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

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

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

PEBB Program contributions

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

- $58.34 each month for an individual subscriber, up to $700.08 for 2021; or
- $116.67 each month for a subscriber with one or more enrolled dependents, up to $1,400.04 for 2021.
- $125 if you qualified for the SmartHealth wellness incentive in 2021. This amount is deposited in your first HSA installment at the end of January 2022.

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

Your contributions

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

The IRS has an annual limit for HSA contributions from all sources. In 2021, the limit is $3,600 (subscriber only) and $7,200 (you and one or more dependents). If you are age 55 or older, you may contribute up to $1,000 more per year. To make sure you do not go beyond the limit, take into account the PEBB Program's contributions, your contributions, and the SmartHealth wellness incentive in January (if you qualify for it).

CDHP and Medicare do not mix

If you choose a CDHP and you or a covered dependent enrolls in Medicare Part A or Part B during the year, you should consider changing to a different type of medical plan, or remove the Medicare-enrolled dependent from PEBB coverage. You cannot contribute to an HSA when you or your dependent are enrolled in Medicare. For details, see "Can I enroll in a CDHP, UMP Select, or a UMP Plus plan and Medicare Part A and Part B?" on page 17.

What happens to my HSA when I leave the CDHP?

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

- You can keep any unspent funds in your HSA. You can spend them on qualified medical expenses in the future. However, you, the PEBB Program, and other individuals can no longer contribute to your HSA.
- If you leave employment or retire, HealthEquity may charge you a monthly fee if you have less than $2,500 in your HSA after December 31. You can avoid this charge by either ensuring you have at least $2,500 in your HSA or by spending all of your HSA funds by December 31. Other fees may apply. For details, call HealthEquity toll-free at 1-877-873-8823.
- You must contact HealthEquity to stop automatic direct deposits to your HSA if you previously set this up.

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

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

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

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

Medicare Advantage Prescription Drug (MAPD) plans offered by UnitedHealthcare include Medicare Part D coverage and are available nationwide (including American Samoa, Guam, the Northern Marianas, Puerto Rico, and the U.S. Virgin Islands). If you choose an MAPD plan, any enrolled members who are not eligible for Medicare will be enrolled in UMP Classic.

Medicare Advantage plans offered by Kaiser Permanente NW and Kaiser Permanente WA are not available in every county. Check "Medical Plans Available by County" starting on page 30. If you or a covered dependent are enrolled in Medicare Part A and Part B, and you choose Kaiser Permanente NW or Kaiser Permanente WA, you must enroll in the Medicare Advantage plan if they offer it in your county. Kaiser Permanente WA also offers an Original Medicare plan for Medicare retirees who live in a county not served by the Kaiser Permanente WA Medicare Advantage plan.

Enrollment in the Medicare Advantage or MAPD plans may not be retroactive. Your enrollment is effective the first of the month after we receive your enrollment forms, or when you enroll in both Medicare Part A and Part B, whichever is later. This date may be different from your retirement date. If we receive the forms after the date your enrollment in PEBB retiree insurance coverage is set to begin, you may not select a Medicare Advantage or MAPD plan until a special open enrollment or the next annual open enrollment.

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

Plan G does not include prescription drug coverage. If you choose this plan, you may have to enroll in a standalone Medicare Part D plan to get your prescriptions, unless you have other creditable prescription drug coverage.

How to Find the Summaries of Benefits and Coverage

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

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

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

- Go to the HCA website at **hca.wa.gov/employee-retiree-benefits/retirees/benefits-and-coverage-plan** to view or print it online.
- Go to the plan's website to view or print it online.
- Request a paper copy at no charge:
  - For your current medical plan: Call your plan.
  - For other PEBB medical plans: Call the PEBB Program at 1-800-200-1004.

You can find the medical plans' websites and phone numbers on page 5 of this booklet.

2021 **PEBB Medical Plans Available by County**

Medicare and non-Medicare

If you move out of your medical plan's service area you may need to change your plan. You must report your new address and any request to change your medical plan **no later than 60 days** after you move.

Washington					
Plan name	**Service area**				**Available to Medicare members?**
Kaiser Permanente NW[1] Classic **Kaiser Permanente NW[1] Consumer-Directed Health Plan (CDHP)**	Clark		Cowlitz		No
Kaiser Permanente NW Senior Advantage	Clark Cowlitz		Skamania Wahkiakum (ZIP codes 98612 and 98647)		Yes
Kaiser Permanente WA Classic **Kaiser Permanente WA Consumer-Directed Health Plan (CDHP)** **Kaiser Permanente WA Value**	Benton Columbia Franklin Island King	Kitsap Kittitas Lewis Mason Pierce	Skagit Snohomish Spokane Thurston	Walla Walla Whatcom Whitman Yakima	No
Kaiser Permanente WA Medicare Advantage	Grays Harbor (ZIP codes 98541, 98557, 98559, 98568) Island King	Kitsap Lewis Mason (ZIP codes 98524, 98528, 98546, 98548, 98555, 98584, 98588, 98592)	Pierce Skagit Snohomish	Spokane Thurston Whatcom	Yes
Kaiser Permanente WA Original Medicare	Benton Columbia Franklin Kittitas		Mason (ZIP code 98560) Walla Walla Whitman Yakima		Yes
Kaiser Permanente WA SoundChoice	King Kitsap Pierce		Snohomish Spokane[2] Thurston		No

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

2 *Not all contracted providers in Spokane County are in the SoundChoice network. Please make sure your provider is in-network before your visit.*

Washington (continued)			
Plan name	**Service area**		**Available to Medicare members?**
Premera Blue Cross Medicare Supplement Plan F and Medicare Supplement Plan G	Available in all Washington counties and nationwide.		Yes
UMP Classic	Available in all Washington counties and worldwide.		Yes
UMP Select	Available in all Washington counties and worldwide.		No
UMP Consumer-Directed Health Plan (CDHP)	Available in all Washington counties and worldwide.		No
UMP Plus – Puget Sound High Value Network	Chelan Douglas King Kitsap	Pierce Snohomish Thurston Yakima	No
UMP Plus – UW Medicine Accountable Care Network	King Kitsap Pierce Skagit	Snohomish Spokane Thurston	No
UnitedHealthcare PEBB Balance **UnitedHealthcare PEBB Complete**	Available in all Washington counties and nationwide (including American Samoa, Guam, the Northern Marianas, Puerto Rico and the US Virgin Islands).		Yes

