Your SEBB benefits for
2021

School Employee Enrollment Guide

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

HCA 20-0049 (10/20)

Who to contact for help

Contact the plans directly for help with:

- Benefit questions
- ID cards
- Claims
- Checking to see if a health care provider is in the plan's network
- Choosing a health care provider
- Making sure your prescriptions are covered

Contact your payroll or benefits office for help with:

- Eligibility for coverage and enrollment questions or changes
- Accessing paper forms
- Premium surcharges questions
- Updating your contact information (name, address, phone, etc.)
- Enrolling or removing dependents
- Payroll deduction information (including pretax or post-tax contributions)
- Appeals (See page 73.)

Help with SEBB My Account

See "How to use SEBB My Account" on page 8.

Medical plans

Kaiser Foundation Health Plan of the Northwest[1]
Kaiser Permanente NW 1, 2, 3
my.kp.org/sebb
503-813-2000 or
1-800-813-2000 (TRS: 711)

Kaiser Foundation Health Plan of Washington
Kaiser Permanente WA Core 1, 2, 3, SoundChoice

Kaiser Foundation Health Plan of Washington Options, Inc.
Kaiser Permanente WA Options Access PPO 1, 2, 3
kp.org/wa/schools
1-888-901-4636
(TTY: 1-800-833-6388 or 711)

Premera Blue Cross
Premera High PPO, Peak Care EPO, Standard PPO
premera.com/sebb
1-800-807-7310 (TRS: 711)

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

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

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

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

For UMP prescription drug questions:
Washington State Rx Services
ump.regence.com/sebb/benefits/prescriptions
1-888-361-1611 (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.*

Dental plans

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

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

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

Vision plans

Davis Vision, underwritten by HM Life Insurance Company
davisvision.com/hcasebb
1-877-377-9353 (TTY: 1-800-523-2847)

EyeMed Vision Care, underwritten by Fidelity Security Life Insurance Company
eyemedvisioncare.com/hcasebboe
1-800-699-0993 (TTY: 1-844-230-6498)

MetLife Vision Plan, underwritten by Metropolitan Life Insurance Company
metlife.com/wshca-sebb
1-855-638-3931 (TTY: 1-800-428-4833)

Additional contacts

HealthEquity
Health savings account for UMP High Deductible
learn.healthequity.com/sebb/hsa
1-844-351-6853 (TRS: 711)

SmartHealth
SEBB voluntary wellness program
hca.wa.gov/sebb-smarthealth
1-855-750-8866

Metropolitan Life Insurance Company
Life and AD&D insurance
metlife.com/wshca-sebb
1-833-854-9624 (TTY: 1-833-854-9624)

Navia Benefit Solutions
Medical Flexible Spending Arrangement and Dependent Care Assistance Program
sebb.naviabenefits.com
1-800-669-3539 or 425-452-3500

Standard Insurance Company
Long-term disability insurance
standard.com/employee-benefits/washington-state-hca-sebb
1-800-368-2860 (TTY: 1-833-229-4177)

HCA is committed to providing equal access to our services. If you need an accommodation, or require documents in another format, please contact your payroll or benefits office.

Contents

Welcome

The *School Employee Enrollment Guide* will provide you with information you need to sign up for, use, or change your School Employees Benefits Board (SEBB) benefits. Please keep this book for later reference. An online version of this guide is available on the Health Care Authority website at **hca.wa.gov/sebb-employee**.

Newly eligible employees have 31 days to enroll in SEBB benefits. In addition, the annual open enrollment in the fall provides an opportunity for employees to make changes to their account.

For information about enrolling in SEBB Continuation Coverage (COBRA or Unpaid Leave), or PEBB retiree insurance coverage, visit the HCA website at **hca.wa.gov/erb**.

Quick start guide

Use this *Quick start guide* for an overview of the enrollment process. Watch for references to page numbers where you'll find more information. Look for the ***Good to know!*** boxes throughout this guide for quick tips, definitions, and where to find more information.

1. Find out if you're eligible

To be eligible for SEBB benefits you must meet the eligibility criteria described in SEBB Program rules. Your employer will determine if you are eligible for SEBB benefits based on your specific work circumstances. See "Subscriber eligibility" on page 11 for more information.

2. Learn about your benefits

A list of the benefits available to eligible employees is on page 10.

You may be able to waive SEBB medical coverage if you have other coverage. See "Waiving medical coverage" on page 19.

You will pay a premium for medical coverage. Premiums for dental and vision coverage, basic life, basic accidental death and dismemberment (AD&D), and basic long-term disability (LTD) insurance are paid by your employer. You will also pay monthly premiums for any supplemental coverage you are eligible for and elect. See "Paying for benefits" on page 20.

3. Get ready to enroll your eligible dependents

Are you enrolling a spouse, state-registered domestic partner, or children on your account? Enroll your dependents in the same plans that you choose for yourself. See "Dependent eligibility" on page 13 for eligibility rules and information.

Information you need to enroll eligible dependents

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

- Name
- Date of birth
- Social Security number
- Verification documents. Make sure you have the right documents on hand to prove their eligibility. These verification documents are listed on page 14. You may need to submit additional forms, see page 16.

4. Choose your health plans

Health plans available to you

A list of medical plans and premiums is on page 36. Check "2021 Medical plans available by county," beginning on page 30, and "School districts by county" beginning on page 32 to see what plans are available to you. To enroll in a plan you must either live or work in a county it serves. **Exception:** For UMP Plus, you must live in one of the counties where it is offered.

Check "Selecting a medical plan," beginning on page 25, "Selecting a dental plan," beginning on page 46, and "Selecting a vision plan," beginning on page 48, for information on the plans available to you.

Compare health plan benefits and premiums

The "2021 SEBB Medical benefits and premiums" starts on page 36. The "Dental benefits comparison" is on page 47. The "Vision benefits comparison" is on page 49. These charts give you some basic cost information to compare plans.

Virtual benefits fair

This online benefits fair is available 24/7 to help you learn more about your benefits. Visit plan booths to watch informative videos and access additional resources. Visit the virtual benefits fair through HCA's website at **hca.wa.gov/vbf-sebb.**

ALEX

This interactive, online benefits advisor provides customized plan suggestions and side-by-side benefits comparisons for your consideration, based on your health care needs. Visit ALEX on the HCA website at **hca.wa.gov/alex.**

Good to know!

You cannot enroll in benefits while using ALEX. Go to SEBB My Account to enroll.

5. Enroll using SEBB My Account

Once you've decided which plans you want, log in to our online enrollment system, SEBB My Account, at **myaccount.hca.wa.gov.** It works on your computer, tablet, or smartphone, and is the best and easiest way to enroll. See "How to enroll in SEBB My Account" on page 8 for step-by-step instructions.

Use SEBB My Account to enroll in medical, dental, and vision coverage. You will be automatically enrolled in basic life, basic accidental death and dismemberment insurance (AD&D), and basic long-term disability (LTD) insurance. You can use SEBB My Account to enroll in supplemental LTD insurance, a Medical Flexible Spending Arrangement (FSA) and Dependent Care Assistance Program (DCAP). You will find links to the websites you need to enroll in supplemental life and supplemental AD&D.

If you are unable to use SEBB My Account, contact your payroll or benefits office.

Enroll any eligible dependents you want, and upload verification documents to prove they are eligible. You must enroll and submit proof of your dependents' eligibility in SEBB My Account (if using paper forms, they must be received by your payroll or benefits office) **no later than 31 days** after you become eligible for SEBB benefits.

Attest to the premium surcharges

There are two premium surcharges that may apply to you. When you enroll in medical coverage, you must attest as to whether you or any enrolled dependents age 13 or older use tobacco products. If you are enrolling a spouse or state-registered domestic partner on your medical coverage, you must also attest as to whether they could have enrolled in an employer-based group medical insurance plan. You can easily attest on SEBB My Account.

If you do not attest, or if your attestation shows the surcharge applies to you, you will be charged these premium surcharges. See "Premium surcharges" on page 22 for details and how to attest.

6. Consider these additional benefits

You can buy supplemental life insurance, supplemental AD&D insurance, and supplemental LTD insurance. See page 52 through page 57 for more information about these important benefits and how to enroll.

You may be eligible to enroll in a Medical Flexible Spending Arrangement (FSA) or the Dependent Care Assistance Program (DCAP). These are pretax accounts used to pay for certain expenses. See page 58 for more information and how to enroll.

Consider supplemental insurance for your dependents

You may also choose to cover your dependents with supplemental life and AD&D insurance. See page 52 through 57 for more information.

7. What's next

The health plans you chose will send you welcome packets. See "After you enroll" on page 62.

Good to know!

Not eligible?

If you are not eligible as described in "Subscriber eligibility" on page 11, you may be eligible for some SEBB Program benefits if your school district, charter school, or ESD negotiated eligibility as described in WAC 182-30-130. If you are a represented employee, please check with your union or union contract regarding eligibility. Otherwise, your payroll or benefits office will notify you if you are eligible under this provision.

How to use SEBB My Account

Eligible school employees can use SEBB My Account, the online enrollment system, on a computer, tablet, or smartphone to enroll in benefits.

What can I do in SEBB My Account?

- Enroll in SEBB benefits
- Waive SEBB medical coverage
- Enroll your eligible dependents in SEBB benefits
- Upload documents to prove dependent eligibility
- Select your medical, dental, and vision plans
- Access vendor websites to enroll in supplemental (employee-paid) life and supplemental accidental death and dismemberment (AD&D) insurance, a Medical Flexible Spending Arrangement (FSA), and Dependent Care Assistance Program (DCAP)
- Enroll in supplemental (employee-paid) long-term disability insurance
- Attest to premium surcharges
- Request a change due to a special open enrollment

Good to know!

Google Chrome is the preferred browser, but Edge, Internet Explorer, Firefox, and Safari will also work.

For more information, check out the *Help with SEBB My Account* webpage at **myaccount.hca.wa.gov**.

Setting up your account

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

When can I access SEBB My Account?

Once your employer enters your eligibility information into SEBB My Account, you can log in and enroll in benefits within your eligibility period. Then, come back any time to check your coverage or request special open enrollment changes.

How to enroll with SEBB My Account

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

1. **Add your dependents.** Enter your dependents' information. If you are not adding dependents, skip to step 3.
2. **Verify your dependents.** You must provide proof of your dependents' eligibility.

   Upload documents from your computer or mobile device to verify your dependents' eligibility. Your documents must be verified and approved before your dependents are enrolled under your coverage. Acceptable documents (like a birth or marriage certificate, or recent tax return) and file types (PDF, JPEG, JPG or PNG) are listed in SEBB My Account.

   If you are unable to upload documents online, you can submit paper documents to your payroll or benefits office.

   HCA may audit dependent eligibility determinations.

   Please make sure to keep the documents you submitted. Receiving approval for verifying your dependents does not mean your dependents are enrolled. You must still select the same plans for your dependents as yourself either on SEBB My Account or the *School Employee Enrollment* form.

3. **Attest to the premium surcharges.** Answer a series of questions to determine whether you'll be charged the monthly $25-per-account tobacco use premium surcharge or the monthly $50 spouse or state-registered domestic partner coverage premium surcharge.
4. **Select your plans.** You can follow a link to ALEX, the online benefits advisor, to learn more about which plans might be the best fit for you. Please note you cannot enroll in benefits while in ALEX.

When you're ready, select your plans in SEBB My Account by checking the box next to the medical, dental, and vision plans you want for you and any dependents you want to enroll.

If you have other employer-based medical coverage, TRICARE, or Medicare, you can waive SEBB medical coverage, but not other benefits. See "Waiving medical coverage" on page 19.

Good to know!

Other enrollments

You will be automatically enrolled in (employer-paid) basic life insurance, basic accidental death and dismemberment (AD&D) insurance, and basic long-term disability insurance (if eligible). (See details on page 52 through page 57). You will be automatically enrolled as a participant under the premium payment plan (see "Payroll deductions and taxes" on page 20).

To enroll in Medical Flexible Spending Arrangement (FSA) and Dependent Care Assistance Program (DCAP), download and print the *Medical Flexible Spending Arrangement and Dependent Care Assistance Program Enrollment Form* on Navia's website at **sebb.naviabenefits.com** or call 1-800-669-3539.

Enrollment checklist

- Check your eligibility and deadlines
- Learn about your benefits
- Check plans available to you
- Review benefits comparison charts
- Visit the virtual benefits fair
- Try ALEX
- Choose your benefits
- Choose to enroll in or waive medical coverage
- Sign in to SEBB My Account
- Enroll yourself
- Enroll dependents and upload verification documents and any additional documents needed to prove their eligibility
- Attest to premium surcharges
- Consider supplemental coverage
- Consider Medical FSA and DCAP
- Sign up for email delivery

Your 2021 SEBB benefits

- Medical insurance (You pay a portion of the total premium.)
- Health savings account (HSA) for those who enroll in UMP High Deductible (administered by Regence BlueShield)
- Dental insurance
- Vision insurance
- Basic life insurance
- Basic accidental death and dismemberment (AD&D) insurance
- Basic long-term disability (LTD) insurance (if eligible)
- Supplemental life insurance
- Supplemental AD&D insurance
- Supplemental LTD insurance (if eligible)
- Medical Flexible Spending Arrangement (FSA)
- Dependent Care Assistance Program (DCAP)

Good to know!

Get the latest news and updates from the SEBB Program by going paperless. When you receive general information and newsletters by email, it's faster for you and helps reduce the toll on the environment. Go to SEBB My Account at **myaccount.hca.wa.gov** to sign up.

Subscriber eligibility

Who is eligible for SEBB benefits?

This guide provides a summary of employee eligibility for SEBB benefits. In this booklet, employees are also called "subscribers."

Your employer will determine if you are eligible for the employer contribution toward SEBB benefits based on your specific work circumstances (see Washington Administrative Code [WAC] 182-31-040). Please contact your payroll or benefits office to find out if you are eligible. All eligibility determinations are based on rules in Chapters 182-30 and 182-31 WAC under *Rules and policy* on the HCA website at **hca.wa.gov/sebb-rules**. If discrepancies arise between WACs and this guide, the WACs take precedence. If you disagree with the eligibility determination, see "Appeals" on page 73.

Generally, you are eligible for the employer contribution toward SEBB benefits if you work in a school district or charter school, or are a represented employee of an educational service district (ESD), and your employer anticipates you will work at least 630 hours during the school year (September 1 through August 31). Paid holidays and paid leave, such as sick, personal, and bereavement leave, count toward the required hours.

If your first day of work is on or after September 1, but not later than the first day of school for the current school year as established by the SEBB organization, you are eligible for the employer contribution on the first day of work. If your first day of work is at any other time during the school year, you are eligible for the employer contribution on that day.

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

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

If you are not anticipated to work 630 hours at the beginning of the school year, but you do actually work 630 hours, you become eligible for the employer contribution toward SEBB benefits on the day you work your 630th hour.

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

If you return to work from approved leave without pay you can maintain or establish eligibility for the employer contribution toward SEBB benefits if the work schedule you return to, had it been in effect at the start of the school year, would have resulted in you being anticipated to work the minimum hours to meet SEBB eligibility. You would regain eligibility for the employer contribution toward SEBB benefits on the day you return from approved leave without pay.

See "When do my benefits begin?" on page 62.

Eligibility based upon date of hire

If you are not anticipated to work 630 hours within the school year because of the time of year you are hired but are anticipated to work at least 630 hours the next school year, you may establish eligibility for the employer contribution toward SEBB benefits if certain criteria is met. Contact your payroll or benefits office for eligibility requirements.

If you are a school employee who establishes eligibility for the employer contribution toward SEBB benefits at any time in the month of August, SEBB benefits begin on September 1 only if you are also determined to be eligible for the employer contribution toward SEBB benefits for the school year that begins on September 1.

Eligibility based on hours worked the previous two school years

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

If your employer does not consider you eligible after having worked at least 630 hours the previous two school years, they must notify you, in writing, of the specific reason(s) why you are not anticipated to work at least 630 hours in the current school year. You have the right to appeal the eligibility determination. See "Appeals" on page 73.

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

All of the hours you work in your capacity as a school employee, and all hours you receive compensation from your employer during an approved leave (e.g., sick leave, personal leave, bereavement leave), are in the calculation of hours to determine your eligibility. You cannot "stack" hours from different school districts, charter schools, or ESDs to reach the eligibility level of 630 hours.

Returning employees have uninterrupted coverage

If you were enrolled in SEBB benefits in August of the previous school year, you will receive uninterrupted coverage from one school year to the next when you return at the start of the next school year to the same school district, charter school, or as a represented employee of the same ESD, as long as you are still anticipated to be eligible for the employer contribution the coming school year.

Eligibility when changing jobs between SEBB organizations

Once enrolled in the SEBB Program, you will have uninterrupted coverage when moving from one SEBB organization to another within the same month or a consecutive month if you are eligible for the employer contribution toward SEBB benefits in the position you are leaving and are anticipated to be eligible for the employer contribution toward SEBB benefits in the new position. SEBB benefits elections also remain the same if you have a break in employment that does not interrupt the employer contribution toward your SEBB benefits.

You may need to change health plans if you move to a new county or your new job is in a different county, which would qualify as a special open enrollment event (see page 65).

