



PROPOSED RULE MAKING

CR-102 (June 2012)

(Implements RCW 34.05.320)

Do **NOT** use for expedited rule making

Agency: Health Care Authority (HCA), Public Employees Benefits Board (PEBB) Admin # 2015-01 Rev 1

- Preproposal Statement of Inquiry was filed as WSR 15-10-080 ; or
- Expedited Rule Making--Proposed notice was filed as WSR _____; or
- Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1).

- Original Notice
- Supplemental Notice to WSR _____
- Continuance of WSR _____

Title of rule and other identifying information: (Describe Subject)

PEBB rules related to enrollment in chapter 182-08 WAC; eligibility in chapter 182-12 WAC; and appeals in chapter 182-16 WAC.

Hearing location(s):
 Health Care Authority
 Cherry Street Plaza Building; Sue Crystal Conf Rm 106A
 626 - 8th Avenue, Olympia WA 98504

Metered public parking is available street side around building. A map is available at:
http://www.hca.wa.gov/documents/directions_to_csp.pdf
 or directions can be obtained by calling: 360-725-1000

Date: October 27, 2015 Time: 10:00 a.m.

Date of intended adoption: Not sooner than October 28, 2015 (Note: This is **NOT** the **effective** date)

Submit written comments to:
 Name: HCA Rules Coordinator
 Address: PO Box 45504, Olympia WA, 98504-5504
 Delivery: 626 – 8th Avenue, Olympia WA 98504
 e-mail arc@hca.wa.gov
 fax (360) 586-9727

by (date) October 27, 2015

Assistance for persons with disabilities:
 Contact Amber Lougheed by October 23, 2015 by telephone at (360) 725-1309 or email amber.lougheed@hca.wa.gov
 TTY (800) 848-5429 or 711

Purpose of the proposal and its anticipated effects, including any changes in existing rules:

See attachment

Reasons supporting proposal: Compliance with federal regulation, state law.

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Statute being implemented: SB 5466

Is rule necessary because of a:

- Federal Law? Yes No
 - Federal Court Decision? Yes No
 - State Court Decision? Yes No
- If yes, CITATION:

DATE
September 21, 2015

NAME (type or print)
Wendy L. Barcus

SIGNATURE

TITLE
HCA Rules Coordinator

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: September 21, 2015
TIME: 9:18 AM

WSR 15-19-119

(COMPLETE REVERSE SIDE)

Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters:

None

Name of proponent: Health Care Authority

- Private
- Public
- Governmental

Name of agency personnel responsible for:

| Name | Office Location | Phone |
|----------------------------------|---|----------------|
| Drafting..... Rob Parkman | Cherry Street Plaza, 626 8th Avenue SE, Olympia, Washington | (360) 725-0883 |
| Implementation.... Barbara Scott | Cherry Street Plaza, 626 8th Avenue SE, Olympia, Washington | (360) 725-0830 |
| Enforcement..... Mary Fliss | Cherry Street Plaza, 626 8th Avenue SE, Olympia, Washington | (360) 725-0822 |

Has a small business economic impact statement been prepared under chapter 19.85 RCW or has a school district fiscal impact statement been prepared under section 1, chapter 210, Laws of 2012?

Yes. Attach copy of small business economic impact statement or school district fiscal impact statement.

A copy of the statement may be obtained by contacting:

Name:

Address:

phone () _____

fax () _____

e-mail _____

No. Explain why no statement was prepared.

The Joint Administrative Rules Review Committee has not requested the filing of a small business economic impact statement, and there will be no costs to small businesses.

Is a cost-benefit analysis required under RCW 34.05.328?

Yes A preliminary cost-benefit analysis may be obtained by contacting:

Name:

Address:

phone () _____

fax () _____

e-mail _____

No: Please explain:

RCW 34.05.328 does not apply to Health Care Authority rules unless requested by the Joint Administrative Rules Review Committee or applied voluntarily.

Attachment to CR-102

Purpose of the proposal and its anticipated effects, including any changes in existing rules: Amends existing rules in Title 182 WAC specific to the PEBB Program with the following effect:

1. Implement PEB Board policy resolution to amend Wellness Incentive Program requirements and TRICARE retiree waiver requirements.
2. Makes technical amendments to:
 - Clarify that blind vendors have a 60-day notification requirement after a loss of group health or health insurance under HIPAA.
 - Clarify what “employer-based group medical insurance,” “pay status,” and “employee” means.
 - Clarify that new employees must either “enroll or waive” coverage within 31 days of eligibility.
 - Clarify within WAC 182-12-205 what conditions a retiring employee must meet in order to defer coverage, the timeline to defer retiree health plan coverage for both new and existing retirees, and when coverage ends for retiring employees who are deferring coverage.
 - Amend the definition of “PEBB program” to remove the reference to “disabled employees”.
 - Amending WAC 182-12-171 to account for retiring employee issues.
 - Clarify within WAC 182-12-123 the notification process between employers who employ the same employee and need to change who is paying the employer contribution.
 - Clarify within WAC 182-08-235 that the employer group actuarial evaluation will be conducted by a PEBB Program designated actuary.
 - Clarify within WAC 182-16-073 what the PEBB Program’s rescheduling and continuance processes are.
 - Amend WAC 182-08-245(1)(e) to replace the words “health plans” with “insurance coverages”.
 - Amend WAC 182-08-240 to include a timeframe, for all group sizes, on how long an employer group evaluation is valid and that like populations will be evaluated against each other during the application process.
 - Amend WAC 182-08-185 to account for surcharge changes and issues.
 - Amend WAC 182-12-260(3) so it says that coverage for children ends on the last day of the month in which they turn 26 years old.
 - Amend WAC 182-08-187 to account for additional error correction issues that have been identified.
 - Amend WAC 182-12-211 to include the ability to “defer” and that the references to WAC 182-12-171 are correct.
 - Clarify within WAC 182-12-262(2)(c) when coverage ends for dependents.
 - Amend WAC 182-12-133 and WAC 182-12-146 to include deadlines for COBRA / LWOP continuation coverage that mirror those requirements for COBRA.
 - Amend WAC 182-12-200 to integrate provisions of Policy 21-1 that deal with retiree deferral form exemptions.
 - Amend WAC 182-16-036(1) so that it also includes eligibility for benefits and add the process flow for FSA appeals.
 - Amend WAC 182-16-040 to determine what must be included versus what may be included in a notice of appeal.
 - Amend WAC 182-12-260 to state the PEBB Program requires dependent verification documents.
 - Amend WAC 182-12-263 to remove “court orders”.
 - Amending WAC 182-08-199(3)(c)(vi) to update the IRS references.
 - Amending WAC 182-12-123 to clarify that eligibility as an employee supersedes eligibility as a dependent in most situations.
 - Amend WAC 182-16-080 to correct reference links.
3. In addition to these specific changes, HCA conducted a full review of these chapters and made some changes for readability.

WAC 182-08-015 Definitions. The following definitions apply throughout this chapter unless the context clearly indicates other meaning:

"Affordable Care Act" means the federal Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, P.L. 111-152, or federal regulations or guidance issued under the Affordable Care Act.

"Annual open enrollment" means an annual event set aside for a period of time when subscribers may make changes to their health plan enrollment and salary reduction elections for the following plan year. Subscribers may transfer from one health plan to another, enroll or remove dependents from coverage, enroll in or waive enrollment in ((a)) PEBB medical ((plan)), or employees may enroll in or change their election under the DCAP, the medical FSA, or the premium payment plan.

"Authority" or "HCA" means the health care authority.

~~(("Benefits eligible position" means any position held by an employee who is eligible for benefits under WAC 182-12-114, with the exception of employees who establish eligibility under WAC 182-12-114 (2) or (3)(a)(ii).))~~

"Board" means the public employees benefits board established under provisions of RCW 41.05.055.

"Calendar days" or "days" means all days including Saturdays, Sundays, and all legal holidays as set forth in RCW 1.16.050.

"Continuation coverage" means the temporary continuation of PEBB health plan coverage available to enrollees after a qualifying event occurs as administered under Title XXII of the Public Health Service (PHS) Act, 42 U.S.C. Secs. 300bb-1 through 300bb-8.

"Creditable coverage" means coverage that meets the definition of "creditable coverage" under RCW 48.66.020 (13)(a) and includes payment of medical and hospital benefits.

"Defer" means to postpone enrollment or interrupt enrollment in a PEBB health plan by a retiree or eligible survivor.

"Dependent" means a person who meets eligibility requirements in WAC 182-12-260, except that "surviving spouses, state registered domestic partners, and dependent children" of emergency service personnel who are killed in the line of duty is defined in WAC 182-12-250.

"Dependent care assistance program" or "DCAP" means a benefit plan whereby state and public employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan authorized in chapter 41.05 RCW.

"Director" means the director of the authority.

"Documents" means papers, letters, writings, e-mails, electronic files, or other printed or written items.