Oregon			
Plan name	**Service area**		**Available to Medicare members?**
Kaiser Permanente NW[1] Classic **Kaiser Permanente NW[1] Consumer-Directed Health Plan (CDHP)**	Benton (ZIP codes 97330, 97331, 97333, 97339, 97370, and 97456) Clackamas Columbia Hood River (ZIP code 97014) Lane	Linn (ZIP codes 97321, 97322, 97335, 97348, 97355, 97358, 97360, 97374, 97377, 97389, and 97446) Marion Multnomah Polk Washington Yamhill	No
Kaiser Permanente NW Senior Advantage	Benton (ZIP codes 97330, 97331, 97333, 97339, and 97370) Clackamas Columbia Hood River	Linn (ZIP codes 97321, 97322, 97335, 97355, 97358, 97360, 97374, and 97389) Marion Multnomah Polk Washington Yamhill	Yes
Premera Blue Cross Medicare Supplement Plan F and Medicare Supplement Plan G	Available in all Oregon counties and nationwide.		Yes
UMP Classic	Available in all Oregon counties and nationwide.		Yes
UMP Select	Available in all Oregon counties and nationwide.		No
UMP Consumer-Directed Health Plan (CDHP)	Available in all Oregon counties and nationwide.		No
UnitedHealthcare PEBB Balance **UnitedHealthcare PEBB Complete**	Available in all Oregon counties and nationwide (including American Samoa, Guam, the Northern Marianas, Puerto Rico and the US Virgin Islands).		Yes

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

Idaho		
Plan name	**Service area**	**Available to Medicare members?**
Premera Blue Cross Medicare Supplement Plan F and Medicare Supplement Plan G	Available in all Idaho counties and nationwide.	Yes
UMP Classic	Available in all Idaho counties and nationwide.	Yes
UMP Select	Available in all Idaho counties and nationwide.	No
UMP Consumer-Directed Health Plan (CDHP)	Available in all Idaho counties and nationwide.	No
UnitedHealthcare PEBB Balance **UnitedHealthcare PEBB Complete**	Available in all Idaho counties and nationwide (including American Samoa, Guam, the Northern Marianas, Puerto Rico and the US Virgin Islands).	Yes

2021 PEBB Medical Benefits Comparison

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

The chart below briefly compares the medical deductibles and per-visit out-of-pocket costs of some in-network benefits for PEBB medical plans. Copays and coinsurance may apply; some copays and coinsurance do not apply until after you have paid your annual deductible. Call the plans directly for more information on specific benefits, including preauthorization requirements and exclusions. If anything in these charts conflicts with the plan's certificate of coverage (COC), the COC takes precedence and prevails. All dental plans include a non-duplication of benefits clause, which applies when you have dental coverage under more than one account.

Annual costs

(You pay)

Plan	Medical deductible Applies to medical out-of-pocket limit	Medical out-of-pocket limit[1] (See separate prescription drug out-of-pocket limit for some plans.)
Kaiser Foundation Health Plan of the Northwest		
Kaiser Permanente NW Classic[2]	$300/person $900/family	$2,000/person • $4,000/family Your deductible, copays, and coinsurance for most covered services apply.
Kaiser Permanente NW CDHP[2]	$1,400/person $2,800/family[3]	$5,100/person • $10,200/family Your deductible, copays, and coinsurance for most covered services apply.
Kaiser Foundation Health Plan of Washington		
Kaiser Permanente WA Classic	$175/person $525/family	$2,000/person • $4,000/family Your deductible, copays, and coinsurance for all covered services apply.
Kaiser Permanente WA CDHP	$1,400/person $2,800/family[3]	$5,100/person • $10,200/family Your deductible, copays, and coinsurance for all covered services apply.
Kaiser Permanente WA SoundChoice	$125/person $375/family	$2,000/person • $4,000/family Your deductible, copays, and coinsurance for all covered services apply.
Kaiser Permanente WA Value	$250/person $750/family	$3,000/person • $6,000/family Your deductible, copays, and coinsurance for all covered services apply.
Uniform Medical Plan (UMP)[4]		
UMP Classic	$250/person $750/family	$2,000/person • $4,000/family Your deductible, copays, and coinsurance for most covered medical services apply.
UMP Select	$750/person $2,250 family	$3,500/person • $7,000 family Your deductible, copays, and coinsurance for most covered medical services apply.
UMP CDHP	$1,400/person $2,800/family[3]	$4,200/person • $8,400/family ($7,000 per person in a family)[5] Your deductible and coinsurance for most covered services apply.
UMP Plus—PSHVN **UMP Plus—UW Medicine ACN**	$125/person $375/family	$2,000/person • $4,000/family Your deductible, copays, and coinsurance for most covered medical services apply.

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

[2] *Kaiser Foundation Health Plan of the Northwest, (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon.*

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

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

[5] *Out-of-pocket expenses for a single member under a family account are not to exceed $7,000*

Annual costs continued

(You pay)

Plans	Prescription drug deductible	Prescription drug out-of-pocket limit[1]
Kaiser Foundation Health Plan of the Northwest		
Kaiser Permanente NW Classic[2]	None	Prescription drug copays and coinsurance are combined with the medical out-of-pocket limit.
Kaiser Permanente NW CDHP[2]	Prescription drug costs combined with medical deductible.	Prescription drug copays and coinsurance are combined with the medical out-of-pocket limit.
Kaiser Foundation Health Plan of Washington		
Kaiser Permanente WA Classic	$100/person • $300/family Does not apply to Value and Tier 1 drugs	$2,000/person • $8,000/family Your prescription drug deductible, copayments, and coinsurance for all covered prescription drugs apply.
Kaiser Permanente WA CDHP	Prescription drug costs are combined with medical deductible.	Prescription drug copays and coinsurance are combined with the medical out-of-pocket limit.
Kaiser Permanente WA SoundChoice	$100/person • $300/family Does not apply to Value and Tier 1 drugs	$2,000/person • $8,000/family Your prescription drug deductible, copayments, and coinsurance for all covered prescription drugs apply.
Kaiser Permanente WA Value	$100/person • $300/family Does not apply to Value and Tier 1 drugs	$2,000/person • $8,000/family Your prescription drug deductible, copayments, and coinsurance for all covered prescription drugs apply.
Uniform Medical Plan (UMP)[3]		
UMP Classic	$100/person • $300/family Tier 2 and specialty drugs except covered insulins only	$2,000/person • $4,000/family Your prescription drug deductible copayments, and coinsurance for all covered prescription drugs apply.
UMP Select	$250/person • $750/family Tier 2 and specialty drugs except covered insulins only	$2,000/person • $4,000/family Your prescription drug deductible and coinsurance for all covered prescription drugs apply.
UMP CDHP	Prescription drug costs are combined with medical deductible	Prescription drug copays and coinsurance are combined with the medical out-of-pocket limit.
UMP Plus—PSHVN **UMP Plus—UW Medicine ACN**	None	$2,000/person • $4,000/family Your coinsurance for all covered prescription drugs applies.