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

You cannot enroll in medical, dental, or vision coverage under two SEBB accounts. If you are an eligible employee and are also eligible as a dependent under your spouse's, state-registered domestic partner's, or parent's account, see "Waiving medical coverage" on page 19 for options available to you.

Employees eligible for locally negotiated benefits

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

Dependent eligibility

You may enroll the following dependents:

- Your legal spouse
- Your state-registered domestic partner as defined in WAC 182-30-020. 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 as defined in WAC 182-31-140(3) through the last day of the month in which they turn age 26.

How are children defined?

For our purposes, children are defined as described in WAC 182-31-140(3). This definition includes:

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

Extended dependents

Children may also include extended dependents (such as a grandchild, niece, nephew, or other child) 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's official residence 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 also include children of any age with a developmental or physical disability that renders them incapable of self-sustaining employment and chiefly dependent upon the employee for support and ongoing care. Their condition must have occurred before they turned age 26. You must provide proof of the disability and dependency for a child age 26 or older to enroll on your SEBB health plan coverage or for an enrolled child turning age 26 to continue their enrollment. Newly eligible employees must submit the *Certification of a Child with a Disability* form within the 31-day enrollment period.

The SEBB Program, with input from your medical plan (if the child is enrolled in SEBB medical coverage), will verify the disability and dependency of a child beginning 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 SEBB 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 of self-support, they do not regain eligibility.

You must notify the SEBB Program in writing when your child with a disability is no longer eligible. The SEBB Program must receive notice **within 60 days** of the last day of the month your child loses eligibility for health plan coverage.

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 listed on the next page. We will not enroll a dependent if we cannot verify their eligibility. We reserve the right to review a dependent's eligibility at any time.

A few exceptions apply to the dependent verification process:

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

Submit the documents when you enroll within the SEBB Program enrollment timelines. You must submit all documents in English. Documents written in a foreign language must include a translated copy prepared by a

professional translator and notarized. These documents must be approved (verified).

You can upload your documents for verification in SEBB My Account (see page 8), or provide them directly to your payroll or benefits office.

Documents to enroll a spouse

Provide a copy of (choose one):

- The most recent year's federal tax return jointly filed that lists the spouse (black out financial information)
- The most recent year's federal tax returns 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 names (black out financial information)
- Petition for dissolution or invalidity of marriage
- Legal separation notice
- Defense Enrollment Eligibility Reporting System (DEERS) registration
- Valid J-1 or J-2 visa issued by the U.S. government

Documents to enroll a state-registered domestic partner 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 state-registered domestic partner's names (black out financial information)
- Petition for invalidity (annulment) of state-registered domestic partnership or legal union
- Petition for dissolution of state-registered domestic partnership or legal union
- Legal separation notice of state-registered domestic partnership or legal union
- Valid J-1 or J-2 visa issued by the U.S. government

If enrolling a state-registered domestic partner, also attach a completed *Declaration of Tax Status* form to indicate whether your state-registered domestic partner qualifies as a dependent for tax purposes under Internal Revenue Code (IRC) Section 152, as modified by IRC Section 105(b).

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

Documents to enroll children

Provide a copy of (choose one):

- The most recent year's federal tax return that includes the child as a dependent (black out financial information). You can submit one copy of your tax return as a verification document for all family members listed who require verification.
- Birth certificate (or hospital certificate with the child's footprints on it) showing the name of the parent who is the subscriber, the subscriber's spouse or state-registered domestic partner. If the dependent is the subscriber's stepchild, the subscriber must also verify the spouse or state-registered domestic partner in order to enroll the child, even if not enrolling them in SEBB insurance coverage.
- Certificate or decree of adoption showing the name of the parent who is the subscriber, the subscriber's spouse, or state-registered domestic partner
- Court-ordered parenting plan
- National Medical Support Notice
- Defense Enrollment Eligibility Reporting System (DEERS) registration
- Valid J-2 visa issued by the U.S. government

See "Additional required forms" on page 16 for information regarding requirements for an extended dependent, state-registered domestic partner or their eligible children, or child with a disability.

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

When a National Medical Support Notice (NMSN) requires you to provide health plan coverage for your dependent child, you may enroll the child and request changes to their health plan coverage as directed by the NMSN. You must make the change in SEBB My Account and upload the NMSN, or complete and submit a *School Employee Change* form and a copy of the NMSN to your payroll and benefits office.

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

The following options are allowed:

- The child will be enrolled under the subscriber's SEBB health plan coverage as directed by the NMSN.
- If you have previously waived SEBB medical coverage, you will be enrolled in medical coverage as directed by the NMSN in order to enroll the child.
- The subscriber's selected health plan will be changed if directed by the NMSN.

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

Good to know!

You have appeals rights

If you disagree with a specific eligibility decision or denial, you can appeal. See "Appeals" on page 73.

What happens when my dependent loses eligibility?

You must remove an ineligible dependent when they no longer meet SEBB Program eligibility. Remove the dependent from your account in SEBB My Account, or submit your completed *School Employee Change* form to your payroll or benefits office. The form must be submitted in SEBB My Account or received by the payroll or benefits office **within 60 days** of the last day of the month they no longer meet SEBB eligibility criteria. If a dependent child with a disability is no longer eligible, written notice must be provided to the SEBB Program. Your dependent will be removed from coverage on the last day of the month they no longer meet the eligibility criteria.

Consequences for not submitting the change within 60 days are explained in WAC 182-31-150(2)(a). The consequences may include (but are not limited to):

- The dependent may lose eligibility to continue SEBB medical, dental, or vision coverage under one of the continuation options described in WAC 182-31-130 and on page 70.
- You may be billed for claims paid by the health plan for services that were rendered after the dependent lost eligibility.
- You may not be able to recover subscriber-paid insurance premiums for dependents who lost eligibility.
- You may be responsible for premiums paid by the state for a dependent's health plan coverage after the dependent lost eligibility.

See "When coverage ends" on page 70.

What happens if I die, or my dependent dies?

See "When coverage ends" on page 70.

How to enroll

When do I enroll?

You must enroll **within 31 days** of becoming eligible for SEBB benefits. If you do not enroll, you will be automatically enrolled as a single subscriber. See "Am I required to enroll? What if I don't enroll?" below. You may also have the option to waive your SEBB medical, see "Waiving medical coverage" on page 19.

How do I enroll?

The easiest way to enroll yourself and your dependents is with our online enrollment system, SEBB My Account, at **myaccount.hca.wa.gov**. See these pages for details:

- "Quick start guide" on page 6.
- "Setting up your account" on page 8.
- "How to enroll with SEBB My Account" on page 8.

If you cannot access the internet to enroll, use the *School Employee Enrollment* form, available from your payroll or benefits office. Your payroll or benefits office must receive any forms **no later than 31 days** after you become eligible for SEBB benefits.

You will automatically be enrolled in basic life, basic accidental death and dismemberment (AD&D), and basic long-term disability (LTD) insurance (if eligible).

Upload proof of your dependent's eligibility in SEBB My Account (or submit proof to your payroll or benefits office) **no later than 31 days** after you become eligible for SEBB benefits. If the documents are not received in time, your dependents will not be enrolled and you will not be able to enroll them until open enrollment or a special open enrollment event. A list of documents we will accept as proof is on page 14.

To enroll in supplemental life, supplemental AD&D, or supplemental LTD insurance, see page 52 through page 57.

To enroll in a Medical Flexible Spending Arrangement (FSA) or Dependence Care Assistance Program (DCAP), see page 58.

Additional required forms

If you are enrolling one of the dependents described below, in addition to enrolling on SEBB My Account or submitting a *School Employee Enrollment* form, you must also submit the applicable forms when you enroll.

SEBB Declaration of Tax Status: You must submit this form when enrolling an extended dependent, state-registered domestic partner, or their eligible children, regardless of tax status.

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

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

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

Good to know!

Forms are available on the HCA website at **hca.wa.gov/sebb-employee** under the *Forms & publications* tab.

Am I required to enroll? What happens if I don't waive or enroll?

If your employer determines that you are eligible for SEBB benefits, you are required to enroll in or waive SEBB medical within SEBB Program timelines. You may waive enrollment in SEBB medical coverage if you are enrolled in other employer-based group medical insurance, a TRICARE plan, or Medicare. You must actively indicate your intention to enroll or waive in SEBB My Account or by submitting an enrollment form to your payroll or benefits office. See "Waiving medical coverage" on page 19 for instructions and timelines.

If you do not enroll or waive medical:

- You will be automatically enrolled as a single subscriber in UMP Achieve 1 for medical coverage. Other plans you will be automatically enrolled in include Uniform Dental Plan and MetLife vision, basic life insurance, basic AD&D insurance, and basic LTD insurance (if you are eligible).
- **You will be charged a monthly $33 premium for your medical coverage and a $25 tobacco use premium surcharge.**

- You can change your tobacco use attestation anytime. See "Premium surcharges" on page 22.
- You cannot change plans until the next annual open enrollment, unless you have a special open enrollment event that allows the change.
- Your dependents will not be enrolled. You cannot enroll your eligible dependents until the next annual open enrollment, unless you have a special open enrollment event that allows the change.
- If you are enrolled on your spouse's, state-registered domestic partner's, or parent's SEBB health plan coverage, you will be removed from that coverage.

Can I enroll on two SEBB accounts?

No. You cannot enroll in medical, dental, or vision coverage under two SEBB accounts. Medical, dental, and vision coverage is limited to a single SEBB enrollment per individual.

However, if you are an eligible employee and are also eligible as a dependent under your spouse's, state-registered domestic partner's, or parent's account, you may choose one of these options:

- Waive SEBB medical under your own account and, instead, remain enrolled in SEBB medical under your spouse's, state-registered domestic partner's, or parent's account. You must be removed from their dental and vision accounts. You must enroll in SEBB dental and vision coverage, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, and basic long-term disability (LTD) insurance (if you're eligible) under your own account. See "Waiving medical coverage" on page 19.
- Enroll in SEBB medical (as well as SEBB dental and vision coverage, basic life insurance, basic AD&D insurance, and basic LTD insurance) under your own account. You must be removed from the other medical, dental, and vision accounts.

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

Yes. If you are enrolled in SEBB Program benefits, and your spouse, state-registered domestic partner, or parent is enrolled in Public Employees Benefits Board (PEBB) Program benefits, you can be enrolled in both programs. Your primary coverage would be through the SEBB Program and your secondary coverage would be through the PEBB Program, which is also administered by the Health Care Authority. There is no added benefit of enrolling in dental in both plans.

How does being enrolled in both SEBB and PEBB affect the premium surcharge?

If you are enrolled in the SEBB Program covering yourself as well as your spouse or state-registered domestic partner as a dependent, and your spouse is enrolled in the Public Employees Benefits Board (PEBB) Program and covers you as a dependent, or vice versa, you and your spouse would not incur the $50 spouse or state-registered domestic partner coverage premium surcharge, as long as you attest that it does not apply to you.

However, if your spouse or state-registered domestic partner waives their PEBB medical coverage and enrolls on your account, you will be charged the $50 spouse or state-registered domestic partner coverage premium surcharge in addition to your monthly medical premium.

Alternately, if you waive enrollment in SEBB medical and your spouse or state-registered domestic partner enrolls you as a dependent on their PEBB medical coverage, they will be charged the $50 spouse or state-registered domestic partner coverage premium surcharge in addition to their monthly medical premium. See "Premium surcharges" on page 22.

Weigh the options of dual enrollment

Having one person enrolled in both the PEBB and SEBB programs is currently allowed, but it may not give your family an advantage — especially financially. Whether it works to your advantage depends on your specific health care circumstances . Research both PEBB and SEBB benefits to compare. Be sure to consider the premiums, deductibles, copays, coinsurance, and premium surcharges if you're thinking about dual enrolling. Neither program will pay more than the allowed amount for care. If you aren't sure how a plan you're considering would share costs with another plan, contact the plan and ask about coordination of benefits. You can also read your plan's certificate of coverage, available at **hca.wa.gov/erb**.

Another thing to consider is that the Washington State Legislature recently passed a law that limits dual enrollment between the PEBB and SEBB programs starting with the 2022 plan year.

Medicare and SEBB

For employees and their enrolled spouses age 65 and older, SEBB medical plans provide primary coverage, and Medicare coverage is usually secondary.

When you retire

If you retire and are eligible for PEBB retiree insurance coverage (see "When coverage ends" on page 70), you and any covered dependent must enroll and stay enrolled in Medicare Part A and Part B, if eligible, to remain enrolled in a PEBB retiree health plan. Medicare will become the primary insurer, and PEBB medical becomes secondary.

Waiving SEBB medical

You may choose to waive your enrollment in SEBB medical coverage and have Medicare as your primary medical coverage. However, you will remain enrolled in SEBB dental and vision coverage, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, and basic long-term disability (LTD) insurance. See "Waiving medical coverage" on page 19.

If you waive SEBB medical, you can enroll only during the next annual open enrollment (for coverage effective January 1 of the following year). The exception is if you have a special open enrollment event that allows you to enroll in SEBB medical coverage after having waived enrollment. See "What changes can I make during a special open enrollment?" on page 65.

Deferring Medicare Parts A and B

When you or your covered dependents become eligible for Medicare Part A and Part B, either by age or disability, the member eligible for Medicare should contact the nearest Social Security office to ask about the advantages of immediate or deferred enrollment in Medicare Part B. Find contact information for your local office on the Social Security Administration's website at **ssa.gov/agency/contact.**

In most cases, employees and their spouses covered under a SEBB medical plan can defer Medicare Part B enrollment without a late enrollment penalty. They can sign up for Medicare Part B during a special enrollment period when the employee terminates employment or retires. If you are receiving a monthly Social Security benefit, you cannot defer Medicare Part A. Contact your nearest Social Security office or call 1-800-772-1213 for information on deferring or reinstating Medicare.

If the eligibility is due to a disability, contact a local Social Security office or call 1-800-772-1213 regarding deferred enrollment.

Deciding on Medicare Part D

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

All SEBB medical plans available to employees provide creditable prescription drug coverage. Creditable coverage is as good as or better than Medicare Part D coverage. When you become enrolled in Medicare Part A or Part B, you can keep your SEBB insurance coverage and not pay a Medicare Part D late enrollment penalty if you decide to enroll in a Medicare Part D plan later. To avoid a premium penalty, you cannot be without creditable prescription drug coverage for more than two full months. If you enroll in a Medicare Part D plan, your SEBB medical plan may not coordinate prescription drug benefits with that plan.

If you lose or terminate SEBB medical coverage

To avoid paying a higher premium, you should enroll in a Medicare Part D plan within two months after your SEBB medical coverage ends, unless you have other creditable prescription drug coverage. If you don't enroll within the two-full month deadline, you may have to wait for coverage and your Medicare Part D plan's monthly premium may increase by 1 percent or more for every month you don't have creditable coverage.

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

Be aware of enrollment deadlines

Be sure you understand the Medicare enrollment timelines, especially if you will be leaving employment within a few months of you or your covered dependent becoming enrolled in Medicare.

Good to know!

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

Waiving medical coverage

What does waiving mean?

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

If you waive enrollment in medical coverage

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

How do I waive medical coverage?

To waive enrollment in SEBB medical coverage, use SEBB My Account or the *School Employee Enrollment* form (see your payroll or benefits office for the form) **no later than 31 days** after you become eligible for SEBB benefits, or during an annual open enrollment or special open enrollment (as described on page 65 through page 69).

What if I'm already enrolled in SEBB health plan coverage?

If you are a newly eligible employee who is already enrolled in health plan coverage as a dependent under your spouse's, state-registered domestic partner's, or parent's SEBB account, you may choose one of these two options:

- Waive SEBB medical and stay enrolled in medical under your spouse's, state-registered domestic partner's, or parent's SEBB account. You must enroll in SEBB dental and vision coverage, basic life insurance, basic AD&D insurance, and basic LTD insurance under your own account. Your spouse, state-registered domestic partner, or parent must use SEBB My Account or submit the *SEBB Employee Change* form and remove you from their dental and vision coverage to prevent dual enrollment in SEBB dental and vision coverage.
- Enroll in SEBB health plan coverage under your own account. To do this, enroll in SEBB My Account **no later than 31 days** after the date you become eligible for SEBB benefits. Your spouse, state-registered domestic partner, or parent will need to remove you from their SEBB account to prevent dual enrollment in SEBB health plan coverage.

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

If you waive medical coverage, you can only enroll during the next annual open enrollment (for coverage effective January 1 the following year). The exception is if you have a special open enrollment event that allows you to enroll in medical coverage, such as losing eligibility for other coverage, getting married, or having a child. See "What changes can I make with a special open enrollment?" on page 65.

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

If you are eligible for the employer contribution toward SEBB benefits but do not either enroll in or waive SEBB medical coverage within SEBB Program timelines, you will be automatically enrolled as a single subscriber in UMP Achieve 1 (administered by Regence BlueShield). Other plan defaults for employees who do not make elections include Uniform Dental Plan, MetLife vision insurance, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, and basic long-term disability (LTD) insurance (if you are eligible).

You will be charged a monthly $33 premium for your medical coverage as well as a $25 tobacco use premium surcharge.