~~(("Effective date of enrollment" means the first date when an enrollee is entitled to receive covered benefits.))~~ "Employee" includes all employees of the state, whether or not covered by civil service; elected and appointed officials of the executive branch of government, including full-time members of boards, commissions, or committees; justices of the supreme court and judges of the court of appeals and the superior courts; and members of the state legislature. Pursuant to contractual agreement with the authority, "employee" may also include: (a) Employees of a county, municipality, or other political subdivi-

sion of the state and members of the legislative authority of any county, city, or town who are elected to office after February 20, 1970, if the legislative authority of the county, municipality, or other political subdivision of the state seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.04.205 and 41.05.021 (1)(g); (b) employees of employee organizations representing state civil service employees, at the option of each such employee organization, and, effective October 1, 1995, employees of employee organizations currently pooled with employees of school districts for the purpose of purchasing insurance benefits, at the option of each such employee organization; (c) employees of a school district if the authority agrees to provide any of the school districts' insurance programs by contract with the authority as provided in RCW 28A.400.350; (d) employees of a tribal government, if the governing body of the tribal government seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(f) and (g); (e) employees of the Washington health benefit exchange if the governing board of the exchange established in RCW 43.71.020 seeks and receives approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(g) and (n); and (f) employees of a charter school established under chapter 28A.710 RCW. "Employee" does not include: Adult family home providers; unpaid volunteers; patients of state hospitals; inmates; employees of the Washington state convention and trade center as provided in RCW 41.05.110; students of institutions of higher education as determined by their institution; and any others not expressly defined as employees under this chapter or by the authority under this chapter.

"Employer-based group medical insurance" means group medical insurance coverage related to a current employment relationship. It does not include medical insurance coverage available to retired employees, individual market medical insurance coverage or government-sponsored programs such as medicare or medicaid.

"Employer group" means those ((employee organizations representing state civil service employees,)) counties, municipalities, political subdivisions, the Washington health benefit exchange, tribal governments, school districts, ((charter schools, and)) educational service districts ((participating in PEBB insurance coverage under contractual agreement)), and employee organizations representing state civil service employees, obtaining employee benefits through a contractual agreement with the authority as described in WAC 182-08-245.

"Employing agency" means a division, department, or separate agency of state government, including an institution of higher education; a county, municipality, school district, educational service district, or other political subdivision; charter school; or a tribal government covered by chapter 41.05 RCW.

"Enrollee" means a person who meets all eligibility requirements defined in chapter 182-12 WAC, who is enrolled in PEBB benefits, and for whom applicable premium payments have been made.

"Exchange" means the Washington health benefit exchange established in RCW 43.71.020, and any other health benefit exchange established under the Affordable Care Act.

"Exchange coverage" means coverage offered by a qualified health plan through an exchange.

"Faculty" means an academic employee of an institution of higher education whose workload is not defined by work hours but whose ap-

pointment, workload, and duties directly serve the institution's academic mission; as determined under the authority of its enabling statutes, its governing body, and any applicable collective bargaining agreement.

~~(("Federal retiree plan" means the Federal Employees' Health Benefits Program (FEHB) and Tricare.))~~

"Health plan" means a plan offering medical or dental, or both developed by the public employees benefits board and provided by a contracted vendor or self-insured plans administered by the HCA.

"Institutions of higher education" means the state public research universities, the public regional universities, The Evergreen State College, the community and technical colleges, and the state board for community and technical colleges.

"Insurance coverage" means any health plan, life insurance, long-term care insurance, long-term disability (LTD) insurance, or property and casualty insurance administered as a PEBB benefit.

"Layoff," for purposes of this chapter, means a change in employment status due to an employer's lack of funds or an employer's organizational change.

~~(("LTD insurance" includes basic long term disability insurance paid for by the employing agency and long term disability insurance offered to employees on an optional basis.))~~

"Life insurance" includes basic life insurance paid for by the employing agency, life insurance offered to employees on an optional basis, and retiree life insurance.

"LTD insurance" includes basic long-term disability insurance paid for by the employing agency and long-term disability insurance offered to employees on an optional basis.

"Mail" or "mailing" means placing a document in the United States Postal system, commercial delivery service, or Washington state consolidated mail services properly addressed.

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby state and public employees may reduce their salary before taxes to pay for medical expenses not reimbursed by insurance as provided in the salary reduction plan authorized in chapter 41.05 RCW.

"PEBB" means the public employees benefits board.

"PEBB appeals committee" means the committee that considers appeals relating to the administration of PEBB benefits by the PEBB program. The director has delegated the authority to hear appeals at the level below an administrative hearing to the PEBB appeals committee.

"PEBB benefits" means one or more insurance coverages or other employee benefits administered by the PEBB program within the health care authority.

"PEBB program" means the program within the HCA (~~(which)~~) that administers insurance and other benefits for eligible employees (as ((defined)) described in WAC 182-12-114), eligible retired ((and disabled)) employees (as ((defined)) described in WAC 182-12-171), eligible dependents (as ((defined)) described in WAC 182-12-250 and 182-12-260) and others as defined in RCW 41.05.011.

"Premium payment plan" means a benefit plan whereby state and public employees may pay their share of group health plan premiums with pretax dollars as provided in the salary reduction plan.

"Premium surcharge" means a payment required from a subscriber, in addition to the subscriber's premium contribution, due to an enrollee's tobacco use or a subscriber's spouse or registered domestic

partner choosing not to enroll in his or her employer-based group medical insurance when:

- Premiums are less than ninety-five percent of Uniform Medical Plan (UMP) Classic premiums; and
- The actuarial value of benefits is at least ninety-five percent of the actuarial value of UMP Classic benefits.

"Qualified health plan" means a medical plan that is certified to be offered through an exchange.

"Salary reduction plan" means a benefit plan whereby state and public employees may agree to a reduction of salary on a pretax basis to participate in the DCAP, medical FSA, or premium payment plan as authorized in chapter 41.05 RCW.

"School district" means public schools as defined in RCW 28A.150.010 which includes charter schools established under chapter 28A.710 RCW.

"Seasonal employee" means an employee hired to work during a recurring, annual season with a duration of three months or more, and anticipated to return each season to perform similar work.

"Special open enrollment" means a period of time when subscribers may make changes to their health plan enrollment and salary reduction elections outside of the annual open enrollment period when specific life events occur. Subscribers may change health plans and enroll or remove dependents from coverage. Additionally, employees may enroll in or waive enrollment in ((a)) PEBB medical ((plan)), and may enroll in or change their election under the DCAP, medical FSA, or the premium payment plan. For special open enrollment events as they relate to specific PEBB benefits, see WAC 182-08-198, 182-08-199, 182-12-128, and 182-12-262.

"State agency" means an office, department, board, commission, institution, or other separate unit or division, however designated, of the state government and all personnel thereof. It includes the legislature, executive branch, and agencies or courts within the judicial branch, as well as institutions of higher education and any unit of state government established by law.

"Subscriber" means the employee, retiree, COBRA beneficiary, or eligible survivor who has been designated by the HCA as the individual to whom the HCA and contracted vendors will issue all notices, information, requests and premium bills on behalf of enrollees.

~~(("Termination of the employment relationship" means that an employee resigns or an employee is terminated and the employing agency has no anticipation that the employee will be rehired.))~~

"Tobacco products" means any product made with or derived from tobacco that is intended for human consumption, including any component, part, or accessory of a tobacco product. This includes, but is not limited to, cigars, cigarettes, chewing tobacco, snuff, and other tobacco products. It does not include United States Food and Drug Administration (FDA) approved quit aids or e-cigarettes until their tobacco related status is determined by the FDA.

"Tobacco use" means any use of tobacco products within the past two months. Tobacco use, however, does not include the religious or ceremonial use of tobacco.

"Tribal government" means an Indian tribal government as defined in Section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, or an agency or instrumentality of the tribal government, that has government offices principally located in this state.

"Waive" means to interrupt an eligible employee's enrollment in a PEBB health plan because the employee is enrolled in other employer-based group medical insurance, TRICARE, or medicare as allowed under WAC 182-12-128, or is on approved educational leave and obtains other employer-based group health insurance as allowed under WAC 182-12-136.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-08-185 What are the requirements regarding premium surcharges? (1) A subscriber's account will incur a premium surcharge when any enrollee, thirteen years and older, engages in tobacco use.

(a) A subscriber must attest to whether any enrollee ~~((~~en~~)),~~ thirteen years and older, enrolled in his or her public employees benefits board (PEBB) medical ~~((~~plan~~))~~ engages in tobacco use. The subscriber must attest ~~((~~during the following times~~))~~ as described in (a)(i) through (vii) of this subsection:

(i) ~~((~~When~~))~~ An employee who is newly eligible or regains eligibility for the employer contribution toward PEBB benefits ~~((~~submits an enrollment~~))~~ must complete the required form to ~~((~~add~~))~~ enroll in PEBB medical as described in WAC 182-08-197 (1) or (3). The employee must include his or her attestation on that form. The employee must submit the attestation to his or her employing agency. If the employee's attestation results in a premium surcharge, it will take effect the same ~~((~~time~~))~~ date as PEBB medical begins ~~((~~+~~))~~.

(ii) ~~((~~When~~))~~ If there is a change in the tobacco use status of any enrollee, thirteen years and older on the subscriber's PEBB medical ~~((~~plan. If the change in status results in a surcharge being added or removed, the change to the surcharge will take effect the first day of the month following receipt of the attestation. If that day is the first of the month, the change to the surcharge begins on that day~~))~~, the subscriber must update his or her attestation on the required form. An employee must submit the updated attestation to his or her employing agency. Any other subscriber must submit his or her updated attestation to the PEBB program.

• A change that results in a premium surcharge will begin the first day of the month following the status change. If that day is the first of the month, the change to the surcharge begins on that day.

• A change that results in removing the premium surcharge will begin the first day of the month following receipt of the attestation. If that day is the first of the month, the change to the surcharge begins on that day.