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

[2] *Kaiser Foundation Health Plan of the Northwest (KFHPNW), offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon.*

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

Prescription drug benefits

Retail pharmacy prescription drugs (up to a 30-day supply)
(You pay)

Plans	**Value Tier** (specific high-value prescription drugs used to treat certain chronic conditions)	**Tier 1** (Generics)	**Tier 2** (Preferred brand; high-cost generic drugs, specialty drugs)	**Tier 3** (non-preferred brand-name drugs and non-preferred generic drugs)	**Tier 4** (specialty and certain high cost generic drugs)	**Tier 5** (Non-preferred)
Kaiser Foundation Health Plan of the Northwest (office visits and prescription drugs are not subject to the deductible)						
Kaiser Permanente NW Classic[1]	N/A	$15 (not subject to deductible)	$40 (not subject to deductible)	$75 (not subject to deductible)	50% up to $150 (not subject to deductible)	N/A
Kaiser Permanente NW CDHP[1]	N/A	$15 (after deductible); $0 for some preventive medications	$40 (after deductible)	$75 (after deductible)	50% up to $150 (after deductible)	N/A
Kaiser Foundation Health Plan of Washington						
Kaiser Permanente WA Classic	$5	$20	$40	50% up to $250	N/A	N/A
Kaiser Permanente WA CDHP	$0 for some preventive medications	$20 (after deductible)	$40 (after deductible)	50% up to $250 (after deductible)	N/A	N/A
Kaiser Permanente WA SoundChoice	$5	$15	$60	50%	$150	50% up to $400
Kaiser Permanente WA Value	$5	$25	$50	50%	$150	50% up to $400
Uniform Medical Plan (UMP)[2]						
UMP Classic	5% up to $10	10% up to $25	30% up to $75	N/A	N/A	N/A
UMP Select	5% up to $10	10% up to $25	30% up to $75	N/A	N/A	N/A
UMP CDHP	15% (after deductible)	15% (after deductible)	15% (after deductible)	N/A	N/A	N/A
UMP Plus—PSHVN	5% up to $10	10% up to $25	30% up to $75	N/A	N/A	N/A
UMP Plus—UW Medicine ACN	5% up to $10	10% up to $25	30% up to $75	N/A	N/A	N/A

[1] *Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon*
[2] *UMP Classic and UMP CDHP members who see an out-of-network provider will pay 40% coinsurance of the plan's allowed amount for most services, plus any amount the provider charges over the allowed amount (known as balance billing). UMP Plus members will pay 50% coinsurance for out-of-network providers and any amount the out-of-network provider charges over the plan's allowed amount.*

Prescription benefits

Mail order (up to a 90-day supply unless otherwise noted)

Plans	Value tier	Tier 1	Tier 2	Tier 3	Tier 4
Kaiser Foundation Health Plan of the Northwest					
Kaiser Permanente NW Classic[1]	N/A	$30 (not subject to deductible)	$80 (not subject to deductible)	$150 (not subject to deductible)	50% to $750 (not subject to deductible)
Kaiser Permanente NW CDHP[1]	N/A	$30; (after deductible); $0 for some preventive medications	$80 (after deductible)	$150 (after deductible)	50% to $750 (after deductible)
Kaiser Foundation Health Plan of Washington					
Kaiser Permanente WA Classic	$10	$40	$80	50% up to $750	N/A
Kaiser Permanente WA CDHP	$0 for some preventive medications	$40 (after deductible)	$80 (after deductible)	50% up to $750 (after deductible)	N/A
Kaiser Permanente WA SoundChoice	$10	$30	$120	50%	N/A
Kaiser Permanente WA Value	$10	$50	$100	50%	N/A
Uniform Medical Plan (UMP)[2]					
UMP Classic	5% up to $30	10% up to $75	30% up to $225	N/A	N/A
UMP Select	5% up to $30	10% up to $75	30% up to $225	N/A	N/A
UMP CDHP	15% (after deductible)	15% (after deductible)	15% (after deductible)	N/A	N/A
UMP Plus—PSHVN	5% up to $30	10% up to $75	30% up to $225	N/A	N/A
UMP Plus—UW Medicine ACN	5% up to $30	10% up to $75	30% up to $225	N/A	N/A

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

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

Hospital care

Plans	Inpatient (residential treatment centers, psychiatric hospitals)	Outpatient (hospital affiliated clinics, outpatient facilities, etc.)	Home health
Kaiser Foundation Health Plan of the Northwest			
Kaiser Permanente NW Classic[1]	15%	15%	15%
Kaiser Permanente NW CDHP[1]	15%	15%	15%
Kaiser Foundation Health Plan of Washington			
Kaiser Permanente WA Classic	$150/day up to $750 maximum/admission	$150	$0
Kaiser Permanente WA CDHP	10%	10%	10%
Kaiser Permanente WA SoundChoice	$500/admission	15%	15%
Kaiser Permanente WA Value	$250/day up to $1,250 maximum/admission	$200	$0
Uniform Medical Plan (UMP)[2]			
UMP Classic	$200/day up to $600 maximum/year per person + 15% professional services	15%	15%
UMP Select	$200/day up to$600 maximum/year per person + 20% professional services	20%	20%
UMP CDHP	15% professional services	15%	15%
UMP Plus—PSHVN	$200/day up to $600 maximum/year per person + 15% professional services	15%	15%
UMP Plus—UW Medicine ACN	$200/day up to $600 maximum/year per person + 15% professional services	15%	15%

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

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

Hearing

Plans	Routine annual hearing exam	Hardware
Kaiser Foundation Health Plan of the Northwest		
Kaiser Permanente NW Classic[1]	$35 (not subject to deductible)	One hearing aid per ear covered in full during any consecutive 60 months.[2]
Kaiser Permanente NW CDHP[1]	$30	
Kaiser Foundation Health Plan of Washington		
Kaiser Permanente WA Classic	Primary care $15 Specialist $30	One hearing aid per ear covered in full during any consecutive 60 month period.[2]
Kaiser Permanente WA CDHP	10%	
Kaiser Permanente WA SoundChoice	Primary care $0 Specialist 15%	
Kaiser Permanente WA Value	Primary care $30 Specialist $50	
Uniform Medical Plan (UMP)[3]		
UMP Classic	$0	One hearing aid per ear covered in full, up to the plan's allowed amount, once every five calendar years.
UMP Select	$0	One hearing aid per ear covered in full, up to the plan's allowed amount, once every five calendar years.
UMP CDHP	15%	One hearing aid per ear covered in full, up to the plan's allowed amount after deductible is met, once every five calendar years.
UMP Plus—PSHVN	$0	One hearing aid per ear covered in full, up to the plan's allowed amount, once every five calendar years.
UMP Plus—UW Medicine ACN	$0	One hearing aid per ear covered in full, up to the plan's allowed amount, once every five calendar years.