You can change your tobacco use attestation anytime through SEBB My Account at **myaccount.hca.wa.gov** or by submitting a *SEBB Premium Surcharge Attestation Change* form to your payroll or benefits office. See "Premium surcharges" on page 22.

If you are enrolled on your spouse's, state-registered domestic partner's, or parent's SEBB health plan coverage, you will be removed from that coverage.

If you are automatically enrolled, you cannot change plans or enroll your eligible dependents until the next SEBB Program annual open enrollment, unless you have a special open enrollment event that allows the change.

Paying for benefits

What does my employer pay?

If you are eligible for SEBB benefits, your employer will pay the premiums for dental and vision coverage for you and your dependents.

Your employer also pays the premiums for basic life insurance, basic AD&D insurance, and basic LTD insurance. You pay nothing for these basic benefits.

What do I pay?

Monthly premiums

You pay a monthly medical premium for yourself and any enrolled dependents on your account. Your medical premiums pay for a full calendar month of coverage. Your premiums cannot be prorated for any reason, including when a member dies before the end of the month.

Premium surcharges

In addition to your monthly medical premium, you may be charged a $25-per-account tobacco use premium surcharge and/or a $50 spouse or state-registered domestic partner coverage premium surcharge. See "Premium surcharges" on page 22 for details on whether the premium surcharges apply to you.

Out-of-pocket costs

You are responsible for paying any out-of-pocket costs for deductibles, coinsurance, or copayments for services under the medical, dental, and vision plans you choose. See the medical, dental, and vision benefits comparisons on page 36 through page 45 for a side-by-side comparison of many common benefits and costs for services for each plan.

You can also buy supplemental life and supplemental AD&D insurance for yourself and your eligible dependents, and supplemental LTD insurance for yourself. See more about these benefits on page 52 through page 56.

How much will my monthly premiums be?

See "2021 Medical benefits and premiums" on page 36. There are no employee premiums for dental or vision coverage, basic life insurance, basic AD&D insurance, and basic LTD insurance.

Payroll deductions and taxes

When you enroll, your monthly medical plan premiums and applicable premium surcharges are deducted from your paychecks before taxes are taken out under the premium payment plan, unless you request otherwise.

Exception: If you enroll a dependent who does not qualify as an IRC Section 125 dependent (i.e., state-registered domestic partner), your monthly medical premiums and applicable surcharges for these dependents will be deducted from your paycheck post-tax. However, you will be able to make premium payments for your own insurance coverage with pretax payroll deductions.

Why would I pay my monthly premiums with pretax dollars?

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

Would it benefit me not to have a pretax deduction?

Deducting your premiums pretax may affect the following benefits:

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

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

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

Good to know!

Additional benefits you may like

Medical Flexible Spending Arrangements (FSA) and Dependent Care Assistance Program (DCAP) are benefits that may suit your financial needs. See page 58.

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

Yes. You may opt out or opt in to the state's premium payment plan during the SEBB Program's annual open enrollment or if you have an applicable special open enrollment event as described in WAC 182-30-100. See "What changes can I make during a special open enrollment?" on page 65.

Good to know!

Changing your pretax payments

If you do not want your SEBB medical premiums or applicable premium surcharges paid with pretax earnings, you must complete and submit the *SEBB Premium Payment Plan Election/Change* form to your employer's payroll or benefits office.

Premium surcharges

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

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

For more information on the premium surcharges, visit the Surcharges webpage at **hca.wa.gov/sebb-employee**.

Tobacco use premium surcharge

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

The surcharge will not apply if:

- You and all enrolled dependents age 18 and older who use tobacco products are enrolled in a tobacco cessation program through your medical plan, or
- Enrolled dependents age 13 to 17 who use tobacco products have accessed information and resources on the Smokefree Teen website at **teen.smokefree.gov**.

You do not have to attest for dependents age 12 and younger. You do not need to attest when the dependent turns age 13 unless the dependent uses, or starts using, tobacco products.

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

How to attest to this surcharge

To find out if the tobacco use surcharge applies to your account, use the *SEBB Premium Surcharge Attestation Help Sheet* under *Forms & publications* on the HCA website at **hca.wa.gov/sebb-employee**.

You must attest when you enroll, either online in SEBB My Account or using the *School Employee Enrollment* form. You can find the form on the school employee webpages at **hca.wa.gov/sebb-employee** under *Forms & publications*. If you use the enrollment form, submit it to your payroll or benefits office.

How to report a change in tobacco use

You can report a change in tobacco use anytime if:

- Any enrolled dependent age 13 and older starts using tobacco products.
- You or your enrolled dependent have not used tobacco products within the past two months.
- You or your enrolled dependent who is 18 years or older and uses tobacco products enrolls in the free tobacco cessation program through your SEBB Program medical plan.
- Your enrolled dependent who is 13 to 17 years old and uses tobacco products accesses the tobacco cessation resources on the Smokefree Teen website at **teen.smokefree.gov**.

You may report the change in tobacco product use anytime in one of two ways:

- Go to SEBB My Account at **myaccount.hca.wa.gov** to change your attestation.
- Submit a *SEBB Premium Surcharge Attestation Change* form (under *Forms & publications* on the HCA website at **hca.wa.gov/sebb-employee**) to your payroll or benefits office.

Good to know!

If you don't attest, you will be charged

You will be charged a $25 monthly surcharge in addition to your monthly premium if you do not attest for all dependents you enroll, or if your attestation shows the surcharge applies to you.

You will be charged a $50 monthly surcharge if you enroll a spouse or state-registered domestic partner and do not attest or if your attestation shows the surcharge applies to you.

If the change you report means that the surcharge applies to you, the surcharge is effective the first day of the month after you report 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 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

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

You will be charged a $50 premium surcharge in addition to your monthly medical premium if you enroll a spouse or state-registered domestic partner on your SEBB medical coverage, and one of the following applies:

- That person chose not to enroll in another employer-based group medical insurance that is comparable to the Public Employees Benefits Board (PEBB) Program Uniform Medical Plan (UMP) Classic plan.
- You do not attest by the required deadline.
- Your attestation response results in incurring the premium surcharge.

How to attest to this surcharge

If you enroll a spouse or state-registered domestic partner on your SEBB Program medical coverage, go to *Spouse or state-registered domestic partner coverage premium surcharges* in SEBB My Account or use the *SEBB Premium Surcharge Attestation Help Sheet* under *Forms & publications* on the HCA website at **hca.wa.gov/sebb-employee** to find out if this premium surcharge applies to you. Then, attest either online in SEBB My Account or using the *School Employee Enrollment* form. If you use the form, submit it to your employer's payroll or benefits office.

If you enroll a spouse or state-registered domestic partner on your medical coverage but do not respond to the surcharge, or if the attestation results in you incurring the surcharge, you will be charged the $50 spouse or state-registered domestic partner coverage premium surcharge in addition to your monthly medical premium.

To report a change to this surcharge

Outside of annual open enrollment, you can only report a change to this surcharge **within 60 days** of a change in your spouse's or state-registered domestic partner's employer-based group medical insurance.

To change your attestation, go to SEBB My Account at **myaccount.hca.wa.gov**, or submit the *SEBB Premium Surcharge Attestation Change* form (under *Forms & publications* on the HCA website at **hca.wa.gov/sebb-employee**) to your payroll or benefits office. In most cases, you must provide proof of the qualifying event.

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

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

Good to know!

Premium surcharges and dependents

When you enroll dependents (age 13 and older) on your SEBB medical coverage, you must attest in SEBB My Account or on your enrollment form as to whether the tobacco use premium surcharge applies for each dependent you enroll.

If enrolling a spouse or state-registered domestic partner, you must attest as to whether the spouse or state-registered domestic partner coverage premium surcharge applies.

See the *SEBB Premium Surcharge Attestation Help Sheet* under *Forms & publications* on the HCA website at **hca.wa.gov/sebb-employee** for details.

Choosing your benefits

The SEBB Program and our benefit plan carriers have a variety of tools to help you choose the plans that are right for you and decide which additional benefits you may want to enroll in.

Benefits comparison charts

You'll find benefits comparison charts for health plans in this guide and on the school employee webpages at **hca.wa.gov/sebb-employee**. These charts will help you compare the costs and availability of the most widely used features of plans. See "2021 Medical benefits and premiums" on page 36; "Dental benefits comparison" on page 47; and "Vision benefits comparison" on page 49.

Certificates of coverage

The certificates of coverage (COCs), also called benefits booklets, are produced by the health plans to provide detailed information about plan benefits and what is and is not covered. You can find the COCs for all SEBB health plans on the *Medical plans and benefits* webpage at **hca.wa.gov/sebb-employee**.

Good to know!

Protect your income

Consider buying supplemental life, supplemental accidental death and dismemberment (AD&D), and supplemental long-term disability (LTD) insurance. See how on page 52 through page 57.

Summary of Benefits and Coverage

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

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

The SEBB Program and/or medical plans provide SBCs, or notice of how to get one, at different times throughout the year (like when you apply for coverage, renew your plan, or request an SBC). SBCs are available (upon request) in your preferred language.

You can get SBCs under *Medical plans and benefits* on the HCA website at **hca.wa.gov/sebb-employee,** or from the medical plans' websites. You can also call the plan's customer service or the SEBB Program at 1-800-200-1004 to request a copy at no charge. Medical plan websites and customer service phone numbers are listed at the front of this guide.

SBCs do not replace medical benefits comparisons or the plans' certificates of coverage.

Virtual benefits fair

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

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

ALEX

Our online, interactive benefits advisor, ALEX, will help you understand your benefits and guide you through choosing your medical, dental, and vision plans. ALEX will suggest plans for you to consider. Your responses to ALEX are private and confidential. Go to the ALEX webpage on the HCA website at **hca.wa.gov/alex.**

Next step

On the following pages, "Selecting a medical plan" will provide more information you need to know. Also see "Selecting a dental plan" on page 46 and "Selecting a vision plan" on page 48.

Good to know!

Medicare and SEBB

If you or any of your dependents are enrolled in Medicare or may soon be, read more about how Medicare and SEBB benefits work together on page 18.

Selecting a medical plan

When choosing your medical plan, be sure to consider how it could influence your overall care. This is especially important if you have a high-risk pregnancy, are currently undergoing treatment, have a chronic condition (such as diabetes, heart disease, depression, or cancer), or are taking a high-cost medication. If you cover eligible dependents, they must enroll in the same medical, dental, and vision plans. You should also consider plan eligibility and availability.

Eligibility. Not everyone qualifies to enroll in UMP High Deductible with a health savings account (HSA). See "UMP High Deductible with a health savings account" on page 27.

Availability. You must live or work in the medical plan's service area to join the plan. All school employees are offered a selection of plans based on their county of residence or the county where their school district, charter school, or educational service district is based. **Exception:** To enroll in a UMP Plus plan, you must live in the service area. See "2021 Medical plans available by county" on page 30. Be sure to contact the medical plans you're interested in to ask about provider availability in your county.

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

Good to know!

Only one account

SEBB medical, dental, and vision coverage is limited to a single enrollment per individual. See"What if I'm eligible for SEBB benefits both as an employee and as a dependent?" on page 12.

What types of plans are available?

The SEBB Program offers several types of medical plans.

Value-based plans. Value-based plans aim to provide high-quality care at a lower cost. Providers have committed to follow evidence-based treatment practices, coordinate care with other providers in your network, and meet specific criteria about the quality of care they provide. This means your providers are dedicated to ensuring you get the right care at the right time, which usually results in lower out-of-pocket costs for you. The plans listed to the right in bold are value-based plans.

Managed-care plans. Managed-care plans may require you to select a primary care provider within the medical plan's network to fulfill or coordinate all of your health needs. You can change providers at any time, for any reason within the contracted network. Some outpatient specialty services are available in network participating medical offices without a referral. This type of plan may not pay benefits if you see a non-contracted provider for non-emergency services. The following SEBB medical plans are managed-care plans (value-based plans are in bold).

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

Preferred provider organization (PPO) plans. PPOs allow you to self-refer to any approved provider in most cases, but usually provide a higher level of coverage if the provider contracts with the plan. The following SEBB medical plans are PPO plans (value-based plans are in bold).

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

Exclusive provider organization (EPO) plans. An EPO is a hybrid health plan in which a primary care provider referral is not required when seeking most specialty care, but health care providers must be chosen from within a predetermined network. The following is an EPO plan, as well as a value-based plan.

- **Premera PeakCare EPO**

High-deductible health plans (HDHP). An HDHP lets you use a health savings account (HSA) to help pay for

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

out-of-pocket qualified medical expenses tax-free, have a lower monthly premium than most other medical plans, a higher deductible, and a higher out-of-pocket limit. The SEBB Program has one HDHP. This is a PPO plan.

- UMP High Deductible with a health savings account (HSA), administered by Regence BlueShield

How can I compare the medical plans?

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

Medical plan differences to consider

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

Your providers. If you want to see specific providers, contact the SEBB medical plan to see who is in the plan's network before you join. Plan contact information is listed at the beginning of this guide. For links to the plans' provider searches, visit *Find a provider* on the HCA website at **hca.wa.gov/sebb-employee**.

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

Network adequacy. All health carriers in Washington State are required to maintain provider networks that provide enrollees 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.

Mental health and substance abuse treatment. Carriers must provide additional information on their websites to consumers on the ability to ensure timely access to mental health and substance abuse care. For more information, see page 29 or Engrossed Substitute House Bill 1099 (Brennen's Law) on the Washington State Legislature's website at **leg.wa.gov**.

Coordination with your other benefits. All SEBB medical plans coordinate benefit payments with other group medical plans, 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 medical plan(s) directly to ask how they will coordinate benefits. This is especially important for those coordinating benefits between the SEBB and PEBB programs, and those also enrolled in Apple Health (Medicaid).

SEBB medical, dental, and vision coverage is limited to a single enrollment per individual.

Premiums. A premium is the monthly amount the employee or employer pays to the plan to cover the cost of insurance. The premium does not cover copays, coinsurance, or deductibles. Premium amounts vary by medical plan. A higher premium doesn't necessarily mean higher quality of care or better benefits; each plan has the same basic level of benefits. 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 for all SEBB medical plans are listed on page 36.

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

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

Out-of-pocket limit. The annual out-of-pocket limit is the most you pay in a calendar year for covered benefits. Some plans have a separate out-of-pocket limit for prescription drugs. Once you have reached the out-of-pocket limit, the plan pays 100 percent of allowed charges for most covered benefits for the rest of the calendar year. Certain charges (such as your annual deductible, copays, and coinsurance) may count toward your out-of-pocket limit. Others, such as your monthly premiums, do not count toward your out-of-pocket limit. See the 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. After you join a medical plan, you may change your provider, although the rules vary by plan.

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

UMP High Deductible with a health savings account (HSA)

The SEBB Program's UMP High Deductible plan is combined with a health savings account (HSA). This type of plan generally has lower premiums with higher out-of-pocket costs than other types of medical plans.

When you enroll in UMP High Deductible, 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. For details, see *Publication 969—Health Savings Accounts and Other Tax Favored Health Plans* on the IRS website at **irs.gov.**

The HSA is administered by HealthEquity, Inc.

Who is not eligible for UMP High Deductible with an HSA?

You cannot enroll in UMP High Deductible if:

- You are enrolled in Medicare Part A or Part B or Apple Health (Medicaid).
- You are also enrolled in another health plan that is not an IRS-qualified high-deductible health plan (HDHP), unless it is limited coverage, like dental, vision, or disability coverage.
- You or your spouse or state-registered domestic partner is enrolled in a Voluntary Employee Beneficiary Association Medical Expense Plan (VEBA MEP). However, you may enroll if you convert it to limited health reimbursement account (HRA) coverage.
- You have a TRICARE plan.
- You enrolled in a Medical Flexible Spending Arrangement (FSA). This also applies if your spouse has a Medical FSA, even if you are not covering your spouse on your HDHP. It does not apply if your spouse's Medical FSA or HSA is a limited-purpose account, or a post-deductible Medical FSA. If you try to enroll in both, you will only be enrolled in the UMP High Deductible with an HSA.
- You are claimed as a dependent on someone else's tax return.

Other exclusions apply. To verify whether you qualify, check *The HealthEquity Complete HSA Guidebook* on the HealthEquity website at **learn.healthequity.com/sebb/hsa** under *Documents; IRS Publication 969—Health Savings Accounts and Other Tax-Favored Health Plans* at the IRS website at **irs.gov**; contact your tax advisor; or call HealthEquity toll-free at 1-844-351-6853 (TRS: 711).

Employer contributions

You must establish an HSA with HealthEquity to receive any employer contributions. If you are eligible, the Health Care Authority, on behalf of your employer, will contribute the following amounts to your HSA:

- $31.25 each month for an individual subscriber, up to $375 for 2021; or
- $62.50 each month for a subscriber with one or more enrolled dependents, up to $750 for 2021.

The entire annual amount is not deposited to your HSA in January. Contributions from your employer are deposited into your HSA in installments on the last day of each month.

If you qualify for the SmartHealth wellness incentive, $125 will be deposited in your HSA at the end of January the following year.

Your contributions

You can choose to contribute to your HSA in either of two ways.

- Contact your payroll or benefits office to set up pretax payroll deductions.
- Contact HealthEquity to set up direct deposits to your HSA.