(iii) ~~((~~When~~))~~ If a subscriber submits ~~((~~an enrollment~~))~~ the required form to ~~((~~add~~))~~ enroll a dependent ~~((~~to his or her~~))~~, thirteen years and older, in PEBB medical as described in WAC 182-12-262 ~~((~~- If enrolling the dependent~~))~~, the subscriber must update his or her attestation on the required form. An employee must submit the updated attestation to his or her employing agency. Any other subscriber must submit his or her updated attestation to the PEBB program. A change that results in a premium surcharge ~~((~~being added, it~~))~~ will take effect the same ~~((~~time~~))~~ date as PEBB medical begins ~~((~~+~~))~~.

(iv) ~~((~~When~~))~~ An enrollee, thirteen years and older, who elects to continue ~~((~~health plan~~))~~ medical coverage as described in WAC 182-12-146 ~~((~~- If the attestation results in a surcharge it~~))~~, must

provide an attestation on the required form if he or she has not previously attested as described in (a) of this subsection. The enrollee must submit his or her updated attestation to the PEBB program. An attestation that results in a premium surcharge will take effect the same ((time)) date as PEBB medical begins. ((This action is required only if the enrollee has not previously attested as described in (a) of this subsection;))

(v) ((When)) An employee or retiree ((submits an enrollment form to)) who enrolls in PEBB medical as described in WAC 182-12-171 (1)(a), 182-12-200 ((+2)) (3)(a) and (b), or 182-12-205 ((+4)) (6) (a), (b), (c), (d), and ((+d). If the)) (e), must provide an attestation on the required form if he or she has not previously attested as described in (a) of this subsection. The employee or retiree must submit his or her updated attestation to the PEBB program. An attestation that results in a premium surcharge ((it)) will take effect the same ((time)) date as PEBB medical begins. ((This action is required only if the retiree has not previously attested as described in (a) of this subsection; and))

(vi) ((When a survivor)) A surviving spouse, registered domestic partner, or dependent child ((submits an enrollment form to enroll)), thirteen years and older, who enrolls in PEBB medical as described in WAC 182-12-250(5) or 182-12-265((. If the)), must provide an attestation on the required form to the PEBB program if he or she has not previously attested as described in (a) of this subsection. An attestation that results in a premium surcharge ((it)) will take effect the same ((time)) date as PEBB medical begins. ((This action is required only if the survivor has not previously attested as described in (a) of this subsection;))

(vii) An employee who previously waived PEBB medical must complete the required form to enroll in PEBB medical as described in WAC 182-12-128(3). The employee must include his or her attestation on that form. An employee must submit the attestation to his or her employing agency. An attestation that results in a premium surcharge will take effect the same date as PEBB medical begins.

Exception:

- (1) A subscriber enrolled in both medicare parts A and B and in the medicare risk pool is not required to provide an attestation and no premium surcharge will be imposed on the subscriber's account.
- (2) An employee who waives PEBB medical ((enrollment)) according to WAC 182-12-128 is not required to provide an attestation and no premium surcharge will be applied to his or her account ((until the employee enrolls in a PEBB medical plan)) as long as the employee enrollment remains in waived status.

(b) A subscriber's account will incur a premium surcharge when a subscriber fails to attest to the tobacco use status of all enrollees as described in subsection (1)(a) of this section.

(c) The PEBB program will provide a reasonable alternative for enrollees who use tobacco products ((so a)). A subscriber can avoid the tobacco use premium surcharge if the subscriber attests on the required form that all enrollees who use tobacco products enrolled in or accessed the applicable reasonable alternative offered below:

(i) ((All enrollees have)) An enrollee who is eighteen years and older and uses tobacco products has access to a free tobacco cessation program through ((their)) his or her PEBB medical ((plan. A subscriber can avoid the surcharge if enrollees who use tobacco products are enrolled in their plan's tobacco cessation program)).

(ii) An enrollee who is thirteen through seventeen years old and uses tobacco products may access the information and resources aimed at teens on the Washington state department of health's web site at <http://teen.smokefree.gov>.

(iii) A subscriber may contact the PEBB program to accommodate a physician's recommendation that addresses an enrollee's use of tobacco

products or for information on how to avoid the tobacco use premium surcharge.

(2) A ~~((subscriber's account))~~ subscriber will incur a premium surcharge if an enrolled spouse or registered domestic partner ~~((ehose))~~ elected not to enroll in employer-based group medical insurance that has premiums less than ninety-five percent of the Uniform Medical Plan (UMP) Classic's premiums and benefits with an actuarial value of at least ninety-five percent of the actuarial value of the UMP Classic's benefits.

(a) A subscriber ~~((with))~~ who enrolled a spouse or registered domestic partner ~~((enrolled))~~ under his or her PEBB medical ~~((must))~~ may only attest during the following times:

(i) ~~When ((an employee who is newly eligible or regains eligibility for the employer contribution toward PEBB benefits submits an enrollment form to add PEBB medical as described in WAC 182-08-197 (1) or (3).))~~ a subscriber becomes eligible to enroll a spouse or registered domestic partner in PEBB medical as described in WAC 182-12-262 (1)(a). A subscriber must complete the required form to enroll his or her spouse or registered domestic partner. The subscriber must include his or her attestation on that form. The employee must submit the attestation to his or her employing agency. Any other subscriber must submit an attestation to the PEBB program. If the subscriber's attestation results in a premium surcharge it will take effect the same ((time)) date as PEBB medical begins;

(ii) When a special open enrollment (SOE) event occurs as described in WAC 182-12-262 (1)(c). A subscriber must submit((s an enrollment)) the required form to ((add)) enroll a spouse or registered domestic partner ((to his or her)) in PEBB medical ((as described in WAC 182-12-262. If enrolling the spouse or registered domestic partner)). The subscriber must include his or her updated attestation on that form. An employee must submit an updated attestation to his or her employing agency. Any other subscriber must submit an updated attestation to the PEBB program. If the subscriber's attestation results in a premium surcharge ((being added, the surcharge)) it will take effect the first day of the month following receipt of the attestation. If that day is the first day of the month, the change to the surcharge begins on that day;

(iii) During the annual open enrollment. ((If attesting)) A subscriber must attest if during the month prior to the annual open enrollment the subscriber was:

- Incurring the surcharge;
- Not incurring the surcharge because the spouse's or registered domestic partner's share of the medical premium through his or her employer-based group medical insurance was more than ninety-five percent of the UMP Classic's premiums; or
- Not incurring the surcharge because the actuarial value of benefits provided through the spouse's or registered domestic partner's employer-based group medical insurance was less than ninety-five percent of the UMP Classic's actuarial value.

A subscriber must update his or her attestation on the required form. An employee must submit an updated attestation to his or her employing agency. Any other subscriber must submit an updated attestation to the PEBB program. The subscriber's attestation or any correction to a subscriber's attestation must be received no later than December 31st of the year in which the annual open enrollment occurs. If the subscriber's attestation results in a premium surcharge, being

added or removed, the change to the surcharge (~~((begins))~~) will take effect January 1st of the following year; and

(iv) When there is a change in the spouse's or registered domestic partner's employer-based group medical insurance. (~~((If attesting results in a surcharge being added or removed, the change to the surcharge will take effect the first day of the month following receipt of the attestation. If that day is the first of the month, the change to the surcharge begins on that day.))~~) An employee must submit an updated attestation to his or her employing agency within sixty days of when the spouse's or registered domestic partner's employer-based group medical insurance status changes. Any other subscriber must submit an updated attestation to the PEBB program no later than sixty days after the spouse's or registered domestic partner's employer-based group medical insurance changes.

• A change that results in a premium surcharge will begin the first day of the month following the status change. If that day is the first day of the month, the change to the premium surcharge begins on that day.

• A change that results in removing the premium surcharge will begin the first day of the month following receipt of the attestation. If that day is the first day of the month, the change to the premium surcharge begins on that day.

Exception:

- (1) A subscriber enrolled in both Medicare parts A and B and in the Medicare risk pool is not required to provide an attestation and no premium surcharge will be imposed on the subscriber's account.
- (2) An employee who waives PEBB medical (~~((enrollment))~~) according to WAC 182-12-128 is not required to provide an attestation and no premium surcharge will be applied to his or her account (~~((until the employee enrolls in a PEBB medical plan))~~) as long as the employee remains in waived status.
- (3) An employee who covers his or her spouse or registered domestic partner who has waived his or her own PEBB medical must attest, but a premium surcharge will not be applied.
- (4) A subscriber who covers his or her spouse or registered domestic partner who elected not to enroll in TRICARE must attest, but a premium surcharge will not be applied.

(b) A premium surcharge will be applied to (~~((the account of))~~) a subscriber(~~(s)~~) who (~~((do))~~) does not attest as described in (a) of this subsection.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-08-187 How do employing agencies correct enrollment errors and is there a limit on retroactive enrollment? (~~((If))~~) An employing agency that fails to timely enroll an employee, or his or her dependent, in public employees benefits board (PEBB) benefits must correct the error as described in this section. An agency must correct a failure to notify an employee timely of his or her eligibility for (~~((public employees benefits board (-)))~~)PEBB(~~((+))~~) benefits and the employer contribution (~~((as required in WAC 182-12-113 or the employer group contract, or fails))~~); or a failure to accurately enroll insurance coverage(~~((, the agency is authorized and required to correct the error as described in this section))~~); or a failure to accurately enroll insurance coverage as required by WAC 182-08-197 (1)(b); or a failure to accurately reflect premium surcharge status.