[1] *Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon*
[2] *Kaiser Permanente plans pay up to the allowed amount and in-network providers do not charge for any amount over the allowed amount (known as balance billing). Non-network providers will not be covered. For CDHP, deductible must be met.*
[3] *UMP Classic and UMP CDHP members who see an out-of-network provider will pay 40% coinsurance of the plan's allowed amount for most services, plus any amount the provider charges over the allowed amount (known as balance billing). UMP Plus members will pay 50% coinsurance for out-of-network providers and any amount the out-of-network provider charges over the plan's allowed amount.*

Office visits

Plans	Primary care	Urgent care	Specialist	Mental health (independent provider offices, medical groups, freestanding clinics)	Chemo-therapy (does not include chemotherapy treatment)	Radiation (does not include radiation treatment)	Virtual or telemedicine visit
Kaiser Foundation Health Plan of the Northwest							
Kaiser Permanente NW Classic[1]	$25; $0 ages 0-17 (not subject to deductible)	$45 (not subject to deductible)	$35 (not subject to deductible)	$25; $0 ages 0-17 (not subject to deductible)	$0	$0	$0 (not subject to deductible)
Kaiser Permanente NW CDHP[1]	$20	$40	$30	$20	$0	$0	$0
Kaiser Foundation Health Plan of Washington							
Kaiser Permanente WA Classic	$15	$15	$30	$15	$30	$30	$0 (not subject to deductible)
Kaiser Permanente WA CDHP	10%	10%	10%	10%	10%	10%	$0 (after deductible)
Kaiser Permanente WA SoundChoice	$0 (not subject to deductible)	15%	15%	$0 (not subject to deductible)	15%	15%	$0 (not subject to deducible)
Kaiser Permanente WA Value	$30	$30	$50	$30	$50	$50	$0 (not subject to deductible)
Uniform Medical Plan (UMP)[2]							
UMP Classic	15%	15%	15%	15%	15%	15%	Varies, see COC
UMP Select	20%	20%	20%	20%	20%	20%	Varies, see COC
UMP CDHP	15%	15%	15%	15%	15%	15%	Varies, see COC
UMP Plus—PSHVN	$0	15%	15%	15%	15%	15%	Varies, see COC
UMP Plus—UW Medicine ACN	$0	15%	15%	15%	15%	15%	Varies, see COC

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

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

Other services and equipment

Plans	Ambulance Air or ground, per trip	Diagnostic tests, laboratory, and x-rays	Durable medical equipment, supplies, and prosthetics	Emergency room (Copay waived if admitted)	Preventive care See certificate of coverage or check with plan for full list of services.
Kaiser Foundation Health Plan of the Northwest					
Kaiser Permanente NW Classic[1]	15%	$10 (not subject to deductible)	20%	15%	$0
Kaiser Permanente NW CDHP[1]	15%	15%	20%	15%	$0
Kaiser Foundation Health Plan of Washington					
Kaiser Permanente WA Classic	20% (not subject to deductible)	$0 $30 for MRI/CT/ PET scan	20%	$250	$0
Kaiser Permanente WA CDHP	10%	10%	10%	10%	$0
Kaiser Permanente WA SoundChoice	20% (not subject to deductible)	15%	15%	$75 + 15%	$0
Kaiser Permanente WA Value	20% (not subject to deductible)	$0 $50 for MRI/CT/ PET scan	20%	$300	$0
Uniform Medical Plan (UMP)[2]					
UMP Classic	20%	15%	15%	$75 + 15%	$0
UMP Select	20%	20%	20%	$75 + 20%	$0
UMP CDHP	20%	15%	15%	15%	$0
UMP Plus—PSHVN	20%	15%	15%	$75 + 15%	$0
UMP Plus—UW Medicine ACN	20%	15%	15%	$75 + 15%	$0

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

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

Therapy and alternative medicine

Plans	**Physical, occupational, and speech therapy** (per-visit cost for 60 visits/year combined)	**Chiropractic** Maximum amount | visits per year	**Acupuncture Maximum visits per year**	**Massage therapy Maximum visits per year**
Kaiser Foundation Health Plan of the Northwest (office visits are not subject to the deductible)				
Kaiser Permanente NW Classic[1]	$35 (not subject to deductible)	$35 | 12	$35 no limit with physician referral	Physician referred only
Kaiser Permanente NW CDHP[1]	$30	$30 | 12	$30 no limit with physician referral	Physician referred only
Kaiser Foundation Health Plan of Washington				
Kaiser Permanente WA Classic	$30	$15 | 10	20% | 12	15% (60 visits/per year combined with physical, occupational, speech therapy)
Kaiser Permanente WA CDHP	10%	10% | 10	10% | 12	10% (60 visits/per year combined with physical, occupational, speech therapy)
Kaiser Permanente WA SoundChoice	15%	$0 | 10	20% | 12	15% 16
Kaiser Permanente WA Value	$50	$30 | 10	20% | 12	$50 (60 visits/per year combined with physical, occupational, speech therapy)
Uniform Medical Plan (UMP)[2]				
UMP Classic	15%	15% | 10	15% | 16	15% | 16
UMP Select	20%	20% | 10	20% | 16	20% | 16
UMP CDHP	15%	15% | 10	15% | 16	15% | 16
UMP Plus—PSHVN	15%	15% | 10	15% | 16	15% | 16
UMP Plus—UW Medicine ACN	15%	15% | 10	15% | 16	15% | 16

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

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

Vision care

Plans	Annual vision exam	Glasses and contact lenses	Pediatric vision care (up to age 19) Exam (annual)	Pediatric vision care Glasses and contact lenses (up to age 19)
Kaiser Foundation Health Plan of the Northwest				
Kaiser Permanente NW Classic[1]	$25 (not subject to deductible)	You pay any amount over $150 every two calendar years for frames, lenses, and contacts combined.	$0	$0 frames and lenses 50% for a one-year supply of contact lenses in lieu of glasses
Kaiser Permanente NW CDHP[1]	$20		$0	
Kaiser Foundation Health Plan of Washington				
Kaiser Permanente WA Classic	$15	You pay any amount over $150 every 24 months for frames, lenses, and contacts combined.	$0	$0 frames and lenses 50% for a one-year supply of contact lenses in lieu of glasses
Kaiser Permanente WA CDHP	10%		$0	
Kaiser Permanente WA SoundChoice	15%		$0	
Kaiser Permanente WA Value	$30		$0	
Uniform Medical Plan (UMP)[2]				
UMP Classic UMP Select UMP CDHP UMP Plus—PSHVN UMP Plus—UW Medicine ACN	You pay $0 for routine vision exam; $30 copay for contact lens exam and fitting fee	$0 up to the allowed amount for one pair of standard lenses and frames once every two calendar years; or, the plan pays up to $150 for elective contact lenses in lieu of frames and lenses once every two calendar years.	$0	$0 up to the allowed amount for one pair of standard lenses and frames once every two calendar years; or, the plan pays up to $150 for elective contact lenses in lieu of frames and lenses once every two calendar years. You pay a $30 fitting fee for contact lenses.

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

HCA is committed to providing equal access to our services. If you need an accommodation, or require documents in another format, please contact the following. Employees: Your payroll or benefits office. Retirees and PEBB Continuation Coverage members: The PEBB Program at 1-800-200-1004 (TRS: 711).

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

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

2021 **PEBB Medicare Plans Benefits Comparison**

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

The chart below briefly compares the per-visit costs of some in-network benefits for PEBB medical plans. Some copays and coinsurance do not apply until after you have paid your annual deductible. Call the plans directly for more information on specific benefits, including preauthorization requirements and exclusions. Kaiser Permanente NW and Kaiser Permanente WA offer Medicare Advantage plans, but not in all areas. Premera Blue Cross also offers Medicare Supplement Plan F and Medicare Supplement Plan G. As of January 1, 2020, Plan F is closed to new enrollees.