The IRS has an annual limit for HSA contributions from all sources. In 2021, the limit is $3,600 (for subscriber only) and $7,200 (for you and one or more enrolled dependents). If you are age 55 or older, you may contribute an additional amount up to $1,000 annually.

To make sure you do not go beyond the limit, take into account your employer's contribution amount(s) for the year, your contributions, and the SmartHealth wellness incentive in January (if you qualify for it).

Other features of UMP High Deductible with an HSA

If you cover dependents, you must pay the entire family deductible before the plan begins paying benefits.

Your prescription drug costs count toward the annual deductible and out-of-pocket maximum.

Your HSA balance can grow over the years, earn interest, be invested, and build savings that you can use to pay for health care as needed and/or pay for Medicare Part B premiums.

Can I enroll in UMP High Deductible and Medicare Part A or Part B?

If you enroll in Medicare Part A or Part B and are enrolled in UMP High Deductible with an HSA, you should change medical plans, or you could be subject to IRS tax penalties.

The SEBB Program should receive your medical plan change request 30 days before the Medicare enrollment date, but must receive your request to change plans **no later than 60 days** after the Medicare enrollment date.

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

Yes. Enrolling in UMP High Deductible and opening an HSA mid-year may limit the amount you (or your employer) can contribute in the first year. If you have any questions about this, talk to your tax advisor.

How do I designate or update beneficiaries for my HSA?

You will designate beneficiaries when you enroll in the HSA. To review and update your HSA beneficiary information, use HealthEquity's online member portal at **learn.healthequity.com/sebb/hsa**. You can also download and print the *Beneficiary Designation Form*, or contact HealthEquity at 1-844-351-6853 to request a copy.

What happens to my HSA when I leave UMP High Deductible?

If you later choose a medical plan that is not UMP High Deductible, you won't forfeit any unspent funds in your HSA. You can spend your HSA funds on qualified medical expenses in the future. However, you, your employer, the SEBB Program, and other individuals can no longer contribute to your HSA. If you set up automatic payroll deductions to your HSA, contact your payroll office to stop them. If you set up direct deposits to your HSA, contact HealthEquity to stop them.

If you leave employment or retire, HealthEquity will charge you a monthly fee if you have less than $2,500 in your HSA after December 31. You can avoid this charge by either ensuring you have at least $2,500 in your HSA or by spending all of your HSA funds by December 31. Other fees may apply. Contact HealthEquity for details.

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. Ask your plan about wait times when considering your plan enrollment and 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 the ability to schedule 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 SEBB medical plans'certificates of coverage, which are on the *Medical plans and benefits* webpage at **hca.wa.gov/sebb-employee**.

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 "2021 Medical benefits and premiums" beginning on page 36 includes a high-level summary 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:

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

For additional support:

Refer to the HCA website at **hca.wa.gov/mental-health-crisis-lines** for county-based crisis support assistance options.

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, and/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.

2021 Medical plans available by county

All school employees are offered a selection of plans based on their county of residence or the county where their school district, charter school, or educational service district is based. Some school employees may have more plan options if they work in a district that crosses county lines (see the school districts by county list starting on page 32 for more information). Be sure to call the medical plan(s) you are interested in to ask about provider availability.

Washington

Kaiser Permanente NW 1 **Kaiser Permanente NW 2** **Kaiser Permanente NW 3**	Clark Cowlitz		
Kaiser Permanente WA Core 1 **Kaiser Permanente WA Core 2**	Benton Columbia Franklin Island King Kitsap	Kittitas Lewis Mason Pierce Skagit Snohomish	Spokane Thurston Walla Walla Whatcom Whitman Yakima
Kaiser Permanente WA Core 3	Benton Columbia Franklin Island	Kittitas Lewis Mason Skagit	Walla Walla Whatcom Whitman Yakima
Kaiser Permanente WA SoundChoice	King Kitsap	Pierce Snohomish	Spokane Thurston
	Note: Not all contracted providers in Spokane County are in the SoundChoice network. Please make sure your provider is in-network before your visit.		
Kaiser Permanente WA Access PPO 1 **Kaiser Permanente WA Access PPO 2** **Kaiser Permanente WA Access PPO 3**	Island King Kitsap Lewis	Mason Pierce Skagit Snohomish	Spokane Thurston Whatcom
Premera High PPO	Adams Asotin Benton Chelan Clallam Columbia Cowlitz Ferry Franklin Garfield	Grant King Kitsap Lewis Lincoln Mason Okanogan Pend Oreille Pierce Skagit	Skamania Spokane Stevens Thurston Wahkiakum Walla Walla Whatcom Whitman Yakima

Premera Standard PPO	Adams Asotin Benton Chelan Clallam Columbia Cowlitz Ferry Franklin Garfield Grant	Grays Harbor Jefferson King Kitsap Lewis Lincoln Mason Okanogan Pacific Pend Oreille Pierce	Skagit Skamania Snohomish Spokane Stevens Thurston Wahkiakum Walla Walla Whatcom Whitman Yakima
Premera Peak Care EPO	Pierce	Thurston	Spokane
Uniform Medical Plan (UMP) Achieve 1 UMP Achieve 2 UMP High Deductible	Available in all Washington counties and worldwide.		
UMP Plus–Puget Sound High Value Network	Chelan Douglas King	Kitsap Pierce Snohomish	Thurston Yakima
UMP Plus–UW Medicine Accountable Care Network	King Kitsap Pierce	Skagit Snohomish Spokane	Thurston

Oregon

Kaiser Permanente NW 1 Kaiser Permanente NW 2 Kaiser Permanente NW 3	Benton (ZIP Codes: 97330, 97331, 97333, 97339, 97370, 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
Uniform Medical Plan (UMP) Achieve 1 UMP Achieve 2 UMP High Deductible	Available in all Oregon counties and worldwide.		

Idaho

Uniform Medical Plan (UMP) Achieve 1 UMP Achieve 2 UMP High Deductible	Available in all Idaho counties and worldwide.

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

School districts by county

Use this chart to look up what county your school district is in. Districts with an asterisk (*) cross county lines and are listed under more than one county in the chart. Be sure to check all the counties your school district is listed in to maximize the amount of plans available to you.

Asotin			
Asotin-Anatone	Clarkston*		
Adams			
Benge	Lind	Ritzville*	
Endicott*	North Franklin*	Sprague*	
LaCrosse*	Odessa*	Warden*	
Lamont*	Othello*	Washtucna*	
Benton			
Finley	Kennewick	Paterson	Richland
Grandview*	Kiona-Benton City	Prosser*	
Chelan			
Cascade	Entiat	Manson	Stehekin
Cashmere	Lake Chelan*	Pateros*	Wenatchee
Clallam			
Cape Flattery	Port Angeles	Sequim*	
Crescent	Quillayute Valley*		
Clark			
Battle Ground	Evergreen	Mt. Pleasant*	Washougal*
Camas	Hockinson	Ridgefield	Woodland*
Green Mountain	La Center	Vancouver	
Columbia			
Dayton	Prescott*	Waitsburg*	
Pomeroy*	Starbuck		
Cowlitz			
Castle Rock*	Kelso	Toutle Lake	
Kalama	Longview	Woodland*	
Douglas			
Brewster*	Ephrata*	Orondo	
Bridgeport*	Grand Coulee Dam*	Palisades	
Coulee-Hartline*	Lake Chelan*	Quincy*	
Eastmont	Mansfield	Waterville	
Ferry			
Curlew*	Orient*		
Inchelium	Republic*		
Keller			
Kettle Falls*			

Franklin			
Kahlotus	Othello*	Star	
North Franklin*	Pasco	Washtucna*	
Garfield			
Clarkston*	Pomeroy*		
Grant			
Almira*	Moses Lake	Royal	Wilson Creek*
Coulee-Hartline*	Odessa*	Soap Lake	
Ephrata*	Othello*	Wahluke*	
Grand Coulee Dam*	Quincy*	Warden*	
Grays Harbor			
Aberdeen	Lake Quinault	North Beach	Satsop
Cosmopolis	Mary M. Knight*	North River*	Taholah
Elma*	McCleary*	Oakville*	Wishkah Valley
Hoquiam	Montesano	Ocosta*	
Island			
Coupeville	Oak Harbor	South Whidbey	Standwood-Camano*
Jefferson			
Brinnon	Port Townsend	Quilcene	Sequim*
Chimacum	Queets-Clearwater	Quillayute Valley*	
King			
Auburn*	Highline	Northshore*	Skykomish
Bellevue	Issaquah	Renton	Snoqualmie Valley
Enumclaw	Kent	Riverview	Tahoma
Federal Way	Lake Washington	Seattle	Tukwila
Fife*	Mercer Island	Shoreline	Vashon Island
Kitsap			
Bainbridge Island	Central Kitsap	North Mason*	
Bremerton	North Kitsap	South Kitsap	
Kittitas			
Cle Elum-Roslyn	Easton	Kittitas	Selah*
Damman	Ellensburg	Naches Valley*	Thorp
Klickitat			
Bickleton*	Lyle	Wishram	
Centerville	Prosser*		
Glenwood	Roosevelt		
Goldendale	Trout Lake		
Klickitat	White Salmon Valley*		

Lewis			
Adna	Eatonville*	Oakville*	White Pass
Boistfort	Evaline	Onalaska	Winlock
Castle Rock*	Morton	Pe Ell*	
Centralia*	Mossyrock	Rochester*	
Chehalis	Napavine	Toledo	
Lincoln			
Almira*	Grand Coulee Dam*	Reardan-Edwall*	Wilbur
Creston	Harrington	Ritzville*	Wilson Creek*
Davenport	Odessa*	Sprague*	
Mason			
Elma*	Mary M. Knight*	Pioneer	
Grapeview	McCleary*	Shelton	
Hood Canal	North Mason*	Southside	
Okanogan			
Brewster*	Lake Chelan*	Omak	Tonasket
Bridgeport*	Methow Valley	Oroville	
Curlew*	Nespelem	Pateros*	
Grand Coulee Dam*	Okanogan	Republic*	
Pacific			
Naselle-Grays River Valley*	Ocean Beach	Raymond	
	Ocosta*	South Bend	
North River*	Pe Ell*	Willapa Valley	
Pend Oreille			
Cusick	Loon Lake*	Riverside*	
Deer Park*	Newport*	Selkirk	
Pierce			
Auburn*	Eatonville*	Puyallup	White River
Bethel	Fife*	Steilacoom Historical	Yelm*
Carbonado	Franklin Pierce	Sumner	
Clover Park	Orting	Tacoma	
Dieringer	Peninsula	University Place	
San Juan			
Lopez Island	Orcas Island	San Juan Island	Shaw Island
Skagit			
Anacortes	Concrete*	Darrington*	Mount Vernon
Burlington-Edison	Conway	La Conner	Sedro-Woolley*
Skamania			
Mill A	Washougal*		
Mt. Pleasant*	White Salmon Valley*		
Skamania	Woodland*		
Stevenson-Carson			

Snohomish			
Arlington	Granite Falls	Marysville	Snohomish
Darrington*	Index	Monroe	Stanwood-Camano*
Edmonds	Lake Stevens	Mukilteo	Sultan
Everett	Lakewood	Northshore*	
Spokane			
Central Valley	Great Northern	Nine Mile Falls*	Spokane
Cheney*	Liberty	Orchard Prairie	St. John*
Deer Park*	Mead	Reardan-Edwall*	Tekoa*
East Valley	Medical Lake	Riverside*	West Valley
Freeman	Newport*	Rosalia*	
Stevens			
Chewelah	Evergreen	Nine Mile Falls*	Summit Valley
Columbia	Kettle Falls*	Northport	Valley
Colville	Loon Lake*	Onion Creek	Wellpinit
Deer Park*	Mary Walker	Orient*	
Thurston			
Centralia*	Olympia	Tenino	
Griffin	Rainier	Tumwater	
North Thurston	Rochester*	Yelm*	
Wahkiakum			
Naselle-Grays	River Valley*	Wahkiakum	
Walla Walla			
College Place	Dixie	Touchet	Walla Walla
Columbia	Prescott*	Waitsburg*	
Whatcom			
Bellingham	Ferndale	Mount Baker	
Blaine	Lynden	Nooksack Valley	
Concrete*	Meridian	Sedro-Woolley*	
Whitman			
Cheney*	Endicott*	Oakesdale	St. John*
Clarkston*	Garfield	Palouse	Steptoe
Colfax	LaCrosse*	Pullman	Tekoa*
Colton	Lamont*	Rosalia*	
Yakima			
Bickleton*	Mount Adams	Wahluke*	
East Valley	Naches Valley*	Wapato	
Grandview*	Selah*	West Valley	
Granger	Sunnyside	Yakima	
Highland	Toppenish	Zillah	
Mabton	Union Gap		

2021 Medical benefits and premiums

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

Annual costs (what you pay)	Monthly Premium				Medical deductible (applies to medical out-of-pocket limit)	Medical out-of-pocket limit (see separate prescription drug out-of-pocket limit for some plans)	Prescription drug deductible	Prescription drug out-of-pocket limit
	Subscriber	Subscriber & spouse[1]	Subscriber & children[2]	Subscriber, spouse[1], & children[2]				
Kaiser Foundation Health Plan of the Northwest[3]								
Kaiser Permanente NW 1	$39	$78	$68	$117	$1,250/person $2,500/family	$4,000/person $8,000/family	None	Applies to medical out-of-pocket limit
Kaiser Permanente NW 2	$52	$104	$91	$156	$750/person $1,500/family	$3,500/person $7,000/family	None	Applies to medical out-of-pocket limit
Kaiser Permanente NW 3	$119	$238	$208	$357	$125/person $250/family	$2,000/person $4,000/family	None	Applies to medical out-of-pocket limit
Kaiser Foundation Health Plan of Washington								
Kaiser Permanente WA Core 1	$16	$32	$28	$48	$1,250/person $3,750/family	$4,000/person $8,000/family	None	Applies to medical out-of-pocket limit
Kaiser Permanente WA Core 2	$21	$42	$37	$63	$750/person $2,250/family	$3,000/person $6,000/family	None	Applies to medical out-of-pocket limit
Kaiser Permanente WA Core 3	$91	$182	$159	$273	$250/person $750/family	$2,000/person $4,000/family	None	Applies to medical out-of-pocket limit
Kaiser Permanente WA SoundChoice	$51	$102	$89	$153	$125/person $375/family	$2,000/person $4,000/family	None	Applies to medical out-of-pocket limit
Kaiser Foundation Health Plan of Washington Options, Inc.								
Kaiser Permanente WA Options Access PPO 1	$66	$132	$116	$198	$1,250/person $3,750/family	$4,500/person $9,000/family	None	Applies to medical out-of-pocket limit
Kaiser Permanente WA Options Access PPO 2	$97	$194	$170	$291	$750/person $2,250/family	$3,500/person $7,000/family	None	Applies to medical out-of-pocket limit
Kaiser Permanente WA Options Access PPO 3	$146	$292	$256	$438	$250/person $750/family	$2,500/person $5,000/family	None	Applies to medical out-of-pocket limit
Premera Blue Cross								
Premera High PPO	$76	$152	$133	$228	$750/person $1,875/family	$3,500/person $7,000/family	$125/person $312/family[4]	Applies to medical out-of-pocket limit
Premera Peak Care EPO	$37	$74	$65	$111	$750/person $1,875/family	$3,500/person $7,000/family	$125/person $312/family[4]	Applies to medical out-of-pocket limit
Premera Standard PPO	$28	$56	$49	$84	$1,250/person $3,125/family	$5,000/person $10,000/family	$250/person $750/family[4]	Applies to medical out-of-pocket limit
Uniform Medical Plan (administered by Regence BlueShield)								
UMP Achieve 1	$33	$66	$58	$99	$750/person $2,250/family	$3,500/person $7,000/family	Tier 2 and specialty except covered insulins; $250 person $750/family (applies to prescription out-of-pocket limit)	$2,000/person $4,000/family
UMP Achieve 2	$98	$196	$172	$294	$250/person $750/family	$2,000/person $4,000/family	Tier 2 and specialty except covered insulins; $100/person $300/family (applies to prescription out-of-pocket limit)	$2,000/person $4,000/family
UMP High Deductible	$25	$50	$44	$75	$1,400/person $2,800/family[5]	$4,200/person $8,400/family[6]	Combined (medical and prescription) deductible	Combined (medical and prescription) out-of-pocket limit
UMP Plus (both PSHVN and UW Medicine ACN)	$68	$136	$119	$204	$125 person $375/family	$2,000/person $4,000/family	None	$2,000/person $4,000/family

1 *Or state-registered domestic partner*
2 *You pay the monthly medical premium shown regardless of how many children you enroll*
3 *Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon.*
4 *Waived for preferred generic prescription drugs*
5 *Combined medical and prescription drug deductible*
6 *Out-of-pocket expenses for a single family member are not to exceed $7,000*