The employing agency or the PEBB program's designee must enroll the employee and the employee's dependent, as elected, in PEBB benefits as described in subsection (1) of this section, reconcile premium payments and premium surcharges as described in subsection (2) of this

section, and provide recourse as described in subsection (3) of this section.

Note: If the employing agency failed to provide the notice required in WAC 182-12-113 or the employer group contract before the end of the employee's thirty-one day enrollment period described in WAC 182-08-197 (1)(a), the employing agency must provide the employee a written notice of eligibility for PEBB benefits and offer a new enrollment period. Employees who do not return the required enrollment forms default to enrollment according to WAC 182-08-197 (1)(b).

(1) **Enrollment.**

(a) PEBB medical and dental enrollment is effective the first day of the month following the date the enrollment error is identified, unless the authority determines additional recourse is warranted, as described in subsection (3) of this section. If the enrollment error is identified on the first day of the month, the enrollment correction is effective that day;

(b) Basic life and basic long-term disability (LTD) insurance enrollment is retroactive to the first day of the month following the day the employee became newly eligible, or the first day of the month the employee regained eligibility, as described in WAC 182-08-197. If the employee became newly eligible on the first working day of a month, basic life and basic LTD insurance coverage begins on that date;

(c) Optional life and optional LTD insurance is retroactive to the first day of the month following the day the employee became newly eligible if the employee elects to enroll in this coverage (or if previously elected, the first of the month following the signature date of the employee's application for this coverage). If an employing agency enrollment error occurred when the employee regained eligibility for the employer contribution following a period of leave as described in WAC 182-08-197(3):

(i) Optional insurance coverage is enrolled the first day of the month the employee regained eligibility, at the same level of coverage the employee continued during the period of leave, without evidence of insurability.

(ii) If the employee was not eligible to continue optional LTD insurance coverage during the period of leave, optional LTD insurance coverage is reinstated the first day of the month the employee regained eligibility, to the level of coverage the employee was enrolled in prior to the period of leave, without evidence of insurability.

(iii) If the employee was eligible to continue optional insurance coverage under the period of leave but did not, the employee must provide evidence of insurability and receive approval from the contracted vendor.

(d) If the employee is eligible and elects (or elected) to enroll in the medical flexible spending (~~account~~) arrangement (FSA) or dependent care assistance program (DCAP), enrollment is limited to three months prior to the date enrollment is processed, but not earlier than the current plan year. If an employee was not enrolled in an FSA or DCAP as elected, the employee may adjust his or her election. The employee may either participate at the amount originally elected with a corresponding increase in contributions for the balance of the plan year, or participate at a reduced amount for the plan year by maintaining the per-pay period contribution in effect.

(2) **Premium payments.**

(a) The employing agency must remit to the authority the employer contribution and the employee contribution for health plan premiums, premium surcharges, basic life, and basic LTD from the date insurance coverage begins as described in subsections (1) and (3)(a)(i) of this section. If a state agency failed to notify a newly eligible employee

of his or her eligibility for PEBB benefits, the state agency may only collect the employee contribution for health plan premiums and premium surcharges for coverage for months following notification of a new enrollment period.

(b) When an employing agency fails to correctly enroll the amount of optional life insurance or optional LTD insurance coverage elected by the employee, premiums will be corrected as follows:

(i) When additional premiums are due to the authority, the employee is responsible for premiums for the most recent twenty-four months of coverage. The employing agency is responsible for additional months of premiums.

(ii) When premium refunds are due to the employee, the optional life insurance or optional LTD insurance vendor is responsible for premium refunds for the most recent twenty-four months of coverage. The employing agency is responsible for additional months of premium refunds.

(3) **Recourse.**

(a) Employee eligibility for PEBB benefits begins on the first day of the month following the date eligibility is established as described in WAC 182-12-114. Dependent eligibility is described in WAC 182-12-260, and dependent enrollment is described in WAC 182-12-262. When retroactive correction of an enrollment error is limited as described in subsection (1) of this section, the employing agency must work with the employee, and the authority, to implement retroactive insurance coverage within the following parameters:

(i) Retroactive enrollment in a PEBB health plan;

(ii) Reimbursement of claims paid;

(iii) Reimbursement of amounts paid for medical and dental premiums; or

(iv) Other recourse, upon approval by the authority.

(b) Recourse must not contradict a specific provision of federal law or statute and does not apply to requests for noncovered services or in the case of an individual who is not eligible for PEBB benefits.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-08-190 The employer contribution is set by the health care authority (HCA) and paid to the HCA for all eligible employees. State agencies and employer groups that participate in the public employees benefits board (PEBB) program under contract with the health care authority (HCA) must pay premium contributions to the HCA for insurance coverage for all eligible employees and their dependents.

(1) Employer contributions for state agencies set by the HCA are subject to the approval of the governor for availability of funds as specifically appropriated by the legislature for that purpose. Insurance and health care contributions for ferry employees shall be governed by RCW 47.64.270.

(2) Employer contributions must include an amount determined by the HCA to pay administrative costs to administer insurance coverage for employees of these groups.

(3) Each employee of a state agency eligible under WAC 182-12-131 or each eligible employee of a state agency on leave under the federal Family and Medical Leave Act (FMLA) is eligible for the employer con-

tribution as described in WAC 182-12-138. The entire employer contribution is due and payable to HCA even if PEBB medical is waived as described in WAC 182-12-128.

(4) Employees of employer groups eligible under criteria stipulated under contract with the HCA are eligible for the employer contribution. The entire employer contribution is due and payable to the HCA even if PEBB medical is waived as described in WAC 182-12-128.

(5) Washington state patrol officers disabled while performing their duties as determined by the chief of the Washington state patrol are eligible for the employer contribution for PEBB medical (~~(insurance)~~) as authorized in RCW 43.43.040. No other retiree or disabled employee is eligible for the employer contribution for PEBB benefits unless they are an eligible employee as (~~(defined)~~) described in WAC 182-12-114 or 182-12-131.

(6) The terms of payment to HCA for employer groups shall be stipulated under contract with the HCA.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-08-197 When must a newly eligible employee, or an employee who regains eligibility for the employer contribution, select public employees benefits board (PEBB) benefits and complete (~~(enrollment)~~) required forms? An employee who is newly eligible or who regains eligibility for the employer contribution toward public employees benefits board (PEBB) benefits enrolls as described in this section.

(1) When an employee is newly eligible for PEBB benefits:

(a) An employee must complete the required forms indicating his or her enrollment elections (~~(and return the forms to his or her)~~), including an election to waive PEBB medical if the employee chooses to waive PEBB medical as described in WAC 182-12-128. The required forms must be returned to the employee's employing agency. Forms must be received by (~~(the)~~) his or her employing agency no later than thirty-one days (sixty days for life insurance) after the employee becomes eligible for PEBB benefits under WAC 182-12-114.

(i) An employee may enroll in optional life and optional long-term disability (LTD) insurance up to the guaranteed issue without evidence of insurability if (~~(enrollment)~~) the required forms are returned to the employee's employing agency as required. An employee may apply for enrollment in optional life and LTD insurance coverage over the guaranteed issue at any time during the calendar year by submitting the (~~(evidence of insurability)~~) required form to the vendor for approval.

(ii) If an employee is eligible to participate in the state's salary reduction plan (see WAC 182-12-116) the employee will automatically enroll in the premium payment plan upon enrollment in PEBB medical so employee medical premiums are taken on a pretax basis. To opt out of the premium payment plan, a new employee must complete the required form and return it to his or her state agency. The form must be received by his or her state agency no later than thirty-one days after the employee becomes eligible for PEBB benefits.

(iii) If an employee is eligible to participate in the state's salary reduction plan (see WAC 182-12-116) the employee may enroll in

the state's medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP) or both, except as limited by subsection (4) of this section. To enroll in these optional PEBB benefits, the employee must return the required ~~((enrollment))~~ form to his or her state agency or the PEBB program's designee. The form must be received by the state agency or the PEBB program's designee no later than thirty-one days after the employee becomes eligible for PEBB benefits.

(b) If a newly eligible employee's employing agency does not receive the employee's required forms indicating medical, dental, and LTD ~~((choice))~~ elections and the employee's tobacco use status attestation within thirty-one days and life insurance ~~((choice))~~ elections within sixty days of the employee becoming eligible, his or her ~~((coverage))~~ enrollment will be ~~((enrolled))~~ as follows:

- (i) ~~((Medical enrollment will be))~~ Uniform Medical Plan Classic;
- (ii) ~~((Dental enrollment will be))~~ Uniform Dental Plan;
- (iii) Basic life insurance;
- (iv) Basic long-term disability insurance; ~~((and))~~
- (v) Dependents will not be enrolled; and
- (vi) A tobacco use surcharge will be incurred as described in WAC 182-08-185 (1)(b).

(2) The employer contribution toward insurance coverage ends according to WAC 182-12-131. When an employee's employment ends, participation in the state's salary reduction plan ends.