Annual Costs

(You pay)

Plan	Medical deductible (Applies to medical out-of-pocket limit)	Medical out-of-pocket limit[1] (See separate prescription drug out-of-pocket limit for some plans)	Prescription drug deductible	Prescription drug out-of-pocket limit[1]
Kaiser Foundation Health Plan of the Northwest				
Kaiser Permanente NW Senior Advantage[2]	$0	$1,500/person Your copays and coinsurance for most covered services apply (except prescription drug costs).	None	None
Kaiser Foundation Health Plan of Washington				
Medicare Advantage	$0	$2,500/person Your copays and coinsurance for most covered services apply (except prescription drug costs).	None	None
Original Medicare (coordinates with Medicare)	$250/person $750/family	$2,000/person $4,000/family Your medical deductible, copays, and coinsurance for all covered services apply.	None	Prescription copays and coinsurance apply to the medical out-of-pocket limit.
Uniform Medical Plan				
UMP Classic (Medicare)	$250/person $750/family	$2,500/person $5,000/family Your medical deductible, copays, and coinsurance for most covered services apply.	$100/person $300/family (Tier 2 and specialty except covered insulins)	$2,000/person $4,000/family Your prescription drug deductible and coinsurance for all covered prescription drugs apply.
UnitedHealthcare Medicare Advantage Prescription Drug (MAPD)				
UnitedHealthcare PEBB Balance	$0	$2,000/person	$0 for Tier 1, $100 Tier 2, 3, 4 For both plans	$2,000 (Once out-of-pocket maximum is satisfied, all copays $0.) For both plans
UnitedHealthcare PEBB Complete	$0	$500/person		

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

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

Prescription drug benefits

Retail pharmacy prescription drugs (up to a 30-day supply)
Includes Medicare-approved diabetic disposable supplies (You pay)

Plan	Value tier	Tier 1[1]	Tier 2[2]	Tier 3[3]	Most specialty drugs	Preventive
Kaiser Foundation Health Plan of the Northwest						
Kaiser Permanente NW Senior Advantage	N/A	$20	$40	N/A	N/A	N/A
Kaiser Foundation Health Plan of Washington						
Medicare Advantage	N/A	$20	$40	50% up to $250	N/A	$0
Original Medicare (coordinates with Medicare)	$5					
Uniform Medical Plan						
UMP Classic (Medicare)	5% up to $10	10% up to $25	30% up to $75	N/A	N/A	$0
UnitedHealthcare Medicare Advantage Prescription Drug (MAPD)						
UnitedHealthcare PEBB Balance	5% up to $10 (insulin only)	10% up to $25	30% up to $47	50%	50% up to $100	$0
UnitedHealthcare PEBB Complete						

Mail order prescription drugs (up to a 90-day supply)

Plan	Value tier	Tier 1[1]	Tier 2[2]	Tier 3[3]	Most specialty drugs	Preventive
Kaiser Foundation Health Plan of the Northwest						
Kaiser Permanente NW Senior Advantage	N/A	$40	$80	N/A	N/A	N/A
Kaiser Foundation Health Plan of Washington						
Medicare Advantage	$10	$40	$80	50% up to $750	N/A	N/A
Original Medicare (coordinates with Medicare)	N/A					
Uniform Medical Plan						
UMP Classic (Medicare)	5% up to $30	10% up to $75	30% up to $225	N/A	N/A	$0
UnitedHealthcare Medicare Advantage Prescription Drug (MAPD)						
UnitedHealthcare PEBB Balance	Insulin 5% up to $30	10% up to $75	30% up to $141	50%	50% up to $100 for 30 day supply	N/A
UnitedHealthcare PEBB Complete						

[1] *Generics*
[2] *Preferred brand. For UMP, also includes high-cost generic drugs and specialty drugs.*
[3] *Nonpreferred*

Hospital care

(You pay)

Plan	Inpatient[1]	Outpatient[2]	Home health	Emergency[3] room	Ambulance[4]
Kaiser Foundation Health Plan of the Northwest					
Kaiser Permanente NW Senior Advantage	$500/admission	$50	$0	$50	$50
Kaiser Foundation Health Plan of Washington					
Medicare Advantage	$200/day for the first 5 days, up to $1,000 maximum/ admission	$200	$0 For both plans	$65	$150
Original Medicare (coordinates with Medicare)	$150/day, up to $750 maximum/admission	$150		$250	20%
Uniform Medical Plan					
UMP Classic (Medicare)	$200/day, up to $600 maximum/admission + 15% professional fees	15%	15%	$75 + 15%	20%
UnitedHealthcare Medicare Advantage Prescription Drug (MAPD)					
UnitedHealthcare PEBB Balance	$500/admission	$250	$0 For both plans	$65 For both plans	$100
UnitedHealthcare PEBB Complete	$0	$0			$0

Office visits

(You pay)

Plan	Primary care	Urgent care	Specialist	Mental Health[5]	Chemo-therapy[6]	Radiation[7]	Telemedecine/ virtual care
Kaiser Foundation Health Plan of the Northwest							
Kaiser Permanente NW Senior Advantage	$25	$35	$35	$25	$0	$0	$0
Kaiser Foundation Health Plan of Washington							
Medicare Advantage	$15 For both plans	$15 For both plans	$30 For both plans	$15 For both plans	$0	$0	$0 For both plans
Original Medicare (coordinates with Medicare)					$30	$30	
Uniform Medical Plan							
UMP Classic (Medicare)	15%	15%	15%	15%	15%	15%	15%
UnitedHealthcare Medicare Advantage Prescription Drug (MAPD)							
UnitedHealthcare PEBB PEBB Balance	$15	$15	$30	$15 group/$30 individual	$0 For both plans	$30	$15
UnitedHealthcare PEBB PEBB Complete	$0	$15	$0	$0		$0	$0

[1] *Residential treatment centers, psychiatric hospitals*
[2] *Hospital affiliated clinics, outpatient facilities, etc.*
[3] *Copay waived if admitted*
[4] *Per trip, air or ground*
[5] *Independent provider offices, medical groups, freestanding clinics*
[6] *Does not include chemotherapy treatment*
[7] *Does not include radiation treatment*

Other services and equipment

(You pay)

Plan	Diagnostic tests, laboratory, and x-rays	Physical, occupational, and speech therapy	Durable medical equipment, supplies, and prosthetics	Spinal manipulations	Preventive care[1]
Kaiser Foundation Health Plan of the Northwest					
Kaiser Permanente NW Senior Advantage	$0	$35	$0	$35 (12 visits/year)	$0
Kaiser Foundation Health Plan of Washington					
Medicare Advantage	$0	$30	20 % For both plans	$15 (12 visits/year for non-spinal, unlimited for spinal)	$0 For both plans
Original Medicare (coordinates with Medicare)	$0 MRI/CT/PET scan $30	$30 (per-visit cost for 60 visits/year combined)		$15 (12 visits/year)	
Uniform Medical Plan					
UMP Classic (Medicare)	15%	15% (60 combined visits per year)	15%	15% (10 visits/year)	$0
UnitedHealthcare Medicare Advantage Prescription Drug (MAPD)					
UnitedHealthcare PEBB Balance	$15	$15	$20	$15 (20 visits/year combined with acupuncture)	$0 For both plans
UnitedHealthcare PEBB Complete	$0	$0	$0	$0 (20 visits/year combined with acupuncture)	