Benefits (what you pay)	Ambulance (air or ground) per trip	Diagnostic tests, laboratory, and x-rays	Durable medical equipment, supplies, and prosthetics	Emergency room (copay waived if admitted)	Routine annual hearing exam	Hearing hardware (deductible waived)	Home health	Therapy: Physical, occupational, speech, and neurodevelopmental (per-office visit cost)
Kaiser Foundation Health Plan of the Northwest[1] (Diagnostic tests, lab, and x-rays not subject to deductible)								
Kaiser Permanente NW 1	20%	$30[2]	20%	20%	$40[2]	One hearing aid per ear covered in full up to the plan's allowed amount, during any consecutive 60-month period.[2]	20% for 130 days/year	$40[2] (60 combined visits/year)
Kaiser Permanente NW 2	20%	$25[2]	20%	20%	$35[2]		20% for 130 days/year	$35[2] (60 combined visits/year)
Kaiser Permanente NW 3	20%	$20[2]	20%	20%	$30[2]		20% for 130 days/year	$30[2] (60 combined visits/year)
Kaiser Foundation Health Plan of Washington								
Kaiser Permanente WA Core 1	20%	First $500 covered in full, then 20%	20% ($300 allowance/year for orthotic devices)	$150+20%	$30[2, 3]	One hearing aid per ear covered in full up to the plan's allowed amount, during any consecutive 60-month period.[2]	Covered in full for 130 days/year	$40[2] (60 combined visits/year)
Kaiser Permanente WA Core 2	20%	First $500 covered in full, then 20%	20% ($300 allowance/year for orthotic devices)	$150+20%	$25[2, 3]		Covered in full for 130 days/year	$35[2] (60 combined visits/year)
Kaiser Permanente WA Core 3	20%	20%	20% ($300 allowance/year for orthotic devices)	$150+20%	$20[2, 3]		Covered in full for 130 days/year	$30[2] (60 combined visits/year)
Kaiser Permanente WA SoundChoice	20%	15%	15% ($300 allowance/year for orthotic devices)	$150+15%	$0		Covered in full for 130 days/year	$30[2] (60 combined visits/year)
Kaiser Foundation Health Plan of Washington Options, Inc.								
Kaiser Permanente WA Options Access PPO 1	20%	First $500 covered in full, then 20%	20% ($300 allowance/year for orthotic devices)	$150+20%	$30[2, 3] ($20[2, 3, 4])	One hearing aid per ear covered in full up to the plan's allowed amount, during any consecutive 60-month period.[2]	20% for 130 days/year	$40[2] ($30[4], 60 combined visits/year)
Kaiser Permanente WA Options Access PPO 2	20%	First $500 covered in full, then 20%	20% ($300 allowance/year for orthotic devices)	$150+20%	$25[2, 3] ($15[2, 3, 4])		20% for 130 days/year	$35[2] ($25[4], 60 combined visits/year)
Kaiser Permanente WA Options Access PPO 3	20%	20%	20% ($300 allowance/year for orthotic devices)	$150+20%	$20[2, 3] ($10[2, 3, 4])		20% for 130 days/year	$30[2] ($20[4], 60 combined visits/year)
Premera Blue Cross								
Premera High PPO	25%	25%	25%	$150+25%	$0	One hearing aid per ear covered in full, up to the plan's allowed amount, once every five calendar years.[2]	25%	$40 (45 PT/ST/OT combined/year) $40 (45 NDT/year)
Premera Peak Care EPO	25%	25%	25%	$150+25%	$0		25%	$40 (45 PT/ST/OT combined/year) $40 (45 NDT/year)
Premera Standard PPO	20%	20%	20%	$150+20%	$0		20%	$40 (45 PT/ST/OT combined/year) $40 (45 NDT/year)
Uniform Medical Plan (administered by Regence BlueShield)								
UMP Achieve 1	20%	20%	20%	$75+20%	$0	One hearing aid per ear covered in full, up to the plan's allowed amount, once every five calendar years.[2]	20%	20% (80 combined visits/year)
UMP Achieve 2	20%	15%	15%	$75+15%	$0		15%	15% (80 combined visits/year)
UMP High Deductible	20%	15%	15%	15%	15%	One hearing aid per ear covered in full, once every five calendar years.	15%	15% (80 combined visits/year)
UMP Plus (both PSHVN and UW Medicine ACN)	20%	15%	15%	$75+15%	$0	One hearing aid per ear covered in full, up to the plan's allowed amount, once every five calendar years.[2]	15%	15% (60 combined visits/year)

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

[2] Not subject to deductible.

[3] Primary care copayments are waived for ages 17 and under.

[4] Enhanced benefit: Enhanced in-network cost shares apply when a member uses designated integrated providers and pharmacies (Kaiser Permanente medical centers and providers, or other designated providers as identified in the provider directory).

Benefits (what you pay)	Inpatient services (hospitals, residential treatment centers, psychiatric hospitals, etc.)	Outpatient services (hospital affiliated clinics, outpatient facilities, freestanding clinics, etc.)	Office visit: Primary care	Office visit: Urgent care	Office visit: Specialist	Office visit: Mental health (independent provider offices, medical groups, freestanding clinics, etc.)	Virtual care or telemedicine Care received from a licensed physician without an in-person visit	Chiropractic	Acupuncture	Massage therapy
Kaiser Foundation Health Plan of the Northwest[1]										
Kaiser Permanente NW 1	20%	20%	$30[2, 3]	$50[2]	$40[2]	$30[2, 3]	$0[2]	$40[2] No limit	$40[2] 20 visits/year	$25[2] 20 visits/year
Kaiser Permanente NW 2	20%	20%	$25[2, 3]	$45[2]	$35[2]	$25[2, 3]	$0[2]	$35[2] No limit	$35[2] 20 visits/year	$25[2] 20 visits/year
Kaiser Permanente NW 3	20%	20%	$20[2, 3]	$40[2]	$30[2]	$20[2, 3]	$0[2]	$30[2] No limit	$30[2] 20 visits/year	$25[2] 20 visits/year
Kaiser Foundation Health Plan of Washington										
Kaiser Permanente WA Core 1	20%	20%	$30[2, 3]	$30[2]	$40[2]	$30[2, 3]	$0[2]	$30[2, 3] 20 visits/year	$30[2, 3] 20 visits/year	$40[2] 20 visits/year
Kaiser Permanente WA Core 2	20%	20%	$25[2, 3]	$25[2]	$35[2]	$25[2, 3]	$0[2]	$25[2, 3] 20 visits/year	$25[2, 3] 20 visits/year	$35[2] 20 visits/year
Kaiser Permanente WA Core 3	20%	20%	$20[2, 3]	$20[2]	$30[2]	$20[2, 3]	$0[2]	$20[2, 3] 20 visits/year	$20[2, 3] 20 visits/year	$30[2] 20 visits/year
Kaiser Permanente WA SoundChoice	15%	15%	$0[2]	$30[2]	$30[2]	$0[2]	$0[2]	$0[2] 20 visits/year	$0 20 visits/year	$30[2] 20 visits/year
Kaiser Foundation Health Plan of Washington Options, Inc.										
Kaiser Permanente WA Options Access PPO 1	20%	20%	$30[2, 3] ($20 [2, 3, 4])	$30[2, 3] ($20 [2, 3, 4])	$40[2] ($30[2, 4])	$30[2, 3] ($20 [2, 3, 4])	$0[2]	$30[2, 3] 20 visits/year	$30[2, 3] 20 visits/year	$40[2] 20 visits/year
Kaiser Permanente WA Options Access PPO 2	20%	20%	$25[2, 3] ($15 [2, 3, 4])	$25[2, 3] ($15 [2, 3, 4])	$35[2] ($25[2, 4])	$25[2, 3] ($15 [2, 3, 4])	$0[2]	$25[2, 3] 20 visits/year	$25[2, 3] 20 visits/year	$35[2] 20 visits/year
Kaiser Permanente WA Options Access PPO 3	20%	20%	$20[2, 3] ($10 [2, 3, 4])	$20[2, 3] ($10 [2, 3, 4])	$30[2] ($20[2, 4])	$20[2, 3] ($10 [2, 3, 4])	$0[2]	$20[2, 3] 20 visits/year	$20[2, 3] 20 visits/year	$30[2] 20 visits/year
Premera Blue Cross										
Premera High PPO	25%	25%	$20[2]	25%	$40[2]	$20[2]	Varies, see COC	25% 12 visits/year	25% 12 visits/year	25% 12 visits/year
Premera Peak Care EPO	25%	25%	$20[2]	25%	$40[2]	$20[2]	Varies, see COC	25% 12 visits/year	25% 12 visits/year	25% 12 visits/year
Premera Standard PPO	20%	20%	$20[2]	20%	$40[2]	$20[2]	Varies, see COC	20% 12 visits/year	20% 12 visits/year	20% 12 visits/year
Uniform Medical Plan (administered by Regence BlueShield)										
UMP Achieve 1	$200/day up to $600 for facility + 20% for professional services	20%	20%	20%	20%	20%	Varies, see COC	20% 16 visits/year	20% 16 visits/year	20% 16 visits/year
UMP Achieve 2	$200/day up to $600 for facility + 15% for professional services	15%	15%	15%	15%	15%	Varies, see COC	15% 16 visits/year	15% 16 visits/year	15% 16 visits/year
UMP High Deductible	15% professional services	15%	15%	15%	15%	15%	Varies, see COC	15% 16 visits/year	15% 16 visits/year	15% 16 visits/year
UMP Plus (both PSHVN and UW Medicine ACN)	$200/day up to $600 for facility + 15% for professional services	15%	$0; 15% for other services such as lab and x-rays	15%	15%	15%	Varies, see COC	15% 10 visits/year	15% 16 visits/year	15% 16 visits/year

[1] *Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon.*
[2] *Not subject to deductible.*
[3] *Primary care copayments are waived for ages 17 and under.*
[4] *Enhanced benefit: Enhanced in-network cost shares apply when a member uses designated integrated providers and pharmacies (Kaiser Permanente Medical Centers and providers, or other designated providers as identified in the provider directory).*

Benefits (what you pay) Prescription drugs: Retail pharmacy (up to a 30-day supply)	Value Tier (specific high-value prescription drugs used to treat certain chronic conditions)	Tier 1 (primarily low-cost generic drugs)	Tier 2 (preferred brand-name drugs, high-cost generic drugs, and specialty drugs for UMP)	Tier 3 (nonpreferred brand-name drugs and nonpreferred generic drugs[1])	Tier 4 (specialty and certain high cost generic drugs)
Kaiser Foundation Health Plan of the Northwest[2]					
Kaiser Permanente NW 1	N/A	$20[3]	$40[3]	50% up to $100[3]	50% up to $150[3]
Kaiser Permanente NW 2	N/A	$15[3]	$30[3]	50% up to $100[3]	50% up to $150[3]
Kaiser Permanente NW 3	$5	$10[3]	$20[3]	50% up to $100[3]	50% up to $150[3]
Kaiser Foundation Health Plan of Washington					
Kaiser Permanente WA Core 1	N/A	$5[3]	$25[3]	$50[3]	50% up to $150[3]
Kaiser Permanente WA Core 2	N/A	$10[3]	$25[3]	$50[3]	50% up to $150[3]
Kaiser Permanente WA Core 3	N/A	$10[3]	$25[3]	$50[3]	50% up to $150[3]
Kaiser Permanente WA SoundChoice	N/A	$10[3]	$25[3]	$50[3]	50% up to $150[3]
Kaiser Foundation Health Plan of Washington Options, Inc.					
Kaiser Permanente WA Options Access PPO 1	N/A	$10[3] ($5[3, 4])	$50[3] ($40[3, 4])	50% up to $125[3]	50% up to $150[3]
Kaiser Permanente WA Options Access PPO 2	N/A	$10[3] ($5[3, 4])	$50[3] ($40[3, 4])	50% up to $125[3]	50% up to $150[3]
Kaiser Permanente WA Options Access PPO 3	N/A	$10[3] ($5[3, 4])	$50[3] ($40[3, 4])	50% up to $125[3]	50% up to $150[3]
Premera Blue Cross					
Premera High PPO	N/A	$7[3]	$30	30%	See mail order benefit on next page.
Premera Peak Care EPO	N/A	$7[3]	$30	30%	See mail order benefit on next page.
Premera Standard PPO	N/A	$7[3]	30%	50%	See mail order benefit on next page.
Uniform Medical Plan (prescription drugs administered by Washington State Rx Services)					
UMP Achieve 1	5% up to $10	10% up to $25	30% up to $75 after deductible	N/A	N/A
UMP Achieve 2	5% up to $10	10% up to $25	30% up to $75 after deductible	N/A	N/A
UMP High Deductible	15% after combined (medical and prescription) deductible	15% after combined (medical and prescription) deductible	15% after combined (medical and prescription) deductible	N/A	N/A
UMP Plus (both PSHVN and UW Medicine ACN)	5% up to $10	10% up to $25	30% up to $75	N/A	N/A

[1] Includes nonpreferred generic drugs for Kaiser Permanente WA, Kaiser Permanente WA Options, and Premera plans.
[2] Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon.
[3] Not subject to deductible.
[4] Enhanced benefit: Enhanced in-network cost shares apply when a member uses designated integrated providers and pharmacies (Kaiser Permanente Medical Centers and providers, or other designated providers as identified in the provider directory).

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

Benefits (what you pay) Prescription drugs: Mail order (up to a 90-day supply)	Value Tier (specific high-value prescription drugs used to treat certain chronic conditions)	Tier 1 (primarily low-cost generic drugs)	Tier 2 (preferred brand-name drugs)	Tier 3 (nonpreferred brand-name drugs and nonpreferred generic drugs[1])	Tier 4 (Specialty)
Kaiser Foundation Health Plan of the Northwest[2]					
Kaiser Permanente NW 1	N/A	$40[3]	$80[3]	50% up to $200[3]	N/A
Kaiser Permanente NW 2	N/A	$30[3]	$60[3]	50% up to $200[3]	N/A
Kaiser Permanente NW 3	N/A	$20[3]	$40[3]	50% up to $200[3]	N/A
Kaiser Foundation Health Plan of Washington					
Kaiser Permanente WA Core 1	N/A	$10[3]	$50[3]	$100[3]	N/A
Kaiser Permanente WA Core 2	N/A	$20[3]	$50[3]	$100[3]	N/A
Kaiser Permanente WA Core 3	N/A	$20[3]	$50[3]	$100[3]	N/A
Kaiser Permanente WA SoundChoice	N/A	$20[3]	$50[3]	$100[3]	N/A
Kaiser Foundation Health Plan of Washington Options, Inc.					
Kaiser Permanente WA Options Access PPO 1	N/A	$10[3]	$80[3]	50% up to $250[3]	N/A
Kaiser Permanente WA Options Access PPO 2	N/A	$10[3]	$80[3]	50% up to $250[3]	N/A
Kaiser Permanente WA Options Access PPO 3	N/A	$10[3]	$80[3]	50% up to $250[3]	N/A
Premera Blue Cross					
Premera High PPO	N/A	$14[3]	$60	30%	$50 for a 30-day supply
Premera Peak Care EPO	N/A	$14[3]	$60	30%	$50 for a 30-day supply
Premera Standard PPO	N/A	$14[3]	30%	50%	40% for a 30-day supply
Uniform Medical Plan (prescription drugs administered by Washington State Rx Services)					
UMP Achieve 1	5% up to $30	10% up to $75	30% up to $225	N/A	N/A
UMP Achieve 2	5% up to $30	10% up to $75	30% up to $225	N/A	N/A
UMP High Deductible	15% after combined (medical and prescription) deductible	15% after combined (medical and prescription) deductible	15% after combined (medical and prescription) deductible	N/A	N/A
UMP Plus (both PSHVN and UW Medicine ACN)	5% up to $30	10% up to $75	30% up to $225	N/A	N/A

1 Includes nonpreferred generic drugs for Kaiser Permanente WA, Kaiser Permanente WA Options, and Premera plans.
2 Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon.
3 Not subject to deductible.

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

Selecting a dental plan

If you are eligible for SEBB Program benefits, dental coverage is included for you and your eligible dependents; your employer pays the premium. You and any enrolled dependents must enroll in the same SEBB dental plan. If you do not select a dental plan, you will be automatically enrolled in Uniform Dental Plan.

There are three SEBB Program dental plans to choose from — two managed care plans and one preferred-provider plan. Make sure you check with the plan to see if the dental provider you want is in the plan's network. The "Dental benefits comparison" begins on the next page.

Check with the plan to see if your provider is in the plan's network

Make sure you correctly identify your dental plan's network and group number (see table below). This is especially important because DeltaCare and UDP are both administered by Delta Dental of Washington and are sometimes confused. You can call the dental plan's customer service number (listed in the beginning of this guide), or use the dental plan network's online directory. Carefully review your selection before enrolling.

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 dental provider in that plan's network. If you seek services from a dental provider 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).

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

Willamette Dental Group is underwritten by Willamette Dental of Washington, Inc. Its network is Willamette Dental Group, P.C., with dental offices in Washington, Oregon, and Idaho. Willamette Dental Group administers its own dental network (WA733).

How does the Uniform Dental Plan (UDP) work?

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

When you see a network preferred provider, your out-of-pocket expenses are generally lower than if you chose a provider who is not part of this network. Under UDP, you pay a percentage of the plan's allowed amount (coinsurance) for dental services after you have met the annual deductible.

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

UDP is administered by Delta Dental of Washington. Its network is Delta Dental PPO (Group 9600).

Dental plan options

Make sure you confirm with your dental provider that they accept the specific plan network and plan group.