(3) When an employee loses and later regains eligibility for the employer contribution toward insurance coverage following a period of leave described in WAC 182-12-133(1) and 182-12-142 (1) and (2):

(a) The employee must complete ~~((and return))~~ the required forms indicating his or her enrollment elections ~~((to his or her))~~, including an election to waive PEBB medical if the employee chooses to waive PEBB medical as described in WAC 182-12-128. The required forms must be returned to the employee's employing agency except as described in (d) of this subsection. Forms must be received by the employing agency no later than thirty-one days after the employee regains eligibility, except as described in subsection (3)(b) of this section:

(i) An employee who self-paid for optional life insurance coverage after losing eligibility will have that level of coverage reinstated without evidence of insurability;

(ii) An employee who was eligible to continue optional life under continuation coverage but discontinued that insurance coverage must submit evidence of insurability;

(iii) An employee who was eligible to continue optional LTD under continuation coverage but discontinued that insurance coverage must submit evidence of insurability for optional LTD insurance when he or she regains eligibility for the employer contribution.

(b) An employee in any of the following circumstances does not have to return ~~((a))~~ a form indicating optional LTD insurance elections ~~((form))~~. His or her optional LTD insurance will be automatically reinstated:

(i) The employee continued to self-pay for his or her optional LTD insurance after losing eligibility for the employer contribution;

(ii) The employee was not eligible to continue optional LTD insurance after losing eligibility for the employer contribution.

((Exception:

An employee's insurance coverage elections remain the same when an employee transfers from one employing agency to another employing agency without a break in PEBB coverage. This includes movement of employees between any entities described in WAC 182-12-111 and participating in PEBB benefits. Insurance coverage elections also remain the same when employees have a break in employment that does not interrupt his or her employer contribution toward PEBB insurance coverage.))

(c) If an employee's employing agency does not receive the required forms within thirty-one days of the employee regaining eligibility, medical, dental, life, tobacco use surcharge, and LTD enrollment will be as described in subsection (1)(b) of this section, except as described in (b) of this subsection.

(d) If an employee is eligible to participate in the state's salary reduction plan (see WAC 182-12-116) the employee may enroll in the state's medical FSA or DCAP or both, except as limited by subsection (4) of this section. To enroll in these optional PEBB benefits, the employee must return the required ((enrollment)) form to his or her state agency or the PEBB program's designee. The form must be received by the employee's state agency or the PEBB program's designee no later than thirty-one days after the employee becomes eligible for PEBB benefits.

(4) If an employee who is eligible to participate in the state's salary reduction plan (see WAC 182-12-116) is hired into a new position that is eligible for PEBB benefits in the same year, the employee may not resume participation in DCAP or medical FSA until the beginning of the next plan year, unless the time between employments is less than thirty days and the employee notifies the new state agency and the DCAP or FSA administrator of his or her employment transfer within the current plan year.

(5) An employee's insurance coverage elections remain the same when an employee transfers from one employing agency to another employing agency without a break in PEBB coverage. This includes movement of an employee between any entities described in WAC 182-12-111 and participating in PEBB benefits. Insurance coverage elections also remain the same when an employee has a break in employment that does not interrupt his or her employer contribution toward insurance coverage.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-08-199 When may an employee enroll in or change his or her election under the premium payment plan, medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP)? An employee who is eligible to participate in the state's salary reduction plan as described in WAC 182-12-116 may enroll in or change his or her election under the premium payment plan, medical flexible spending arrangement (FSA), or dependent care assistance program (DCAP) at the following times:

(1) When newly eligible under WAC 182-12-114, as described in WAC 182-08-197(1).

(2) **During annual open enrollment:** An eligible employee may enroll in or change his or her election under the state's premium payment plan, medical FSA or DCAP during the annual open enrollment. For the state's premium payment plan, the required ((enrollment)) form must be submitted to his or her employing agency. To enroll or reenroll in medical FSA or DCAP the employee must submit the required ((enrollment)) form to his or her employing agency or the public employees benefits board (PEBB) program's designee. All required forms must be received no later than the last day of the annual open enroll-

ment. The enrollment or new election will be effective January 1st of the following year.

(3) **During a special open enrollment:** An employee may enroll or change his or her election under the state's premium payment plan, medical FSA or DCAP outside of the annual open enrollment if a special open enrollment event occurs. The enrollment or change in election must be allowable under Internal Revenue Code (IRC) and correspond to and be consistent with the event that creates the special open enrollment. To make a change or enroll, the employee must submit the required ((enrollment)) forms as instructed on the forms. The required ((enrollment)) forms must be received no later than sixty days after the event occurs. The employee must provide evidence of the event that created the special open enrollment.

For purposes of this section, an eligible dependent includes any person who qualifies as a dependent of the employee for tax purposes under IRC Section 152 without regard to the income limitations of that section. It does not include a registered domestic partner unless the domestic partner otherwise qualifies as a dependent for tax purposes under IRC Section 152.

(a) **Premium payment plan.** An employee may enroll or change his or her election under the premium payment plan when any of the following special open enrollment events occur, if the requested change corresponds to and is consistent with the event. The enrollment or change in election will be effective the first day of the month following the later of the event date or the date the required form is received. If that day is the first of the month, the enrollment or change in election begins on that day. If the special open enrollment is due to the birth, adoption or assumption of legal obligation for total or partial support in anticipation of adoption of a child, the enrollment or change in election will begin the first of the month in which the event occurs.

(i) Employee acquires a new dependent due to:

- Marriage;
- Registering a domestic partnership when the dependent is a tax dependent of the subscriber;
- Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption;
- A child becoming eligible as an extended dependent through legal custody or legal guardianship; or
- A child becoming eligible as a dependent with a disability((+)).

(ii) Employee's dependent no longer meets PEBB eligibility criteria because:

- Employee has a change in marital status;
- Employee's domestic partnership with a registered domestic partner who is a tax dependent is dissolved or terminated;
- An eligible dependent child turns age twenty-six or otherwise does not meet dependent child eligibility criteria;
- An eligible dependent ceases to be eligible as an extended dependent or as a dependent with a disability; or
- An eligible dependent dies.

(iii) Employee or an employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);

(iv) Employee or an employee's dependent has a change in employment status that affects the employee's or a dependent's eligibility

for their employer contribution toward employer-based group health insurance;

(v) Employee or an employee's dependent has a change in enrollment under another employer-based group health insurance plan during its annual open enrollment that does not align with the PEBB program's annual open enrollment;

(vi) Employee or an employee's dependent has a change in residence that affects health plan availability;

(vii) Employee's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States;

(viii) A court order or national medical support notice (see also WAC 182-12-263) requires the employee or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former registered domestic partner is not an eligible dependent);

(ix) Employee or an employee's dependent becomes entitled to coverage under medicaid or a state children's health insurance program (CHIP), or the subscriber or a subscriber's dependent loses eligibility for coverage under medicaid or CHIP;

(x) Employee or an employee's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from medicaid or a state children's health insurance program (CHIP);

(xi) Employee or an employee's dependent becomes entitled to coverage under medicare, or the employee or an employee's dependent loses eligibility for coverage under medicare, or enrolls in or ~~(cancels)~~ terminates enrollment in a medicare Part D plan;

(xii) Employee or an employee's dependent's current health plan becomes unavailable because the employee or enrolled dependent is no longer eligible for a health savings account (HSA). The health care authority (HCA) may require evidence that the employee or employee's dependent is no longer eligible for an HSA;

(xiii) Employee or an employee's dependent experiences a disruption of care that could function as a reduction in benefits for the employee or the employee's dependent for a specific condition or ongoing course of treatment. The employee may not change their health plan election if the employee's or dependent's physician stops participation with the employee's health plan unless the PEBB program determines that a continuity of care issue exists. The PEBB program will consider but not limit its consideration to the following:

- Active cancer treatment such as chemotherapy or radiation therapy for up to ninety days or until medically stable; or
- Transplant within the last twelve months; or
- Scheduled surgery within the next sixty days (elective procedures within the next sixty days do not qualify for continuity of care); or
- Recent major surgery still within the postoperative period of up to eight weeks; or
- Third trimester of pregnancy.

(xiv) Employee or employee's dependent becomes eligible and enrolls in TRICARE, or loses eligibility for TRICARE.

If the employee is having premiums taken from payroll on a pretax basis, a plan change will not be approved if it would conflict with provisions of the salary reduction plan authorized under RCW 41.05.300.

(b) **Medical flexible spending ((account)) arrangement (FSA)**. An employee may enroll or change his or her election under the medical

FSA when any one of the following special open enrollment events occur, if the requested change corresponds to and is consistent with the event. The enrollment or change in election will be effective the first day of the month following the later of the event date or the date the required form is received. If that day is the first of the month, the enrollment or change in election begins on that day. If the special open enrollment is due to the birth, adoption or assumption of legal obligation for total or partial support in anticipation of adoption of a child, the enrollment or change in election will begin the first of the month in which the event occurs.

(i) Employee acquires a new dependent due to:

- Marriage;
- Registering a domestic partnership if the domestic partner qualifies as a tax dependent of the subscriber;
- Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption;
- A child becoming eligible as an extended dependent through legal custody or legal guardianship; or
- A child becoming eligible as a dependent with a disability.

(ii) Employee's dependent no longer meets PEBB eligibility criteria because:

- Employee has a change in marital status;
- Employee's domestic partnership with a registered domestic partner who qualifies as a tax dependent is dissolved or terminated;
- An eligible dependent child turns age twenty-six or otherwise does not meet dependent child eligibility criteria;
- An eligible dependent ceases to be eligible as an extended dependent or as a dependent with a disability; or
- An eligible dependent dies.