Hearing and vision

(You pay)

Plan	Hearing Routine annual hearing exam	Hearing hardware	Vision[2] routine annual eye exam	Glasses and contact lenses
Kaiser Foundation Health Plan of the Northwest				
Kaiser Permanente NW Senior Advantage	$35	One hearing aid per ear covered in full, up to the plan's allowed amount, during any consecutive 60 month period.	$25	You pay any amount over $150 every 24 months for frames, lenses and contacts combined.
Kaiser Foundation Health Plan of Washington				
Medicare Advantage	$15	You pay any amount over $1,400 per ear during any consecutive 60-month period	$15	You pay any amount over $150 every 24 months for frames, lenses, and contacts combined.
Original Medicare (coordinates with Medicare)				
Uniform Medical Plan				
UMP Classic (Medicare)	$0	One hearing aid per ear covered in full , up to the plan's allowed amount, once every five calendar years.	$0	$0 up to the allowed amount for one pair of standard lenses and frames once every two calendar years; or, the plan pays up to $150 for elective contact lenses in lieu of frames and lenses once every two calendar years. You pay a $30 fitting fee for contact lenses.
UnitedHealthcare Medicare Advantage Prescription Drug (MAPD)				
UnitedHealthcare PEBB Balance	$0	You pay any amount over $2,500 every 5 years (only available through UnitedHealthcare hearing)	$0	You pay any amount over $300 every 24 months.
UnitedHealthcare PEBB Complete				

[1] *See certificate of coverage or check with plan for full list of services.*

[2] *Contact your plan about copays and limits for children's vision care.*

Outline of Medicare Supplement Coverage
Washington State Health Care Authority

PREMERA | BLUE CROSS

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

Basic Benefits included in all plans:

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

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

*Plan F also has an option called High Deductible Plan F. This high deductible plan pays the same benefits as plan F after one has paid a calendar year $2,340 deductible. Benefits from High Deductible Plan F will not begin until the out-of-pocket expenses exceed $2,340. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the contract. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

Washington State Health Care Authority

SUBSCRIPTION CHARGES AND PAYMENT INFORMATION

(Rates effective January 1, 2021)

Eligible By Reason Of Age Subscription Charges - Per Month

PEBB Retiree	PEBB Retiree & Spouse	State Resident	State Resident & Spouse
Plan G $99.92	Plan G $194.27	Plan G $188.70	Plan G $377.40

Eligible By Reason Of Disability Subscription Charges - Per Month

PEBB Retiree	PEBB Retiree & Spouse	State Resident	State Resident & Spouse
Plan G $165.96	Plan G $326.36	Plan G $320.79	Plan G $641.58

Please Note: The subscription charge amount charged is the same for all plan subscribers with certificates like yours. However, the actual amount a plan subscriber pays can vary depending on if and how much the group contributes toward a particular class of subscribers' subscription charges.

SUBSCRIPTION CHARGE INFORMATION

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

DISCLOSURES

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

READ YOUR CERTIFICATE VERY CAREFULLY

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

RIGHT TO RETURN CERTIFICATE

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

CERTIFICATE REPLACEMENT

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

NOTICE

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

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

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
HOSPITALIZATION* Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,408	$1,408 (Part A Deductible)	$0
61st through 90th day	All but $352 a day	$352 a day	$0
91st day and after: (while using 60 lifetime reserve days)	All but $704 a day	$704 a day	$0
Once lifetime reserve days are used: • Additional 365 days	$0	100% of Medicare eligible expenses	$0***
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $176 a day	Up to $176 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment / coinsurance for outpatient drugs and inpatient respite care	Medicare copayment / coinsurance	$0

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

G **PLAN G (continued):**

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

* Once you have been billed $198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
MEDICAL EXPENSES In or out of the Hospital and Outpatient Hospital Treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $198 of Medicare approved amounts*	$0	$0	$198 (Part B Deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $198 of Medicare approved amounts*	$0	$0	$198 (Part B Deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	$0	$0
MEDICARE (PARTS A & B)			
HOME HEALTH CARE - Medicare approved services			
Medically Necessary Skilled Care Services and Medical Supplies	100%	$0	$0
Durable Medical Equipment			
First $198 of Medicare approved amounts*	$0	$0	$198 (Part B Deductible)
Remainder of Medicare approved amounts	80%	20%	$0
OTHER BENEFITS - NOT COVERED BY MEDICARE			
FOREIGN TRAVEL - Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Discrimination is Against the Law

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

Premera:

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

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

If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
Civil Rights Coordinator — Complaints and Appeals
PO Box 91102, Seattle, WA 98111
Toll free 855-332-4535, Fax 425-918-5592,
TTY 800-842-5357
Email AppealsDepartmentInquiries@Premera.com

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

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

Getting Help in Other Languages

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

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

العربية (Arabic):
يحوي هذا الإشعار معلومات هامة. قد يحوي هذا الإشعار معلومات مهمة بخصوص طلبك أو التغطية التي تريد الحصول عليها من خلال Premera Blue Cross. قد تكون هناك تواريخ مهمة في هذا الإشعار. وقد تحتاج لاتخاذ إجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة في دفع التكاليف. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك دون تكبد أية تكلفة. اتصل بـ800-722-1471 (TTY: 800-842-5357)

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

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

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

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

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

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

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

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

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

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

ລາວ **(Lao):**
ccจ้งภาบบี้มีข้มุบส่าคับ. ccจ้งภาบบี้อาดจะมีข้มุบส่าคับภ่วดกับค่าธ้อวสะหมัภ ซึ่ ดอามคุ้มดอวปะกับไพ่ขอวท่าบผ่าบ Premera Blue Cross. อาดจะมีอับหิส่าคับไบccจ้งภาบบี้. ท่าบอาดจะจ่าเป็บต้อวด่าเบิบภาบตาบภ่าบ์ดเดอาสะเพาะเพื่อธักสาดอามคุ้มดอวปะกับสุขะพาบ ซึ่ ดอามช่วยเหลือเวื่อวค่าใช้จ่ายขอวท่าบไว้. ท่าบมีสิด ได้ธับข้มุบบี้ ccวะ ดอามช่วยเหลือเป็บพาสาขอวท่าบโดยบ่เสยค่า. ใซ้โทสา 800-722-1471 (TTY: 800-842-5357).