Plan name	Plan type	Plan administrator	Plan network	Plan group number
DeltaCare	Managed-care plan	Delta Dental of Washington	DeltaCare	Group 09601
Uniform Dental Plan (UDP)	Preferred-provider plan	Delta Dental of Washington	Delta Dental PPO	Group 09600
Willamette Dental Group Plan	Managed-care plan	Willamette Dental of Washington, Inc.	Willamette Dental Group, P.C.	WA733

Dental benefits comparison

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

Annual costs	Uniform Dental Plan[1] (Group 09600 Delta Dental PPO)	DeltaCare[2] (Group 09601)	Willamette Dental Group[2] (Group WA733)
Deductible	You pay $50/person up to $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 09600 Delta Dental PPO)	DeltaCare[2] (Group 09601)	Willamette Dental Group[2] (Group WA733)
	You pay after deductible:	**You pay:**	**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	Any amount over $1,000 per year and $5,000 in member's lifetime
Oral surgery	20% PPO and out of state; 30% non-PPO	$10 to $50 to extract erupted teeth	$10 to $50 to extract erupted teeth
Orthodontia	50% of costs until the plan has paid a maximum of $1,750 for member's lifetime (separate from the annual maximum of $1,750)	Up to $1,500 copay per case	Up to $1,500 copay per case
Orthognathic surgery	30% of costs until plan has paid $5,000 for PPO, out of state, or non-PPO; then any amount over $5,000 in member's lifetime	30% of the lesser of the maximum allowable or the fees actually charged; then any amount over $5,000 in member's lifetime	30%, then any amount over $5,000 in member's lifetime
Periodontic services (treatment of gum disease)	20% PPO and out of state; 30% non-PPO	$15 to $100	$15 to $100
Preventive/diagnostic (deductible doesn't apply)	$0 PPO; 10% out of state; 20% non-PPO	$0	$0
Restorative fillings	20% PPO and out of state; 30% non-PPO	$10 to $50	$10 to $50
Restorative crowns	50% PPO and out of state; 60% non-PPO	$100 to $175	$100 to $175

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

Selecting a vision plan

If you are eligible for SEBB Program benefits, vision coverage is included for you and your eligible dependents; your employer pays the premium. If you do not select a vision plan, you will be automatically enrolled in MetLife Vision.

You and any enrolled dependents must enroll in the same SEBB vision plan. See "Vision benefits comparison" starting on the next page or the plans' certificates of coverage for details.

Before you select a vision plan, check with the plan to see if the vision provider you want is in the plan's network. You can call the vision plan's customer service number (listed in the beginning of this guide), or use the vision plan network's online directory.

Vision plan options

There are three SEBB Program vision plans to choose from.

- Davis Vision, underwritten by HM Life Insurance Company
- EyeMed Vision Care, underwritten by Fidelity Security Life Insurance Company
- MetLife Vision, underwritten by Metropolitan Life Insurance Company

Vision benefits comparison

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

Adults (19 and older) — what you pay for in-network services

Vision care service	Davis Vision[1]	EyeMed[2]	MetLife
Routine eye exam (once per calendar year, starting January 1)	$0 copay ($40)	$0 copay ($84)	$0 copay ($45)
Frames (once every 24 months starting January 1 in even years)	$0 copay up to $150, then 80% of balance over $150; or $0 at Visionworks; or $0 for any of the Exclusive Frame Collection ($50)	$0 copay up to $150, then 80% of balance over $150 ($75)	$0 copay up to $150, then 80% of balance over $150; or $85 allowance at Costco, Walmart, and Sam's Club ($70)
Lenses (once every 24 months starting January 1 in even years)	$0 copay (Single, $40; bifocal, $60; trifocal, $80; lenticular, $100)	$0 copay (Single, $25; bifocal, $40; trifocal, $55; lenticular, $55)	$0 copay (Single, $30; bifocal, $50; trifocal, $65; lenticular, $100)
Progressive lenses (renews every January 1 in even years)	$50–$175 copay ($60)	$55–$175 copay ($55)	$0–$175 copay ($50)

Lens enhancements	Davis Vision[1]	EyeMed[2]	MetLife
Anti-reflective coating	$35–$85[3] copay	$45–$85 copay ($5)	$41–$85[4] copay
Scratch-resistant	$0[3] copay	$0 copay ($5)	$17–$33[4] copay
Polycarbonate	$30[3] copay	$40[3] copay	$31–$35[4] copay
Photochromic/transitions	$65[3] copay	$75[3] copay	$47–$82[4] copay
Polarized	$75[3] copay	80% of retail price[3]	80% of retail price[4]
Tinting	$0[3] copay	$15[3] copay	$17–$44[4] copay
UV treatment	$12[3] copay	$15[3] copay	$0[4] copay

1 *Underwritten by HM Life Insurance Company, Pittsburgh.*
2 *Underwritten by Fidelity Security Life Insurance Company (FSL).*
3 *No out-of-network lens enhancement reimbursement is available.*
4 *Reimbursement for out-of-network lens enhancements is applied to the out-of-network reimbursement amount for each lens (single, $30; bifocal, $50; trifocal, $65; lenticular, $100; progressive, $50).*

continued

Contact lenses (in lieu of glasses)	Davis Vision[1]	EyeMed[2]	MetLife
Conventional[3]	$0 copay up to $150, then 85% of balance over $150; or four boxes from Collection lenses ($105)	$0 copay up to $150, then 85% of balance over $150 ($150)	$0 copay up to $150, then 100% of balance over $150 ($105)
Disposable[3]	$0 copay up to $150, then 85% of balance over $150; or eight boxes from Collection lenses ($105)	$0 copay up to $150, then 100% of balance over $150 ($150)	$0 copay up to $150, then 100% of balance over $150 ($105)
Medically necessary	$0 copay ($225)	$0 copay ($300)	$0 copay ($210)

Additional member savings	Davis Vision[1]	EyeMed[2]	MetLife
Additional glasses	30% off	Up to 40% off	20% off
LASIK surgery	40–50% off national average	15% off retail price; or, 5% off a promotional offer	15% off retail price; or, 5% off a promotional offer

1 *Underwritten by HM Life Insurance Company, Pittsburgh.*
2 *Underwritten by Fidelity Security Life Insurance Company (FSL).*
3 *Conventional contact lenses, with proper care and cleaning, can be used for longer periods of time (from one month to up to one year). Disposable contact lenses are single-use lenses and are removed and discarded after a determined period of time, typically at the end of each day or week.*

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

Vision care service (once per calendar year)	Davis Vision[1]	EyeMed[2]	MetLife
Routine eye exam	$0 copay	$0 copay	$0 copay
Frames	$0 copay up to $150, then 80% of balance above $150; or $0 at Visionworks; or $0 for any of the Exclusive Frame Collection ($50)	$0 copay up to $150, then 80% of balance above $150	$0 copay up to $150, then 80% of balance above $150
Lenses	$0 copay	$0 copay	$0 copay
Progressive lenses	$50–$175 copay	$0–$175 copay	$0–$175 copay

Lens enhancements	Davis Vision[1]	EyeMed[2]	MetLife
Anti-reflective coating	$35–$85 copay	$45–$85 copay	$41–$85 copay
Scratch-resistant	$0 copay	$0 copay	$0 copay
Polycarbonate	$0 copay	$0 copay	$0 copay
Photochromic/transitions	$65 copay	$75 copay	$47–$82 copay
Polarized	$0 copay	$0 copay	$0 copay
Tinting	$0 copay	$15 copay	$17–$44 copay
UV treatment	$0 copay	$15 copay	$0 copay

Contact lenses (in lieu of glasses)	Davis Vision[1]	EyeMed[2]	MetLife
Conventional[3]	$0 copay up to $300, then 85% of balance over $300; or 4 boxes from Collection lenses ($105)	Any amount over $300	Any amount over $300
Disposable[3]	$0 copay up to $300, then 85% of balance over $300; or 8 boxes from Collection lenses ($105)	Any amount over $300	Any amount over $300
Medically necessary	$0 copay	Any amount over $300	$0 copay

Additional member savings	Davis Vision[1]	EyeMed[2]	MetLife
Additional glasses	30% off	Up to 40% off	20% off
LASIK surgery	40–50% off national average	15% off retail price; or, 5% off a promotional offer	15% off retail price; or, 5% off a promotional offer

1 *Underwritten by HM Life Insurance Company, Pittsburgh.*
2 *Underwritten by Fidelity Security Life Insurance Company (FSL).*
3 *Conventional contact lenses, with proper care and cleaning, can be used for longer periods of time (from one month to up to one year). Disposable contact lenses are single-use lenses and are removed and discarded after a determined period of time, typically at the end of each day or week.*

Life and AD&D insurance

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

You can enroll in supplemental life insurance and supplemental AD&D insurance for yourself and your eligible dependents.

These benefits are not available to employees whose eligibility was locally negotiated under Washington Administrative Code (WAC) 182-30-130 (see "Subscriber eligibility" on page 11).

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

What is (employer-paid) basic life insurance?

As an employee, you are automatically enrolled in basic life insurance, which covers you and pays your designated beneficiaries in the event of your death. This benefit is paid for by your employer, and you do not have to provide evidence of insurability (proof of good health).

Basic life insurance coverage is $35,000 for death from any cause.

What is (employee-paid) supplemental life insurance?

The following are the kinds of supplemental life insurance you can buy.

Supplemental life insurance for employees

You may enroll in supplemental life insurance for yourself in increments of $10,000 up to $1,000,000. You can enroll up to $500,000 of coverage without evidence of insurability if elected **no later than 31 days** after becoming eligible for the employer contribution toward SEBB benefits. Evidence of insurability is always required for coverage above $500,000, up to the maximum of $1,000,000.

Supplemental life insurance for spouse or state-registered domestic partner

If you are enrolled in supplemental life insurance, you may enroll in supplemental life insurance for your spouse or state-registered domestic partner in increments of $5,000 up to $500,000, not to exceed one-half the supplemental amount you get for yourself as an employee. You can enroll in up to $100,000 of coverage without evidence of insurability if elected **no later than 31 days** after becoming eligible for the employer contribution toward SEBB benefits. Evidence of insurability is always required for coverage above $100,000, up to the maximum of $500,000.

Supplemental life insurance for children

If you enroll in supplemental life insurance for yourself, you may enroll in coverage for your children in $5,000 increments up to $20,000 without evidence of insurability if elected **no later than 31 days** after becoming eligible for the employer contribution towards SEBB benefits. One premium covers all your enrolled children. Evidence of insurability is not required for children when enrolled within the 31-day window of eligibility. Any increases in coverage or late enrollment require evidence of insurability.

Evidence of insurability

MetLife must approve your evidence of insurability if you apply for:

- Any amount of supplemental life Insurance for yourself, spouse, or state-registered domestic partner, or children **after 31 days** from becoming eligible for SEBB benefits.
- More than $500,000 in supplemental life insurance **within 31 days** of becoming eligible for PEBB benefits .
- More than $100,000 in supplemental spouse or state-registered domestic partner life insurance **within 31 days** of becoming eligible for SEBB benefits.

What does supplemental life insurance cost?

The table on the next page shows the monthly cost per $1,000 of coverage, based on your (the employee's) age as of December 31, 2020, and tobacco use by the insured person.

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

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

Good to know!

Example of supplemental life insurance

To cover yourself, the monthly rate at age 40 to 44 for a non-tobacco user is $0.088 per $1,000 coverage. For $10,000 of supplemental life insurance coverage, the monthly cost is $0.88.

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

When can I enroll in supplemental life insurance?

You may enroll in life insurance or dependent life insurance at any time. The guaranteed issue amounts are available for supplemental life insurance and dependent life insurance (without submitting evidence of insurability) when your enrollment is no later than:

- **31 days** after the date you become eligible for SEBB benefits.
- **60 days** after the date of marriage or registering a state-registered domestic partnership.
- **60 days** after the birth or adoption of a child. A newly born child must be at least 14 days old before supplemental dependent life insurance coverage is effective.

Once you have enrolled one child in child dependent life insurance, each succeeding child will automatically be covered for the same amount on the date that child becomes eligible as defined in MetLife's certificate of coverage. If you apply for or change your employee or spouse or state-registered domestic partner supplemental life insurance coverage after the deadline, you must provide evidence of insurability to MetLife for approval, regardless of the coverage amount requested.

Requests submitted within the above deadlines for coverage over the guaranteed issue amount will require evidence of insurability only for the amount over the guaranteed issue. If the additional amount is denied, the employee or family member will be enrolled in the guaranteed issue amount.

How do I enroll in supplemental life insurance?

Enroll online using MetLife's MyBenefits portal at **mybenefits.metlife.com/wasebb**. If you have any questions about enrollment or need a paper form, please contact MetLife at 1-833-854-9624.

How do I create an online account with MetLife?

1. Visit MetLife's MyBenefits portal at **mybenefits.metlife.com/wasebb**. A *Welcome to MyBenefits* screen will appear.
2. You should see *WA State Health Care Authority SEBB* in the *Account Sign-in* box.
3. Select the *Register now* button.
4. Complete the registration form and verification process.
5. Select *Go to Accounts* in the registration confirmation pop-up.

If you have questions regarding enrollment or the MetLife website, or need paper forms, please contact MetLife at 1-833-854-9624, Monday through Friday, 5 a.m. to 8 p.m. Pacific Time (except for major holidays).

How do I designate beneficiaries for my life insurance?

You must name a beneficiary for your life insurance. To name or update beneficiaries for life insurance, use MetLife's MyBenefits portal at **mybenefits.metlife.com/wasebb**. You can also call MetLife at 1-833-854-9624 to request a *Group Term Life Insurance Beneficiary Designation* form or download

the form under *Forms & publications* on HCA's website **hca.wa.gov/sebb-employee**.

Can I waive life and AD&D insurance?

If you are eligible for SEBB benefits, you cannot waive basic life and AD&D insurance. However, you have two options if you object to this coverage:

- You can name a charity as your beneficiary.
- On your enrollment form, you can leave the beneficiary information blank. Tell your family and anyone who might be handling your estate not to file a claim on your death. If you choose not to identify a beneficiary, the benefit amount will be turned over to the state as abandoned property.

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

If you're eligible for portability or conversion due to termination or other reasons, MetLife will send you information and an application. When porting or converting your employee life insurance coverage, your coverage will become an individual policy that is not tied to the SEBB Program.

Portability Provision

Under the Portability Provision you can apply to continue all or part of your employee basic life, supplemental life, and dependent life insurance. You must be actively enrolled and apply **within 60 days** from when your coverage ended to have the opportunity to continue your coverage through portability.

Dependent child and spouse or state-registered domestic partner life insurance may be continued even if you choose not to continue your life insurance.

To continue life insurance under the Portability Provision, you must apply to MetLife **within 60 days** after the date your SEBB Program employee life insurance ends, including when you move to PEBB retiree term life insurance. Any amount of life insurance not ported may be converted.

Conversion Provision

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

You have **60 days** to apply for conversion coverage after your employee life insurance ends.

Is there an accelerated benefit in SEBB Program life insurance coverage?

Yes, our basic and supplemental life insurance plans have an accelerated benefits option. If a subscriber becomes terminally ill and is expected to die within 24 months, they can request to receive a portion of their life insurance benefit before their death.

Subscribers may receive up to 80 percent of their basic life benefit amount, not to exceed $28,000.

Subscribers may receive up to 80 percent of their combined basic life and supplemental life benefit amount, not to exceed $500,000.

This option is also available for spouse or state-registered domestic partner dependent life insurance.

What is (employer-paid) basic AD&D insurance?

You will be automatically enrolled in basic accidental death and dismemberment (AD&D) insurance, which provides benefits for certain injuries or death resulting from a covered accident. This benefit is paid for by your employer.

Basic AD&D coverage is $5000).

What is (employee-paid) supplemental AD&D insurance?

The following are types of supplemental AD&D insurance you can buy.

Supplemental AD&D insurance for employees

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

Supplemental AD&D insurance for your spouse or state-registered domestic partner

If you enroll in supplemental AD&D insurance for yourself, you can choose to cover your spouse or state-registered domestic partner with AD&D coverage in increments of $10,000 up to $250,000. Evidence of insurability is not required.

Supplemental AD&D insurance for children

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

What does supplemental AD&D insurance cost?

The table below shows the monthly cost per $1,000 of coverage.

Supplemental AD&D insurance monthly rates

	Monthly cost per $1,000
Employee	$0.019
Spouse or state-registered domestic partner	$0.019
All dependent children	$0.016

Good to know!

Example of supplemental AD&D insurance

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

$10,000 coverage:	10
Monthly rate:	x 0.019
Monthly cost:	$ 0.19

When can I enroll in supplemental AD&D insurance?

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

How do I enroll in supplemental AD&D insurance?

Enroll online using MetLife's MyBenefits portal at **mybenefits.metlife.com/wasebb**. If you have any questions about enrollment or need to request a form, please contact MetLife at 1-833-854-9624.

How do I designate beneficiaries for my AD&D insurance?

To name or update beneficiaries for AD&D insurance, use MetLife's MyBenefits portal at **mybenefits.metlife.com/wasebb**. You can also call MetLife at 1-833-854-9624 to request a *Group Term Life Insurance Beneficiary Designation* form or download the form under *Forms & publications* on HCA's website at **hca.wa.gov/sebb-employee**.