(iii) Employee or an employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);

(iv) Employee or an employee's dependent has a change in employment status that affects the employee's or a dependent's eligibility for the FSA;

(v) A court order or national medical support notice requires the employee or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former registered domestic partner is not an eligible dependent);

(vi) Employee or an employee's dependent becomes entitled to coverage under medicaid or a state children's health insurance program (CHIP), or the employee or an employee's dependent loses eligibility for coverage under medicaid or CHIP;

(vii) Employee or an employee's dependent becomes entitled to coverage under medicare.

(c) **Dependent care assistance program (DCAP).** An employee may enroll or change his or her election under the DCAP when any one of the following special open enrollment events occur, if the requested change corresponds to and is consistent with the event. The enrollment or change in election will be effective the first day of the month following the later of the event date or the date the required form is received. If that day is the first of the month, the enrollment or change in election begins on that day. If the special open enrollment is due to the birth, adoption or assumption of legal obligation for total or partial support in anticipation of adoption of a child, the

enrollment or change in election will begin the first of the month in which the event occurs.

(i) Employee acquires a new dependent due to:

- Marriage;
- Registering a domestic partnership if the domestic partner qualifies as a tax dependent of the subscriber;
- Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption;
- A child becoming eligible as an extended dependent through legal custody or legal guardianship; or
- A child becoming eligible as a dependent with a disability.

(ii) Employee or an employee's dependent has a change in employment status that affects the employee's or a dependent's eligibility for DCAP;

(iii) Employee or an employee's dependent has a change in enrollment under another employer-based group health insurance plan during its annual open enrollment that does not align with the PEBB program's annual open enrollment;

(iv) Employee changes dependent care provider; the change to DCAP can reflect the cost of the new provider;

(v) Employee or the employee's spouse experiences a change in the number of qualifying individuals as defined in IRC Section 21 (b)(1);

(vi) Employee's dependent care provider imposes a change in the cost of dependent care; employee may make a change in the DCAP to reflect the new cost if the dependent care provider is not a qualifying relative of the employee as defined in Internal Revenue Code Section 152 ((d)(1) through (5), incorporating the rules of Section 152 (b)(1) through (3) of the IRC)).

AMENDATORY SECTION (Amending WSR 07-20-129, filed 10/3/07, effective 11/3/07)

WAC 182-08-220 Advertising or promotion of public employees benefits board (PEBB) benefit plans. (1) In order to assure equal and unbiased representation of public employees benefits board (PEBB) benefits, contracted vendors must comply with all of the following:

(a) All materials describing PEBB benefits must be prepared by or approved by the health care authority (HCA) before use.

(b) Distribution or mailing of all benefit descriptions must be performed by or under the direction of the HCA.

(c) All media announcements or advertising by a contracted vendor which include any mention of the "public employees benefits board," "PEBB," "health care authority," ((~~or~~)) "HCA," any reference to benefits for "state employees," or "retirees," or any group of employees covered by PEBB benefits, must receive the advance written approval of the HCA.

(2) Failure to comply with any or all of these requirements by a PEBB contracted vendor or subcontractor may result in contract termination by the HCA, refusal to continue or renew a contract with the noncomplying party, or both.

WAC 182-08-235 Employer group application process. This section applies to employer groups as defined in WAC 182-08-015. An employer group may apply to obtain insurance coverage through a contract with the health care authority (HCA). With the exception of school districts and educational service districts, the authority will approve or deny applications through the evaluation criteria described in WAC 182-08-240. To apply, employer groups must submit the documents and information described in this rule to the public employees benefits board (PEBB) program at least sixty days before the requested coverage effective date. School districts and educational service districts are only required to provide the documents described in subsections (1), (2), and (3) of this section. If school districts or educational service districts are required by the superintendent of public instruction to purchase insurance coverage provided by the authority, they are required to submit documents and information described in subsections (1)(c), (2), and (3) of this section.

(1) A letter of application that includes the information described in (a) through (d) of this subsection:

(a) A reference to the employer group's authorizing statute;

(b) A description of the organizational structure of the employer group and a description of the employee bargaining (~~(unit(s))~~) unit or group of nonrepresented employees for which the employer group is applying;

(c) Employer tax ID number (TIN); and

(d) A statement of whether the employer group is requesting only medical or medical, dental, life, and long-term disability (LTD) insurance. School districts and educational service districts must purchase medical, dental, life, and LTD insurance.

(2) A resolution from the employer group's governing body authorizing the purchase of PEBB insurance coverage.

(3) A signed governmental function attestation document that attests to the fact that employees for whom the employer group is applying are governmental employees whose services are substantially all in the performance of essential governmental functions.

(4) A member level census file for all of the employees for whom the employer group is applying. The file must be provided in the format required by the authority and contain the following demographic data, by member, with each member classified as employee, spouse or registered domestic partner, or child:

(a) Employee ID (any identifier which uniquely identifies the employee; for dependents the employee's unique identifier must be used);

(b) Age;

(c) Gender;

(d) First three digits of the member's zip code based on residence;

(e) Indicator of whether the employee is active or retired, if the employer group is requesting to include retirees; and

(f) Indicator of whether the member is enrolled in coverage.

(5) If the application is for a subset of the employer group's employees (e.g., bargaining unit), the employer group must provide a member level census file of all employees eligible under their current health plan who are not included on the member level census file in subsection (4) of this section. This includes retired employees par-

ticipating under the employer group's current health plan. The file must include the same demographic data by member.

(6) In addition to the requirements of subsections (1) through (5) of this section, additional information is required based upon the total number of employees that the employer group employs who are eligible under their current health plan:

(a) Employer groups with fewer than eleven eligible employees must provide proof of current coverage or proof of prior coverage within the last twelve months.

(b) Employer groups with three hundred one to two thousand five hundred eligible employees must provide the following:

(i) Large claims history for twenty-four months, by quarter that excludes the most recent three months; and

(ii) Ongoing large claims management report for the most recent quarter provided in the large claims history.

(c) Employer groups with greater than two thousand five hundred eligible employees must submit to an actuarial evaluation of the group by an actuary designated by the PEBB program. The employer group must pay for the cost of the evaluation. This cost is nonrefundable. An employer group that is approved will not have to pay for an additional actuarial evaluation if it applies to add another bargaining unit within two years of the evaluation. Employer groups of this size must provide the following:

(i) Large claims history for twenty-four months, by quarter that excludes the most recent three months;

(ii) Ongoing large claims management report for the most recent quarter provided in the large claims history;

(iii) Executive summary of benefits;

(iv) Summary of benefits and certificate of coverage; and

(v) Summary of historical plan costs.

(d) The following definitions apply for purposes of this section:

(i) "Large claim" is defined as a member that received more than twenty-five thousand dollars in allowed cost for services in a quarter; and

(ii) An "ongoing large claim" is a claim where the patient is expected to need ongoing case management into the next quarter for which the expected allowed cost is greater than twenty-five thousand dollars in the quarter.

(e) If the current health plan does not have a case management program then the primary diagnosis code designated by the authority must be reported for each large claimant and if the code indicates a condition which is expected to continue into the next quarter, the claim is counted as an ongoing large claim.

AMENDATORY SECTION (Amending WSR 13-22-019, filed 10/28/13, effective 1/1/14)

WAC 182-08-240 How will the health care authority (HCA) decide to approve or deny an employer group application? Employer group applications for participation in insurance coverage provided through the public employees benefits board (PEBB) program are approved or denied by the health care authority (HCA) based upon the information and documents submitted by the employer group and the employer group evaluation (EGE) criteria described in this rule. The authority may auto-

matically deny an employer group application if the employer group fails to provide the required information and documents described in WAC 182-08-235.

(1) Employer groups are evaluated as a single unit. To support this requirement the employer group must provide a census ((data)) file, as described in WAC 182-08-235 (1) through (5), and additional information as described in WAC 182-08-235(6) for all employees eligible to participate under the employer group's current health plan. ((This includes retired employees participating under the employer group's current health plan.)) If the employer group's application is for both employees and retirees, the census file data and additional information for retired employees participating under the employer group's current health plan must also be included.

(a) If the employer group's application is only for participation of its employees, the PEBB enrollment data used to evaluate the employer group will be state agency employee data.

(b) If an employer group's application is for participation of both its employees and retirees, the PEBB enrollment data used to evaluate the employer group will include data from the PEBB nonmedicare risk pool which includes retiree enrollment data and state agency employee data.

(2) An employer group must pass the EGE criteria or the actuarial evaluation required in subsection (3) of this section as a single unit before the application can be approved. For purposes of this section a single unit includes all employees eligible under the employer group's current health plan. If the application is only for a bargaining unit, then the bargaining unit must be evaluated using the EGE criteria in addition to all eligible employees of employer group as a single unit. If the employer group passes the EGE criteria as a single unit, but an individual bargaining unit does not, the employer group may only participate if all eligible employees of the entity participate.

(3) The authority will determine which of the criteria in (a) through (d) of this subsection is used to evaluate the employer group based upon the total number of eligible employees in the single unit.

(a) **Micro groups** (a single unit of one to ten employees) must meet the following criteria in order to pass the EGE evaluation:

(i) Provide proof of current coverage or proof of prior coverage within the last twelve months; and

(ii) The member level census file demographic data must indicate a relative underwriting factor that is equal to or better than the relative underwriting factor as determined by the authority for the like population within the nonmedicare PEBB risk pool as ((determined by the authority)) described in subsection (1) of this section.