ភាសាខ្មែរ (Khmer):
សេចក្តីជូនដំណឹងនេះមានព័ត៌មានយ៉ាងសំខាន់។
សេចក្តីជូនដំណឹងនេះប្រហែលជាមានព័ត៌មានយ៉ាងសំខាន់អំពីទម្រង់បៃបបទ ឬការរ៉ាប់រងរបស់អ្នកតាមរយៈ Premera Blue Cross ។ ប្រហែលជាមានកាលបរិច្ឆេទសំខាន់នៅក្នុងសេចក្តីជូនដំណឹងនេះ។ អ្នកប្រហែលជាត្រូវការបញ្ចេញសមត្ថភាព ដល់កំណត់ថ្ងៃជាក់ច្បាស់នានា ដើម្បីនឹងរក្សាទុកការជានារ៉ាប់រងសុខភាពរបស់អ្នក ឬជ្រាក់ជំនួយចេញផ្លែ។ អ្នកមានសិទ្ធិទទួលព័ត៌មាននេះ និងជំនួយនៅក្នុងភាសារបស់អ្នកដោយមិនអស់លុយឡើយ។ សូមទូរស័ព្ទ 800-722-1471 (TTY: 800-842-5357)។

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

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

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

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

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

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

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

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

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

ไทย (Thai):
ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้อาจมีข้อมูลที่สำคัญเกี่ยวกับการการสมัครหรือขอบเขตประกันสุขภาพของคุณผ่าน Premera Blue Cross และอาจมีกำหนดการในประกาศนี้ คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิ์ที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 800-722-1471 (TTY: 800-842-5357)

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

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

Choosing a PEBB Dental Plan

To enroll in dental, you must enroll in medical. You and any dependents must enroll in the same PEBB dental plan. Once enrolled, you must keep dental coverage for at least two years unless you defer (postpone) or terminate enrollment as allowed under PEBB Program rules. You may change dental plans within those two years. If you terminate dental coverage for your dependents, they will also lose medical coverage.

Before you enroll, check with the plan (not your dentist) to make sure your provider is in the plan's network and group. The table below lists the dental plans' network and group numbers. To find a provider, the plans' phone numbers are listed in the front of this booklet, or you can visit their online directories.

How do the DeltaCare and Willamette Dental Group plans work?

DeltaCare and Willamette Dental Group are managed-care plans. You must choose and receive care from a primary care dentist (PCD) in that plan's network. Your primary care dentist must give you a referral to see a specialist. You may change network providers at any time. If you seek services from a dentist not in the plan's network, these plans will not pay your claims.

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

How does Uniform Dental Plan (UDP) work?

UDP is a preferred-provider organization (PPO) plan. You can choose any dental provider and change providers at any time. More than three out of four dentists in Washington State participate with this PPO. When you see a network preferred provider, your out-of-pocket expenses are generally lower than if you chose a provider who is not part of this network or just a participating provider.

Under UDP, you pay a percentage of the plan's allowed amount (coinsurance) for dental services after you have met the annual deductible. UDP pays up to an annual maximum of $1,750 for covered benefits for each member, including preventive visits.

Dental Plan Options

Make sure you contact the dental plan before you enroll to confirm that your dentist is part of the specific plan network and plan group.

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

2021 **PEBB Dental Benefits Comparison**

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

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). Managed-care plans have a closed network. If anything in these charts conflicts with the plan's certificate of coverage (COC), the COC takes precedence and prevails. All dental plans include a non-duplication of benefits clause, which applies when you have dental coverage under more than one plan.

Annual costs	Uniform Dental Plan[1] (Group 3000 Delta Dental PPO)	DeltaCare[2] (Group 3100)	Willamette Dental Group[2] (Group WA82)
Deductible	You pay $50/person, $150/family	None	None
Plan maximum (See specific benefit maximums below)	You pay amounts over $1,750	No general plan maximum	No general plan maximum

Benefits	Uniform Dental Plan[1] (Group 3000 Delta Dental PPO) You pay after deductible:	DeltaCare[2] (Group 3100) You pay:	Willamette Dental Group[2] (Group WA82) You pay:
Dentures	50% PPO and out of state; 60% non-PPO	$140 for complete upper or lower	$140 for complete upper or lower
Endodontics (root canals)	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	30% of costs, then any amount after plan has paid $1,000 per year, then any amount over $5,000 in member's lifetime
Oral surgery	20% PPO and out of state; 30% non-PPO	$10 to $50 to extract a tooth	$10 to $50 to extract a tooth
Orthodontia	50% of costs until plan has paid $1,750 for PPO, out of state, or non-PPO; then any amount over $1,750 in member's lifetime (deductible doesn't apply)	Up to $1,500 copay per case	Up to $1,500 copay per case
Orthognathic surgery	30% of costs until plan has paid $5,000 for PPO, out of state, or non-PPO; then any amount over $5,000 in member's lifetime	30% of costs until plan has paid $5,000; then any amount over $5,000 in member's lifetime	30% of costs until plan has paid $5,000; then any amount over $5,000 in member's lifetime
Periodontic services (treatment of gum disease)	20% PPO and out of state; 30% non-PPO	$15 to $100	$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

HCA is committed to providing equal access to our services. If you need an accommodation, or require documents in another format, please contact the following. Employees: Your payroll or benefits office. Retirees and PEBB Continuation Coverage members: Call us at 1-800-200-1004 (TRS: 711).

1 Preferred-provider plan (PPO)
2 Managed-care plans

Retiree Term Life Insurance

Can I buy life insurance when I retire?

You may be eligible to purchase retiree term life insurance through Metropolitan Life Insurance Company (MetLife).

Retiree term life insurance is available to subscribers who meet the eligibility and procedural requirements defined in WAC 182-12-209. Retiree term life insurance is only available to those who:

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

Your dependents are not eligible. You cannot have a break in life insurance coverage, and retiree term life insurance cannot be deferred. See "What happens to my retiree term life insurance if I start working again?" on page 59.

How do I enroll?

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

Choose your payment method for retiree term life insurance on the *PEBB Retiree Election Form* (form A). You will make monthly premium payments directly to MetLife for your coverage. If you wish to change your payment method in the future, call MetLife.

If you enroll when you become eligible and pay premiums on time, your coverage is effective the first day of the month after the date your PEBB or SEBB employee basic life insurance coverage ends.

How much can I buy?

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

How do I continue my employee life insurance coverage?

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

Whom can I name as my beneficiary?

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

How do my survivors file a claim?

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

Where can I get the retiree term life insurance certificate?

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

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

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

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

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

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

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

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

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

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

Retiree term life insurance premiums (administered by Metlife[1])

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

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

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

1 Metropolitan Life Insurance Company

SmartHealth (for non-Medicare subscribers only)

SmartHealth is included in your benefits and is a voluntary wellness program that supports you on your journey toward living well. Participate in activities to help support your whole person well-being, including managing stress, building resiliency, and adapting to change. As you progress on your wellness journey, you can qualify for SmartHealth wellness incentives.

Who is eligible?

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

Eligibility exceptions

- If you defer PEBB medical coverage, you will not have access to SmartHealth.
- Subscribers enrolled in Medicare Part A and Part B are not eligible to participate in SmartHealth. If you become eligible for Medicare, you will no longer be able to access the SmartHealth platform to earn points toward the wellness incentives.

What are the wellness incentives?

Eligible subscribers can qualify for two wellness incentives:

- A $25 **Amazon.com** gift card (Please note that this is a taxable benefit.)
- Either a $125 reduction in the subscriber's 2022 PEBB medical deductible, or a one-time deposit of $125 into the subscriber's health savings account (if enrolled in a PEBB consumer-directed health plan in 2022)

How do I get started?

1. Visit **smarthealth.hca.wa.gov** and click Get Started.

2. Take the SmartHealth well-being assessment.
   - Only takes 15 minutes
   - Earn a $25 gift card for Amazon.com*
   - Learn your top strengths and areas to improve.