Long-term disability insurance

Long-term disability (LTD) insurance protects a portion of your salary if you are unable to work due to serious injury or illness. When you enroll in LTD coverage, it pays a percentage of your monthly earnings to you if you become disabled.

The SEBB Program offers basic (employer-paid) LTD insurance at no cost to school employees who are eligible for the employer contribution toward SEBB benefits. If eligible, you will automatically be enrolled in basic LTD insurance coverage, even if you waive SEBB medical coverage. You may also enroll in (employee-paid) supplemental LTD insurance. **Exception:** Basic and supplemental LTD insurance are not available to employees whose eligibility was locally negotiated under WAC 182-30-130 (see "Subscriber eligibility" on page 11).

These benefits are provided through Standard Insurance Company. The information below is a summary. If anything conflicts with the LTD plan booklet, the LTD plan booklet takes precedence and prevails. To see the LTD plan booklet or to get a form, go to the *LTD* webpage on HCA's website at **hca.wa.gov/sebb-ltd** or contact your payroll or benefits office.

What is (employer-paid) basic LTD insurance?

The SEBB Program's basic LTD insurance provides you with a monthly payment ranging between $100 a month and $400 a month in the event of a disability. The amount you receive is based on 60 percent of the first $667 of your predisability earnings, reduced by any deductible income. It will not exceed $400 a month. You may want to consider paying for supplemental LTD insurance if you would like to protect more of your income.

Waiting period before benefits become payable for basic and supplemental LTD

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

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

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

What is (employee-paid) supplemental LTD insurance?

If you are eligible for basic LTD, you may buy supplemental LTD to ensure that you protect more of your income in the event you become disabled and cannot work.

Supplemental LTD provides you with a monthly payment ranging between $100 a month and $10,000 a month in the event of a disability. The amount you receive is based on 60 percent of the first $16,667 of your insured earnings, reduced by any deductible income.

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

What does supplemental LTD insurance cost?

Your monthly supplemental LTD premium is based on your age and your insured earnings (your monthly gross pay before you became disabled). To calculate your premium, multiply your monthly base pay (up to $16,667) by the appropriate age-banded rate (your age on January 1, 2021) shown in the table below.

Supplemental LTD rates based on your age on January 1, 2021

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

Good to know!

Example of supplemental LTD insurance

If your monthly earnings are $1,000, the 40 to 44 age rate is $4.10 per month.

Earnings:	$1,000 per month
40–44 age rate:	x 0.0041
Monthly cost:	$4.10

When can I enroll in supplemental LTD insurance?

You may enroll in supplemental LTD coverage **no later than 31 days** after becoming eligible for SEBB benefits without providing evidence of insurability.

If you apply for supplemental LTD coverage **after 31 days**, you must provide evidence of insurability. Your *SEBB Long Term Disability (LTD) Evidence of Insurability* form must be approved by Standard Insurance Company before your insurance becomes effective.

How do I enroll in supplemental LTD insurance?

If you are newly eligible and **within 31 days** of becoming eligible for SEBB Program benefits, you can enroll online using SEBB My Account or by submitting the *SEBB Long-term Disability Enrollment/Change* form to your payroll or benefits office.

If you apply for supplemental LTD coverage **after 31 days**, submit the *SEBB Long-term Disability Enrollment/Change* form to your employer's payroll or benefits office. You must also complete the *SEBB Long Term Disability (LTD) Evidence of Insurability* form and submit it to Standard Insurance Company.

For questions about enrollment, contact your payroll or benefits office. If you have a specific question about a claim, contact Standard Insurance Company at 1-833-229-4177.

Terms and conditions apply

LTD insurance has limitations, including a 12-month exclusion period and a preexisting condition exclusion. Please read your certificate of coverage carefully to understand this benefit.

What is considered a disability?

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

After the first 24 months, disability as a result of sickness, injury, or pregnancy means being unable to perform with reasonable continuity the material duties of any gainful occupation for which you are reasonably able through education, training, or experience. During this period, you are considered partially disabled if you are working but unable to earn more than 60 percent of your indexed predisability earnings in that occupation and in all other occupations for which you are reasonably suited.

What is the maximum benefit period?

For both basic and supplemental LTD insurance, the "maximum benefit period" means the benefit duration, which is based on your age when the disability begins.

Age	Maximum benefit period
61 or younger	To age 65, or to SSNRA[1] or 42 months, whichever is longer
62	To SSNRA* or 42 months, whichever is longer
63	To SSNRA* or 36 months, whichever is longer
64	To SSNRA* or 30 months, whichever is longer
65	24 months
66	21 months
67	18 months
68	15 months
69 or older	12 months

1 *SSNRA is your Social Security normal retirement age*

Medical FSA and DCAP

Both the Medical Flexible Spending Arrangement (FSA) and Dependent Care Assistance Program (DCAP) are available to school employees eligible for SEBB benefits. These benefits are not available to employees whose eligibility was locally negotiated under WAC 182-30-130 (see "Subscriber eligibility" on page 11).

The Medical FSA and DCAP are administered by Navia Benefit Solutions, Inc. For full details, visit the Navia website at **sebb.naviabenefits.com** or call 1-800-669-3539. Email questions to **customerservice@naviabenefits.com**.

What is a Medical Flexible Spending Arrangement (FSA)?

A Medical FSA allows you to set aside money from your paycheck on a pretax basis to pay for qualifying out-of-pocket health care costs for you and your qualified tax dependents. You can set aside as little as $240 or as much as $2,750 per calendar year.

You cannot enroll in both a Medical FSA and UMP High Deductible with a health savings account (HSA). If you try to enroll in both, you will be enrolled only in UMP High Deductible with an HSA.

How does the Medical FSA work?

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

To figure out how much you may want to contribute, estimate your out-of-pocket health care expenses for the calendar year and enroll in a Medical FSA for that amount. The more accurate you are in estimating your expenses, the better this benefit will work for you. The full amount you elect to set aside for your Medical FSA is available on the first day your benefits become effective.

The amount you set as your annual election cannot be changed unless a special open enrollment event (also called a qualifying event) occurs during the plan year. Common special open enrollment events include birth, death, adoption, marriage, and divorce. Your change in election amount must be consistent with the qualifying event.

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

What is the Dependent Care Assistance Program (DCAP)?

The DCAP allows you to set aside money from your paycheck on a pretax basis to help pay for qualifying child care or elder care expenses while you and your spouse attend school full-time, work, or look for work.

A qualifying dependent must live with you and must be 12 years old or younger. A dependent age 13 or older qualifies only if they are physically or mentally incapable of self-care and regularly spend at least eight hours each day in your household. The care must be provided during the hours the parent(s) work, look for work, or attend school.

You can set aside as much as $5,000 annually (for a single person or married couple filing a joint income tax return) or $2,500 annually (for a married person filing a separate income tax return).

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

How does DCAP work?

The DCAP helps you pay for eligible expenses including elder day care, babysitting, day care, preschool, and registration fees.

Estimate your child or elder care expenses for the calendar year and enroll in the DCAP for that amount. Your election amount is deducted from your pay, divided by the number of paychecks you will receive in the calendar year. Your election amount will be deducted from your paychecks pretax, which reduces your taxable income.

When can I enroll in Medical FSA and DCAP?

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

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

How do I enroll in Medical FSA and DCAP?

Before you enroll, make sure to review the SEBB Medical FSA or DCAP enrollment guides on the Navia website at **sebb.naviabenefits.com**. You can also call Navia Benefit Solutions at 1-800-669-3539 if you have questions.

To enroll in these benefits, download and print the *Medical Flexible Spending Arrangement (FSA) and Dependent Care Assistance Program (DCAP) Enrollment* form on the Navia member portal at **sebb.naviabenefits.com**, if you are enrolling anytime other than open enrollment. You must return the form to your payroll or benefits office **no later than 31 days** after you become eligible for SEBB benefits.

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

When can I change my Medical FSA or DCAP election?

Once you enroll in a Medical FSA or DCAP, you can change your election only if you have a qualifying life event that creates a special open enrollment. Your election change must be consistent with the qualifying event. For example, you cannot reduce your annual election if you get married; you can only increase it.

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

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

SmartHealth

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

Participate in activities to 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 the SmartHealth wellness incentive.

Who is eligible?

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

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

What is the wellness incentive?

Subscribers can qualify for a $125 wellness incentive each year. The incentive is either a $125 reduction in the subscriber's 2022 SEBB medical deductible or a one-time deposit of $125 into the subscriber's health savings account (if enrolled in a SEBB high deductible health plan in 2022). The 2021 incentive is distributed by January 31, 2022 if you qualify.

How do I qualify for the wellness incentive?

To get the incentive, complete the SmartHealth well-being assessment and earn a total of 2,000 points within the deadline requirement. To receive the $125 wellness incentive, the subscriber must still be enrolled in a SEBB medical plan in 2022.

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

How do I get started?

1. Visit the SmartHealth portal at **smarthealth.hca.wa.gov** and click *Get Started*.

2. Take the SmartHealth well-being assessment.
   - ✓ It only takes 15 minutes.
   - ✓ This is the first step to qualify for the wellness incentive.
   - ✓ 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).

What is my deadline to qualify for the wellness incentive?

Your deadline to qualify for a $125 wellness incentive depends on the date your SEBB medical coverage becomes effective.

- If you are already enrolled in SEBB medical coverage or are a new subscriber with an effective date of January through September 2021: Deadline is November 30, 2021.
- If your SEBB medical coverage effective date is October through December 2021: Deadline is December 31, 2021.

What if I don't have internet access?

Contact SmartHealth Customer Service to participate in SmartHealth by phone.

SmartHealth contacts

Find out more on HCA's website at **hca.wa.gov/sebb-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.

After you enroll

What to expect next

Once you make your health plan elections, you can download a copy of your Statement of Insurance (the plans you chose) in SEBB My Account. This shows your elections regardless of whether your dependents are approved. After you're enrolled in coverage, your current coverage is displayed on the *Coverage summary* tab.

You should receive a welcome packet or letter from your health plans.

If you have questions that you can't find on HCA's website at **hca.wa.gov/sebb-employee** or in this guide, contact your payroll or benefits office.

When do my benefits begin?

If you are newly eligible, your medical, dental, and vision coverage, basic life insurance, basic AD&D insurance, and basic LTD insurance begin as described below. Contact your payroll or benefits office with questions about eligibility and when your benefits begin.

September start work dates

If your first day of work is on or after September 1, but not later than the first day of school for the school year, benefits begin the first day of work. The same effective date will apply for enrollment in the Medical Flexible Spending Arrangement (FSA) or Dependent Care Assistance Program (DCAP) if you are eligible for these benefits and elect them.

Other start work dates

If your first day of work is at any other time during the school year, benefits begin the first day of the month following the date you become eligible for the employer contribution toward SEBB benefits. The same effective date will apply for enrollment in the Medical FSA or DCAP if you are eligible for these benefits and elect them.

If you elect supplemental life insurance, supplemental AD&D insurance, or supplemental LTD insurance, insurance begins the first day of the month following the date the contracted vendor receives the required form or approves the enrollment.

Several other circumstances, such as a revision in your work pattern or returning from approved leave without pay, have specific dates for eligibility and benefits to begin.

Returning employees

If you have SEBB benefits during the 2020–21 school year and return to the same SEBB organization or a different SEBB organization and are anticipated to work at least 630 hours in the 2021–22 school year, you will receive uninterrupted coverage from one school year to the next.

When do my benefits begin when I am regaining eligibility?

If you are returning from unpaid leave that did not last more than 29 months after losing the employer contribution, your medical, dental, and vision coverage will begin the first day of the month after you return to work and are expected to be eligible for the employer contribution.

If you continued your supplemental life or supplemental AD&D insurance while on leave, your coverage will start the first day of the month that you regain eligibility for the employer contribution. Your supplemental LTD insurance will begin the first day of the month you regain eligibility for the employer contribution. If you were eligible to continue your supplemental life, supplemental AD&D, or supplemental LTD insurance and chose not to, your insurance begins the first day of the month following the date the contracted vendor receives the required form or approves the enrollment.

Changing jobs

A school employee will have uninterrupted coverage when moving from one SEBB organization to another within the same month or a consecutive month if they are eligible for the employer contribution toward SEBB benefits in the position they are leaving and are anticipated to be eligible for the employer contribution in the new position. This includes when you transfer to a different SEBB organization at the start of the school year. (If you move and your new residence is out of your medical plan's service area, you may need to change plans. See "What is a special open enrollment?" on page 65.) If you have a Medical Flexible Spending Arrangement (FSA) or Dependent Care Assistance Program (DCAP), submit a *School Employment Transfer Form*, available on the Navia website at **sebb.naviabenefits.com**.

Good to know!

ID cards

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

The Uniform Dental Plan does not mail ID cards, but you may download one from the UDP website at **deltadentalwa.com/sebb**.

Good to know!

Special open enrollment

When a special open enrollment event occurs, coverage will begin as noted below. See "What changes can I make during a special open enrollment?" on page 65 for more information.

When coverage begins

SEBB Program annual open enrollment

January 1 of the following year

Newly eligible enrollment (outside September 1 through first day of school)

The first of the month following eligibility

Marriage or registering a domestic partnership

The first of the month after the event or the date your payroll or benefits office receives your completed enrollment form with proof of your dependent's eligibility, whichever is later. If that day is the first of the month, coverage begins on that day. You can submit the proof of eligibility later than the online enrollment or form, as long as it is within 60 days of the event.

Birth, adoption, or assumed legal obligation for total or partial support in anticipation of adoption

The date of birth (for a newly born child); the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier (for a newly adopted child)

If you enroll yourself in order to enroll a newly born or newly adopted child, medical coverage begins the first day of the month in which the event occurs.

If you enroll your eligible spouse or state-registered domestic partner in your SEBB health plan coverage due to your child's birth or adoption, their medical coverage begins the first day of the month in which the birth or adoption occurs.

If the child's date of birth or adoption is before the 16th day of the month, you pay the higher premium for the full month (if adding the child increases the premium). If the child's date of birth or adoption is on or after the 16th, the higher premium will begin the next month.

You can submit the proof of eligibility later than the online enrollment or form, as long as it is within 60 days of the event.

A newly born child must be at least 14 days old before supplemental dependent life insurance and AD&D insurance coverage purchased by the employee becomes effective. You can submit the proof of eligibility later than the enrollment form, as long as it is **within 60 days** of the event period.

Child becomes eligible as an extended dependent

The first day of the month following eligibility certification

Other events that create a special open enrollment

The first of the month after the date of the event or the date your payroll or benefits office receives your completed online enrollment or form (and proof of the event that created the special open enrollment) with any other required documents, whichever is later. If that day is the first of the month, coverage begins on that day. You can submit the proof of eligibility later than the online enrollment or form, as long as it is within 60 days of the event.

Changing your coverage

How do I make changes in my health plan coverage?

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

- Log in to SEBB My Account during the annual open enrollment period, and change your selections.
- Submit the required forms to your employer's payroll or benefits office during the annual open enrollment period.
- Log in to SEBB My Account or submit the required forms to your payroll or benefits office within the SEBB Program's timelines when a special open enrollment event occurs.

What changes can I make anytime?

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

- Change your name or address by notifying your payroll or benefits office. You cannot change this through SEBB My Account.
- Apply for or cancel coverage, change coverage amounts, and update beneficiary information for supplemental life insurance, and supplemental accidental death and dismemberment (AD&D) insurance. Evidence of insurability may be required. (See "Life and AD&D insurance" on page 52.)
- Remove dependents from coverage due to loss of eligibility (this is required). Make this change in SEBB My Account or submit the completed *School Employee Change* form to your payroll or benefits office **within 60 days** of the last day of the month the dependent loses eligibility for SEBB health plan coverage. You may also need to provide proof of the event before the dependent can be removed.
- Enroll in or cancel supplemental long-term disability insurance. You can do this on SEBB My Account during the annual open enrollment period or with the *SEBB Long-Term Disability Enrollment/Change* form after the annual open enrollment period.
- Make changes to your tobacco use surcharge attestation. You can do this on SEBB My Account or use the *SEBB Premium Surcharge Change* form under *Forms & publications* on HCA's website at **hca.wa.gov/sebb-employee**.
- Start, stop, or change your contribution to your health savings account (HSA). Use the *SEBB Employee Authorization for Payroll Deduction to Health Savings Account* form under *Forms & publications* on the HCA website at **hca.wa.gov/sebb-employee**.
- Change your HSA beneficiary information. Use the *Health Savings Account Beneficiary Designation* form available on HealthEquity's website at **learn.healthequity.com/sebb/hsa**.

What changes can I make during annual open enrollment?

Many of the changes described in the list below can be completed using SEBB My Account at **myaccount.hca.wa.gov**. Click on *Supplemental Coverage* to access the Medical FSA and DCAP enrollment website. Some require that your payroll or benefits office (marked with an asterisk) or Navia Benefit Solutions (for Medical FSA or DCAP) receive the form(s) by the last day of open enrollment. Enrollment changes will become effective January 1 of the following year.