(b) **Small and medium groups** (a single unit of eleven to three hundred employees) must meet the following criterion in order to pass the EGE evaluation: The member level census file demographic data must indicate a relative underwriting factor that is equal to or better than the relative underwriting factor as determined by the authority for the like population within the nonmedicare PEBB risk pool as ((determined by the authority)) described in subsection (1) of this section.

(c) **Large groups** (a single unit of three hundred one to two thousand five hundred employees) must meet the following criteria in order to pass the EGE evaluation:

(i) The member level census file demographic data must indicate a relative underwriting factor that is equal to or better than the relative underwriting factor as determined by the authority for the like

population within the nonmedicare PEBB risk pool as ((determined by the authority)) described in subsection (1) of this section;

(ii) One of the following two conditions must be met:

- The frequency of large claims must be less than or equal to the historical benchmark frequency for the PEBB like population within the nonmedicare population as described in subsection (1) of this section; and

- The ongoing large claims management report must demonstrate that the frequency of ongoing large claims is less than or equal to the recurring benchmark frequency for the PEBB like population within the nonmedicare population as described in subsection (1) of this section.

(d) **Jumbo groups** (a single unit of two thousand five hundred one or more employees) must meet the following criteria in order to pass the actuarial evaluation:

(i) The member level census file demographic data must indicate a relative underwriting factor that is equal to or better than the relative underwriting factor as determined by the authority for the like population within the nonmedicare PEBB risk pool as ((determined by the authority)) described in subsection (1) of this section;

(ii) One of the following two conditions must be met:

- The frequency of large claims must be less than or equal to the PEBB historical benchmark frequency for the PEBB like population within the nonmedicare population as described in subsection (1) of this section;

- The ongoing large claims management report must demonstrate that the frequency of ongoing large claims is less than or equal to the recurring benchmark frequency for the PEBB like population within the nonmedicare population((+)) as described in subsection (1) of this section.

(iii) Provide an executive summary of benefits;

(iv) Provide a summary of benefits and certificate of coverage;

(v) Provide a summary of historical plan costs; and

(vi) The evaluation of criteria in (d)(iii), (iv) and (v) of this subsection must indicate that the historical cost of benefits for the employer group is equal to or less than the historical cost of the PEBB like population within the nonmedicare population as described in subsection (1) of this section for a comparable plan design.

(4) ~~((The group evaluation for a jumbo group))~~ An approved group application is valid for ((two years after approval)) three hundred sixty-five calendar days after the date the application is approved by the authority. If an employer group applies to add additional bargaining units after ((two years)) the three hundred sixty-five calendar day period has ended, the group must be reevaluated.

(5) An entity whose employer group application is denied may appeal the authority's decision to the PEBB appeals committee through the process described in WAC 182-16-038.

(6) An entity whose employer group application is approved may purchase insurance for its employees under the participation requirements described in WAC 182-08-245.

WAC 182-08-245 Employer group participation requirements. This section applies to an employer group as defined in WAC 182-08-015 that is approved to purchase insurance for its employees through a contract with the health care authority (HCA).

(1) Prior to enrollment of employees in public employees benefits board (PEBB) insurance coverage, the employer group must:

(a) Remit to the authority the required start-up fee in the amount publicized by the PEBB program;

(b) Sign a contract with the authority;

(c) Determine employee and dependent eligibility and terms of enrollment for insurance coverage (~~((in accordance with))~~) by the criteria outlined in the employer group's contract with the authority;

(d) Determine eligibility in order to ensure the PEBB program's continued status as a governmental plan under Section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA) as amended. This means (~~((that only))~~) the employer group may only consider employees whose services are substantially all in the performance of essential governmental functions, but not in the performance of commercial activities, whether or not those activities qualify as essential governmental functions (~~((may be considered eligible by the employer group))~~) to be eligible; and

(e) Ensure PEBB (~~((health plans are))~~) insurance coverage is the only employer-sponsored (~~((health plans))~~) coverage available to groups of employees eligible for PEBB insurance coverage under the contract.

(2) Pay premiums (~~((in accordance with))~~) under its contract with the authority based on the following premium structure:

(a) The premium rate structure for school districts and educational service districts will be a composite rate equal to the rate charged to state agencies plus an amount equal to the employee premium based on health plan (~~((choice))~~) election and family enrollment. School districts and educational service districts must collect an amount equal to the premium surcharge(s) applied to an employee's account by the authority from their employees and include the funds in their payment to the authority.

Exception: The authority will allow districts that enrolled prior to September 1, 2002, to continue participation based on a tiered rate structure. The authority may require the district to change to a composite rate structure with ninety days advance written notice.

(b) The premium rate structure for employer groups other than districts described in (a) of this subsection will be a tiered rate based on health plan (~~((choice))~~) election and family enrollment. Employer groups must collect an amount equal to the premium surcharge(s) applied to an employee's account by the authority from their employees and include the funds in their payment to the authority.

Exception: The authority will allow employer groups that enrolled prior to January 1, 1996, to continue to participate based on a composite rate structure. The authority may require the employer group to change to a tiered rate structure with ninety days advance written notice.

(3) If an employer group wants to make subsequent changes to the contract, the changes must be submitted to the authority for approval.

(4) The employer group must maintain participation in PEBB insurance coverage for at least one full year. An employer group may only end participation at the end of a plan year unless the authority approves a mid-year termination. To end participation, an employer group must provide written notice to the PEBB program at least sixty days before the requested termination date.

(5) Upon approval to purchase insurance through a contract with the authority, the employer group must provide a list of employees and dependents that are enrolled in (~~COBRA benefits~~) Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage and the remaining number of months available to them based on their qualifying event. These employees and dependents may enroll in PEBB medical and dental as COBRA enrollees for the remainder of the months available to them based on their qualifying event.

(6) Enrollees in PEBB insurance coverage under one of the continuation of coverage provisions allowed under chapter 182-12 WAC or retirees included in the transfer unit as allowed under WAC 182-08-237 cease to be eligible as of the last day of the contract and may not continue enrollment beyond the end of the month in which the contract is terminated.

Exception:

If an employer group, other than a school district or educational service district, ends participation, retired and disabled employees who began participation before September 15, 1991, are eligible to continue enrollment in PEBB insurance coverage if the employee continues to meet the procedural and eligibility requirements of WAC 182-12-171. Employees who enrolled after September 15, 1991, who are enrolled in PEBB retiree insurance coverage cease to be eligible under WAC 182-12-171, but may continue health plan enrollment under COBRA (see WAC 182-12-146).

WAC 182-12-109 Definitions. The following definitions apply throughout this chapter unless the context clearly indicates another meaning:

"Affordable Care Act" means the federal Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, P.L. 111-152, or federal regulations or guidance issued under the Affordable Care Act.

"Annual open enrollment" means an annual event set aside for a period of time when subscribers may make changes to their health plan enrollment and salary reduction elections for the following plan year. Subscribers may transfer from one health plan to another, enroll or remove dependents from coverage, enroll or waive enrollment in ((a)) PEBB medical ((plan)), or employees may enroll in or change their election under the DCAP, the medical FSA, or the premium payment plan.

"Authority" or "HCA" means the health care authority.

"Benefits-eligible position" means any position held by an employee who is eligible for benefits under WAC 182-12-114, with the exception of employees who establish eligibility under WAC 182-12-114 (2) or (3)(a)(ii).

"Blind vendor" means a "licensee" as defined in RCW 74.18.200.

"Board" means the public employees benefits board established under provisions of RCW 41.05.055.

"Calendar days" or "days" means all days including Saturdays, Sundays, and all legal holidays as set forth in RCW 1.16.050.

"Continuation coverage" means the temporary continuation of PEBB health plan coverage available to enrollees after a qualifying event occurs as administered under Title XXII of the Public Health Service (PHS) Act, 42 U.S.C. Secs. 300bb-1 through 300bb-8.

"Creditable coverage" means coverage that meets the definition of "creditable coverage" under RCW 48.66.020 (13)(a) and includes payment of medical and hospital benefits.

"Defer" means to postpone enrollment or interrupt enrollment in a PEBB health plan by a retiree or eligible survivor.

"Dependent" means a person who meets eligibility requirements in WAC 182-12-260, except that "surviving spouses, state registered domestic partners, and dependent children" of emergency service personnel who are killed in the line of duty is defined in WAC 182-12-250.

"Dependent care assistance program" or "DCAP" means a benefit plan whereby state and public employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan authorized in chapter 41.05 RCW.

"Director" means the director of the authority.

"Documents" means papers, letters, writings, e-mails, electronic files, or other printed or written items.

"Effective date of enrollment" means the first date when an enrollee is entitled to receive covered benefits.