3. Join and track activities to earn at least 2,000 points by your deadline to qualify for a $125 wellness incentive (distributed by January 31, 2022).

* After completing the assessment, you earn the $25 Amazon.com gift card. The gift card is taxable. If you don't have internet access, call SmartHealth Customer Service toll-free at 1-855-750-8866 (Monday through Friday, 7 a.m. to 7 p.m. Pacific Time) to complete the assessment by phone.

How do I qualify for the wellness incentives?

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

- Be eligible as described above.
- Complete the SmartHealth well-being assessment.
- Claim the gift card by December 31, 2021.

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

- Be eligible as described above.
- Complete the SmartHealth well-being assessment.
- Earn 2,000 total points by the deadline requirement.

To receive the incentive in 2022, the subscriber must still be enrolled in a PEBB medical plan in 2022.

If you qualified for the $125 wellness incentive in 2021, and enroll in Medicare Part A and Part B while enrolled in a PEBB medical plan after January 1, 2022, you will still receive the incentive in 2022.

SmartHealth will work with a subscriber who cannot complete a wellness incentive requirement to provide an alternate requirement that will allow the subscriber to qualify for the wellness incentive, or will waive the requirement.

What are the deadlines?

The deadline to qualify for and claim the $25 **Amazon.com** gift card wellness incentive is December 31, 2021.

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

- If you are already enrolled in PEBB medical or are a new subscriber with a PEBB medical effective date in January through September 2021, your deadline is November 30, 2021.
- If your PEBB medical effective date is in October through December 2021, your deadline is December 31, 2021.

What if I don't have internet access?

Call SmartHealth Customer Service at 1-855-750-8866 to participate in SmartHealth by phone.

SmartHealth contacts

Find out more on HCA's website at **hca.wa.gov/pebb-smarthealth**. Visit the SmartHealth portal at **smarthealth.hca.wa.gov** to track activities.

If you have questions, call SmartHealth Customer Service, 7 a.m. to 7 p.m., Monday through Friday, at 1-855-750-8866.

Auto and Home Insurance

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

What does Liberty Mutual offer?

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

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

When can I enroll?

You can choose to enroll in auto and home insurance coverage anytime.

How do I enroll?

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

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

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

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

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

Bellevue

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

Spokane

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

Tukwila

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

Olympia

1-360-705-0600
400 Union Ave. SE, Suite 253
Olympia, WA 98501

Portland, OR

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

Outside Washington

1-800-706-5525

PEBB Appeals

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

Mail: PEBB Appeals Unit
PO Box 45504
Olympia, WA 98504-5504

Fax: 360-763-4709

Use the guide to the right to find instructions for filing your appeal. You will find more help on filing an appeal in chapter 182-16 WAC and on the HCA website at **hca.wa.gov/pebb-appeals**.

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

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

Instructions and submission deadlines

If you are:

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

And your appeal concerns:

- A decision from the PEBB Program about:
  - Eligibility for benefits
  - Enrollment
  - Premium payments
  - Premium surcharges
  - Eligibility to participate in SmartHealth or receive a wellness incentive

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

If you are:

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

And your appeal concerns:

- The administration of medical or dental plan or benefit
- A benefit or claim
- Completion of the SmartHealth requirements or a reasonable alternative request

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

Which retiree forms should I complete?

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Please use dark ink to complete the forms.

If you need forms, visit HCA's website at hca.wa.gov/pebb-retirees and click on *Forms & publications*.

Due to the COVID-19 pandemic, the PEBB Program has temporarily changed the deadline to enroll in PEBB retiree insurance coverage when first eligible. To learn more about this exception to the timelines listed in this packet, visit HCA's website at hca.wa.gov/coronavirus.

Enrolling when first eligible or after deferring (postponing) coverage

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

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

Deferring (postponing) enrollment when you're first eligible

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

Step 1. Complete "Required" section on the first page, as well as Sections 1 and 7. You must maintain continuous enrollment in qualifying medical coverage if you wish to enroll in a PEBB retiree health plan in the future.
Step 2. Submit the form to the PEBB Program. We must receive it by the deadline.

Need help with Form A?

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

Making changes to your existing account

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

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

Deferring or terminating your coverage after you have already enrolled

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

Step 1. Complete Sections 1, 2, and 8. If deferring, you must maintain continuous enrollment in qualifying medical coverage if you wish to enroll in a PEBB retiree health plan in the future.
Step 2. If you or a dependent is enrolled in a Medicare Advantage plan, also complete the *PEBB Medicare Advantage Plan Disenrollment Form* (form D).
Step 3. Submit the forms to the PEBB Program. Your PEBB retiree health plan coverage will end on the last day of the month in which we receive all of your forms. If the forms arrive on the first day of the month, coverage will end on the previous day.

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

If you are enrolling or deferring when you first become eligible, or enrolling after deferring	
To enroll in these plans or defer	**Use**
Kaiser Permanente NW[1] Classic or Consumer Directed Health Plan (CDHP)	**Form A only**
Kaiser Permanente WA Classic, CDHP, Original Medicare, SoundChoice, or Value	
Uniform Medical Plan (UMP) Classic, UMP Select, UMP CDHP	
UMP Plus—Puget Sound High Value Network (PSHVN) or UMP Plus—UW Medicine Accountable Care Network (ACN)	
To enroll in these plans	**Use**
Kaiser Permanente NW Senior Advantage	**Forms A and C**
Kaiser Permanente WA Medicare Advantage	
UnitedHealthcare PEBB Balance or UnitedHealthcare PEBB Complete	
Premera Blue Cross Medicare Supplement Plan G	**Forms A and B**

If you are making changes, deferring, or terminating coverage (after you have already enrolled)	
To terminate, remove a dependent, or defer	**Use:**
Kaiser Permanente NW Senior Advantage	**Forms E and D**
Kaiser Permanente WA Medicare Advantage	
UnitedHealthcare PEBB Balance or UnitedHealthcare PEBB Complete	
To make changes or switch to these plans, terminate coverage, or defer	**Use**
Kaiser Permanente NW[1] Classic or CDHP	**Form E** Also include **Form D** if switching out of Kaiser Permanente WA Medicare, Kaiser Permanente NW Senior Advantage, UnitedHealthcare PEBB Balance, or UnitedHealthcare PEBB Complete.
Kaiser Permanente WA Classic, CDHP, Original Medicare, SoundChoice, or Value	
UMP Classic, UMP Select, UMP CDHP	
UMP Plus–PSHVN or UMP Plus–UW Medicine ACN	
To make changes or switch to these plans, terminate coverage, or defer	**Use**
Kaiser Permanente NW Senior Advantage	**Forms E and C**
Kaiser Permanente WA Medicare Advantage	
UnitedHealthcare PEBB Balance or UnitedHealthcare PEBB Complete	
Premera Blue Cross Medicare Supplement Plan G	**Forms E and B** Also include **Form D** if switching out of KPWA Medicare or KPNW Senior Advantage, UnitedHealthcare PEBB Balance, or UnitedHealthcare PEBB Complete.

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