During the annual open enrollment you can:

- Change your medical, dental, and vision plans.
- Enroll or remove eligible dependents.
- Enroll in a medical plan, if you previously waived SEBB medical.
- Waive SEBB medical coverage. See "Waiving medical coverage" on page 19.
- Attest to the spouse or state-registered domestic partner coverage premium surcharge.
- Enroll or re-enroll in a Medical FSA.
- Enroll or re-enroll in DCAP.
- Enroll or opt out of participation under the premium payment plan. See "Paying for benefits" on page 20.

What is a special open enrollment?

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

The change in enrollment must be allowable under the Internal Revenue Code and Treasury Regulations, and correspond to and be consistent with the event that creates the special open enrollment for the employee, the employee's dependents, or both. A special open enrollment event must be an event other than an employee gaining initial eligibility for SEBB benefits.

The changes shown on page 66 through page 69 may be allowed as a special open enrollment.

In addition, subscribers can make changes to supplemental life and AD&D insurance, Medical FSA, DCAP, or the premium payment plan during a special open enrollment.

What changes can I make with a special open enrollment?

See the table of situations beginning on the next page that create a special open enrollment, what changes are allowed, and what documents you may need.

How do I make changes during a special open enrollment?

You must provide evidence of the event that created the special open enrollment (for example, a marriage or birth certificate) via SEBB My Account or with the *School Employee Change* form (and other required forms) to your payroll or benefits office, **no later than 60 days** after the event. In many instances, the date your change is received affects the effective date of the change in enrollment.

Good to know!

Need more?

For more information about the changes you can make during these events, see SEBB Program Administrative Policy Addendum 45-2A on the HCA website at **hca.wa.gov/sebb-rules**.

continued

Changes you can make with a special open enrollment

If this event happens	Add dependent	Remove dependent	Change SEBB medical, dental, or vision plan	Waive SEBB medical coverage	Enroll after waiving SEBB medical coverage	Submit these documents (This list is not inclusive.)
Marriage or registration of a domestic partner	Yes[1]	Yes[2]	Yes	Yes[3]	Yes	Marriage certificate; certificate of state-registered domestic partnership or legal union. Also provide evidence the marriage/ partnership is still valid (e.g., a utility bill dated within the past six months showing both names)
Birth, adoption, or assuming a legal obligation for total or partial support of a child in anticipation of adoption	Yes	Yes	Yes	Yes[3]	Yes	Birth certificate (or hospital certificate with child's footprints); certificate or decree of adoption; placement letter from adoption agency. All valid documents for proof of this event must show the name of the parent who is the subscriber, subscriber's spouse, or the subscriber's state-registered domestic partner.
Child becomes eligible as an extended dependent through legal custody or legal guardianship	Yes	No	Yes	No	Yes	Valid court order showing legal custody, guardianship, or temporary guardianship, signed by a judge or officer of the court AND a signed *SEBB Extended Dependent Certification* form
Employee or dependent loses eligibility for other coverage under a group health plan or through health insurance, as defined by the Health Insurance Portability and Accountability Act (HIPAA)	Yes	No	Yes	No	Yes	Certificate of creditable coverage; letter of termination of coverage from health plan or payroll or benefits office; COBRA election notice
Employee has a change in employment status that affects the employee's eligibility for their employer contribution toward their employer-based group health plan	Yes	Yes	Yes	Yes[3]	Yes	Employee hire letter from employer that contains information about benefits eligibility; employment contract; termination letter; letter of resignation; statement of insurance; certificate of coverage
Employee's dependent has a change in their employment status that affects their eligibility for the employer contribution under their employer-based group health plan. "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 54.9801-6.	Yes	Yes	Yes	Yes[3]	Yes	Employee hire letter from employer that contains information about benefits eligibility; employment contract; termination letter; letter of resignation; statement of insurance; certificate of coverage
Employee has a change in employment from a SEBB organization to a school district that results in having different medical plans available	No	No	Yes	No	No	Employee hire letter from employer that contains information about benefits eligibility; employment contract
Employee or dependent has a change in enrollment under another employer-based group health plan during its annual open enrollment that does not align with the SEBB Program's annual open enrollment	Yes	Yes	No	Yes[3]	Yes	Certificate of credible coverage; letter of enrollment or termination of coverage from the health plan; letter of enrollment or termination of coverage from employer's payroll or benefits office; proof of waiver
Employee's dependent moves from another country to live within the United States, or from within the U.S. to another country, and that change in residence results in the dependent losing their health insurance	Yes	Yes	No	No	Yes	Visa or passport with date of entry; proof of former and current residence (e.g., utility bill); letter or document showing coverage was lost (e.g., certificate of credible coverage)

1 *Subscriber may add only the new spouse, state-registered domestic partner, or children of the spouse or partner. Existing dependents may not be added.*
2 *Subscriber may only remove a dependent from SEBB health plan coverage if the dependent enrolls in the new spouse's or state-registered domestic partner's plan.*
3 *Waiving for this event is allowed only if the employee enrolls in medical under the new spouse or state-registered domestic partner's employer-based group health plan.*

If this event happens	Add dependent	Remove dependent	Change SEBB medical, dental, or vision plan	Waive SEBB medical coverage	Enroll after waiving SEBB medical coverage	Submit these documents (This list is not inclusive.)
Employee or dependent has a change in residence that affects health plan availability	No	No	Yes	No	No	Proof of former and current residence (e.g., utility bill); certificate of credible coverage
A court order requires the employee or any other individual to provide a health plan for an eligible child of the employee	Yes	Yes	Yes	No	Yes	Valid court order
Employee or dependent enrolls in or loses eligibility for Apple Health (Medicaid) or a state Children's Health Insurance Program (CHIP)	Yes	Yes	Yes	No	Yes	Enrollment or termination letter from Medicaid or CHIP reflecting the date the subscriber or subscriber's dependent enrolled in Medicaid or CHIP or the date at which the subscriber or subscriber's dependent lost eligibility for Medicaid or CHIP
Employee or dependent enrolls in a state premium assistance subsidy for SEBB health plan from Apple Health (Medicaid) or CHIP	Yes	No	Yes	No	Yes	Eligibility letter from Medicaid or CHIP
Employee or a dependent enrolls in or loses eligibility for coverage under Medicare	No	No	Yes	Yes	Yes	Medicare benefit verification letter; copy of Medicare card; notice of denial of Medicare coverage; Social Security denial letter; Medicare entitlement or cessation of disability form
Employee's or dependent's current health plan becomes unavailable because the employee or dependent is no longer eligible for a health savings account (HSA)	No	No	Yes	No	No	Cancellation letter from the health plan; coverage confirmation in a new health plan; Medicare entitlement letter; copy of current tax return claiming employee as a dependent
Employee or a dependent experiences a disruption of care that could function as a reduction in benefits for the employee or their dependent for a specific condition or ongoing course of treatment (requires approval by the SEBB Program)	No	No	Yes, if approved by the SEBB Program	No	No	Submit request for a plan change to: Health Care Authority SEBB Program PO Box 42684 Olympia, WA 98504-5502
Employee or dependent becomes eligible and enrolls in a TRICARE plan, or loses eligibility for a TRICARE plan	No	No	No	Yes	Yes	Certificate of credible coverage; proof of enrollment or termination of coverage from TRICARE

When coverage ends

Your SEBB insurance coverage ends as described below.

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

Your dependents' insurance coverage will end if you fail to comply with the SEBB Program's procedural requirements, including failure to provide information or documentation requested by the due date in written requests from the SEBB Program.

What happens if I or my dependent lose eligibility?

In the event you lose eligibility, your employer will notify you and give you the opportunity to appeal the decision. You can find information on how to appeal on page 73.

If your dependent loses eligibility, you must remove the ineligible dependent from your account. Your payroll or benefits office must receive your request to remove the dependent via SEBB My Account or the *School Employee Change* form **within 60 days** of the last day of the month your dependent is no longer eligible.

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

What are my options when coverage ends?

If applicable, you may be eligible to enroll on your spouse's, state-registered domestic partner's, or parent's SEBB insurance coverage as a dependent.

You, your dependents, or both may be able to temporarily continue your SEBB insurance coverage by self-paying the premiums and applicable premium surcharges on a post-tax basis with no contribution from your employer. This is called SEBB Continuation Coverage.

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

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

The first two options temporarily extend SEBB health plan coverage when your or your dependent's SEBB health plan coverage ends due to a qualifying event. If you qualify for both SEBB Continuation Coverage options, you may choose to enroll in only one of the options.

How does SEBB Continuation Coverage work?

The SEBB Program will mail a *SEBB Continuation Coverage Election Notice* booklet to you or your dependent at the address we have on file when your employer-paid coverage ends. This booklet explains the continuation coverage options and includes enrollment forms to apply.

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

The SEBB Program administers all SEBB Continuation Coverage options. For information about your rights and obligations under SEBB rules and federal law, refer to the *SEBB Initial Notice of COBRA and Continuation Coverage Rights* (mailed to you after you enroll in SEBB insurance coverage), or the *SEBB Continuation Coverage Election Notice* under *Forms & publications* on the HCA website at **hca.wa.gov/sebb-employee**. You can also call the SEBB Program at 1-800-200-1004.

SEBB Continuation Coverage (COBRA)

SEBB Continuation Coverage (COBRA) includes eligibility and administrative requirements under federal law and also includes coverage for some members who are not qualified beneficiaries under federal COBRA continuation coverage. COBRA eligibility is defined in federal law and governed by federal rules.

SEBB Continuation Coverage (Unpaid Leave)

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

PEBB retiree insurance

The SEBB Program does not offer retiree insurance coverage. However, retiree insurance coverage for SEBB members is offered through the Public Employees Benefits Board (PEBB) Program.

PEBB retiree insurance is available only to those who meet eligibility and procedural requirements. You can also find information on HCA's website at **hca.wa.gov/pebb-retirees**.

When you plan to terminate your employment and want to enroll in PEBB retiree insurance coverage, contact the PEBB Program about 90 days prior to terminating employment at 1-800-200-1004 to ask general PEBB retiree insurance questions. This phone line is only for retiring employees and continuation coverage members. Employees should contact their payroll or benefits office with questions about the SEBB Program or their account-related questions.

You can also request a *PEBB Retiree Enrollment Guide* or download it from HCA's website at **hca.wa.gov/pebb-retirees**. You have **60 days** from the date your employer-paid SEBB coverage or COBRA coverage ends for the PEBB Program to receive your application for retiree insurance coverage. Once your form is received, PEBB Program staff will review your form for eligibility and contact you if they need additional information.

When you become eligible for Medicare Part A and Part B, you must enroll and maintain enrollment in Medicare Part A and Part B to enroll or remain enrolled in PEBB retiree insurance coverage. Be sure you understand the Medicare enrollment timelines, especially if you are leaving employment within a few months of becoming eligible for Medicare or are in your Medicare Initial Enrollment Period (IEP) and want to enroll in PEBB retiree insurance coverage.

What happens to my Medical FSA funds when coverage ends?

When your SEBB insurance coverage ends or you go on unpaid leave that is not approved under the Family and Medical Leave Act (FMLA), the Washington Paid Family and Medical Leave program, or military leave, you are no longer eligible to contribute to your Medical Flexible Spending Arrangement (FSA).

Eligibility ends on the last day of the month of loss of coverage or unapproved leave. You will be able to claim only expenses incurred while employed, up to your remaining benefit, unless you are eligible to continue your Medical FSA under SEBB Continuation Coverage (COBRA) or SEBB Continuation Coverage (Unpaid Leave), through Navia Benefit Solutions. Claims may be submitted up to your account balance and must be submitted to Navia Benefit Solutions by March 31 of the following plan year.

Good to know!

Learn more

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

What happens to my DCAP funds when coverage ends?

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

What happens to my HSA when coverage ends?

If you enroll in UMP High Deductible with a health savings account (HSA), then later switch to another type of plan, leave employment, or retire, any unspent funds in your HSA will remain available to you, unless you close your account. There is a fee for account balances below a certain threshold. Contact HealthEquity for information about fees.

You can use your HSA funds on qualified medical expenses, or you can leave them for the future. However, you, your employer, the SEBB Program, and others may no longer contribute to your HSA.

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

See "UMP High Deductible with a health savings account (HSA)" on page 27.

What happens to my life and AD&D insurance when coverage ends?

If your SEBB Program life insurance ends, you may have an opportunity to continue all or part of your coverage through a portability or conversion option. If you are eligible for these options, MetLife will send you information and an application. Accidental death and dismemberment (AD&D)

insurance is not eligible for portability or conversion. For more information, see "Life and AD&D insurance" on page 52 or contact MetLife at 1-833-854-9624.

If I die, are my surviving dependents eligible?

If you die, your dependents will lose their eligibility for the employer contribution toward SEBB Program benefits. Your dependents (a spouse, state-registered domestic partner or dependent child) may be eligible to enroll in or defer (postpone) enrollment in PEBB retiree insurance coverage as a survivor. To do so, they must meet the procedural and eligibility requirements described in WAC 182-12-265.

The PEBB Program must receive all required forms **no later than 60 days** after the the date of the employee's death or the date the survivor's SEBB insurance coverage ends, whichever is later.

If your surviving spouse, state-registered domestic partner, or dependent child does not meet the eligibility requirements described in WAC 182-12-265, they may be eligible to continue health plan enrollment in SEBB Continuation Coverage (COBRA) as described in WAC 182-12-146. See "What are my options when coverage ends?" on page 70.

What happens when a dependent dies?

If your covered dependent dies, you must submit the *School Employee Change* form to your payroll or benefits office to remove the deceased dependent from your coverage **no later than 60 days** after the event.

By submitting this form, your premium may be reduced to reflect the change in coverage. For example, if the deceased person was the only dependent on your account, then the premium withheld from your paycheck will be lower when they are removed.

The SEBB Program collects premiums for the entire calendar month and will not prorate them for any reason, including when a member dies before the end of the month. The deceased dependent's coverage will end the last day of the month in which the dependent dies. Any change to your premium will be effective the first day of the following month.

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

How do I appeal a decision made by a health plan?

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

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

If you or your dependent disagree with a specific decision or denial, you or your dependent may file an appeal. You can find guidance on filing an appeal in WAC 182-32 and on the SEBB Program webpages at **hca.wa.gov/sebb-appeals**, or see "Instructions and deadlines," beginning on this page.

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

You can appeal the SEBB Appeals Unit's presiding officer's initial order by filing a written request for review or by making an oral request for review.

Information detailing your right to request review is included in the SEBB Appeals Unit's presiding officer's initial order. Once your request for review is received by the Appeals Unit, a final order will generally be mailed within 20 days.

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

By fax: 360-763-4709

Request a review by calling 1-800-351-6827.

Deadline for requesting an appeal

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

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

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

Instructions and deadlines

If your situation is:

You disagree with a decision made by your employer and you are requesting your employer's review about your preimium surcharges or eligibility for or enrollment in:

- Medical coverage
- Dental coverage
- Vision coverage
- Life insurance
- AD&D insurance
- Long-term disability insurance
- Accidental death and dismemberment (AD&D) insurance
- Medical Flexible Spending Arrangement (FSA)
- Dependent Care Assistance Program (DCAP)

Instructions: Complete Sections 1 through 3 of the *Employee Request for Review/Notice of Appeal* form (available under *Forms & publications* on HCA's website at **hca.wa.gov/sebb-employee**) and submit it to your employer's payroll or benefits office.
Deadline: Your employer must **receive** the form **no later than 30 calendar days** after the date on the initial denial notice or decision you are appealing.

If your situation is:

You disagree with a review decision made by your employer, or agree that further review is needed because your employer believes there was an error but did not grant you the relief you requested, and you are now requesting the SEBB Appeals Unit review of your employer's decision.
Instructions: Complete Section 7 of the *SEBB Employee Request for Review/Notice of Appeal* form to the SEBB Appeals Unit as directed on the form.
Deadline: The SEBB Appeals Unit must **receive** the form **no later than 30 calendar days** after your employer's written review decision date in Section 4 of the form.

continued

If your situation is:

Your appeal concerns a decision from the SEBB Program about:

- Eligibility for or enrollment in:
  - Premium payment plan
  - Medical Flexible Spending Arrangement (FSA)
  - Dependent Care Assistance Program (DCAP)
  - Life insurance
  - AD&D insurance
  - Long-term disability insurance
- Eligibility to participate in SmartHealth or receive a wellness incentive
- Eligibility and enrollment for a dependent, extended dependent, or dependent with a disability
- Premium surcharges
- Premium payments

Instructions: Follow the appeal instructions on the decision letter you received from the SEBB Program.

If your situation is:

You are seeking a review of a decision made by a SEBB medical, dental, or vision plan or insurance carrier about:

- A benefit or claim
- Completion of SmartHealth requirements or a request for a reasonable alternative to a SmartHealth requirement
- Life insurance premium payments

Instructions: Contact the medical, dental, or vision plan or insurance carrier to request information on how to appeal the decision.

Enrollment forms

These forms referenced in this book are available online:

SEBB Premium Surcharge Attestation Help Sheet

hca.wa.gov/assets/pebb/20-0040-sebb-premium-surcharge-attestation-help-sheet-2021.pdf

SEBB Long-term Disability Enrollment Form

standard.com/eforms/7533_756494.pdf

Washington State
Health Care Authority

SCHOOL EMPLOYEES BENEFITS BOARD