"Employee" includes all employees of the state, whether or not covered by civil service; elected and appointed officials of the executive branch of government, including full-time members of boards, commissions, or committees; justices of the supreme court and judges of the court of appeals and the superior courts; and members of the state legislature. Pursuant to contractual agreement with the authority, "employee" may also include: (a) Employees of a county, municipal-

ity, or other political subdivision of the state and members of the legislative authority of any county, city, or town who are elected to office after February 20, 1970, if the legislative authority of the county, municipality, or other political subdivision of the state seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.04.205 and 41.05.021 (1)(g); (b) employees of employee organizations representing state civil service employees, at the option of each such employee organization, and, effective October 1, 1995, employees of employee organizations currently pooled with employees of school districts for the purpose of purchasing insurance benefits, at the option of each such employee organization; (c) employees of a school district if the authority agrees to provide any of the school districts' insurance programs by contract with the authority as provided in RCW 28A.400.350; (d) employees of a tribal government, if the governing body of the tribal government seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(f) and (g); (e) employees of the Washington health benefit exchange if the governing board of the exchange established in RCW 43.71.020 seeks and receives approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(g) and (n); and (f) employees of a charter school established under chapter 28A.710 RCW. "Employee" does not include: Adult family home providers; unpaid volunteers; patients of state hospitals; inmates; employees of the Washington state convention and trade center as provided in RCW 41.05.110; students of institutions of higher education as determined by their institution; and any others not expressly defined as employees under this chapter or by the authority under this chapter.

"Employer-based group medical insurance" means group medical insurance coverage related to a current employment relationship. It does not include medical insurance coverage available to retired employees, individual market medical insurance coverage, or government-sponsored programs such as medicare or medicaid.

"Employer group" means those ((~~employee organizations representing state civil service employees,~~) counties, municipalities, political subdivisions, the Washington health benefit exchange, tribal governments, school districts, ((~~charter schools, and~~)) educational service districts ((~~participating in PEBB insurance coverage under contractual agreement~~)), and employee organizations representing state civil service employees, obtaining employee benefits through a contractual agreement with the authority as described in WAC 182-08-245.

"Employing agency" means a division, department, or separate agency of state government, including an institution of higher education; a county, municipality, school district, educational service district, or other political subdivision; charter school; or a tribal government covered by chapter 41.05 RCW.

"Enrollee" means a person who meets all eligibility requirements defined in chapter 182-12 WAC, who is enrolled in PEBB benefits, and for whom applicable premium payments have been made.

"Exchange" means the Washington health benefit exchange established in RCW 43.71.020, and any other health benefit exchange established under the Affordable Care Act.

"Exchange coverage" means coverage offered by a qualified health plan through an exchange.

"Faculty" means an academic employee of an institution of higher education whose workload is not defined by work hours but whose appointment, workload, and duties directly serve the institution's academic mission, as determined under the authority of its enabling statutes, its governing body, and any applicable collective bargaining agreement.

"Federal (~~(Retiree Plan)~~) retiree medical plan" means the Federal Employees Health Benefits program (FEHB) (~~(and Tricare)~~) or TRICARE which are not employer-based group medical insurance.

"Health plan" means a plan offering medical or dental, or both, developed by the public employees benefits board and provided by a contracted vendor or self-insured plans administered by the HCA.

"Institutions of higher education" means the state public research universities, the public regional universities, The Evergreen State College, the community and technical colleges, and the state board for community and technical colleges.

"Insurance coverage" means any health plan, life insurance, long-term care insurance, long-term disability (LTD) insurance, or property and casualty insurance administered as a PEBB benefit.

"Layoff," for purposes of this chapter, means a change in employment status due to an employer's lack of funds or an employer's organizational change.

"Life insurance" includes basic life insurance paid for by the employing agency, life insurance offered to employees on an optional basis, and retiree life insurance.

"LTD insurance" includes basic long-term disability insurance paid for by the employing agency and long-term disability insurance offered to employees on an optional basis.

"Mail" or "mailing" means placing a document in the United States Postal system, commercial delivery service, or Washington state consolidated mail services properly addressed.

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby state and public employees may reduce their salary before taxes to pay for medical expenses not reimbursed by insurance as provided in the salary reduction plan authorized in chapter 41.05 RCW.

"Pay status" means all hours for which an employee receives pay.

"PEBB" means the public employees benefits board.

"PEBB appeals committee" means the committee that considers appeals relating to the administration of PEBB benefits by the PEBB program. The director has delegated the authority to hear appeals at the level below an administrative hearing to the PEBB appeals committee.

"PEBB benefits" means one or more insurance coverages or other employee benefits administered by the PEBB program within the health care authority.

"PEBB program" means the program within the HCA (~~(which)~~) that administers insurance and other benefits for eligible employees (as (~~defined~~) described in WAC 182-12-114), eligible retired (~~and disabled~~) employees (as (~~defined~~) described in WAC 182-12-171), eligible dependents (as (~~defined~~) described in WAC 182-12-250 and 182-12-260) and others as defined in RCW 41.05.011.

"Premium payment plan" means a benefit plan whereby state and public employees may pay their share of group health plan premiums with pretax dollars as provided in the salary reduction plan.

"Premium surcharge" means a payment required from a subscriber, in addition to the subscriber's premium contribution, due to an enrollee's tobacco use or a subscriber's spouse or registered domestic

partner choosing not to enroll in his or her employer-based group medical insurance when:

- Premiums are less than ninety-five percent of Uniform Medical Plan (UMP) Classic premiums; and
- The actuarial value of benefits is at least ninety-five percent of the actuarial value of UMP Classic benefits.

"Qualified health plan" means a medical plan that is certified to be offered through an exchange.

"Salary reduction plan" means a benefit plan whereby state and public employees may agree to a reduction of salary on a pretax basis to participate in the DCAP, medical FSA, or premium payment plan as authorized in chapter 41.05 RCW.

"School district" means public schools as defined in RCW 28A.150.010 which includes charter schools established under chapter 28A.710 RCW.

"Seasonal employee" means an employee hired to work during a recurring, annual season with a duration of three months or more, and anticipated to return each season to perform similar work.

"Special open enrollment" means a period of time when subscribers may make changes to their health plan enrollment and salary reduction elections outside of the annual open enrollment period when specific life events occur. Subscribers may change health plans and enroll or remove dependents from coverage. Additionally, employees may enroll in or waive enrollment in ((a)) PEBB medical ((plan)), and may enroll in or change their election under the DCAP, medical FSA, or the premium payment plan. For special open enrollment events as they relate to specific PEBB benefits, see WAC 182-08-198, 182-08-199, 182-12-128, and 182-12-262.

"State agency" means an office, department, board, commission, institution, or other separate unit or division, however designated, of the state government and all personnel thereof. It includes the legislature, executive branch, and agencies or courts within the judicial branch, as well as institutions of higher education and any unit of state government established by law.

"Subscriber" means the employee, retiree, COBRA beneficiary, or eligible survivor who has been designated by the HCA as the individual to whom the HCA and contracted vendors will issue all notices, information, requests and premium bills on behalf of enrollees.

~~(("Termination of the employment relationship" means that an employee resigns or an employee is terminated and the employing agency has no anticipation that the employee will be rehired.))~~

"Tobacco products" means any product made with or derived from tobacco that is intended for human consumption, including any component, part, or accessory of a tobacco product. This includes, but is not limited to, cigars, cigarettes, chewing tobacco, snuff, and other tobacco products. It does not include United States Food and Drug Administration (FDA) approved quit aids or e-cigarettes until their tobacco related status is determined by the FDA.

"Tobacco use" means any use of tobacco products within the past two months. Tobacco use, however, does not include the religious or ceremonial use of tobacco.

"Tribal government" means an Indian tribal government as defined in Section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, or an agency or instrumentality of the tribal government, that has government offices principally located in this state.

"Waive" means to interrupt an eligible employee's enrollment in a PEBB health plan because the employee is enrolled in other employer-based group medical insurance, TRICARE, or medicare as allowed under WAC 182-12-128, or is on approved educational leave and obtains other employer-based group health insurance as allowed under WAC 182-12-136.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-12-111 (~~(Eligible entities and individuals.)~~) Which entities and individuals are eligible for public employees benefits board (PEBB) benefits? The following entities and individuals shall be eligible for public employees benefits board (PEBB) benefits subject to the terms and conditions set forth below:

(1) **State agencies.** State agencies, as defined in WAC 182-12-109, are required to participate in all PEBB benefits. Insurance and health care contributions for ferry employees shall be governed by RCW 47.64.270.

(2) **Employer groups.** Employer groups may apply to participate in insurance coverage for groups of employees described in ~~((subsection))~~ (a) of this ~~((section))~~ subsection at the option of each employer group:

(a) All eligible employees of the entity must transfer as a unit with the following exceptions:

~~((+))~~ (i) Bargaining units may elect to participate separately from the whole group;

~~((+))~~ (ii) Nonrepresented employees may elect to participate separately from the whole group provided all nonrepresented employees join as a group; and

~~((+))~~ (iii) Members of the employer group's governing authority may participate as described in the employer group's governing statutes and RCW 41.04.205.

(b) ~~((The))~~ Employer groups must apply through the process described in WAC 182-08-235. School district and educational service district applications must provide the documents described in WAC 182-08-235 (1), (2), and (3). If a school district or educational service district is required by the superintendent of public instruction to purchase insurance coverage provided by the authority, the school district or educational service district is required to submit documents and information described in WAC 182-08-235 (1)(c), (2), and (3). Employer group applications are subject to review and approval by the health care authority (HCA). With the exception of a school district or educational service district, the authority will approve or deny an employer group's application based on the employer group evaluation criteria described in WAC 182-08-240.

(c) Employer groups participate through a contract with the authority as described in WAC 182-08-245.

(3) **School districts and educational service districts.** In addition to subsection (2) of this section, the following applies to school districts and educational service districts:

(a) The HCA will collect an amount equal to the composite rate charged to state agencies, plus an amount equal to the employee premium by health plan and family size and an amount equal to any applica-

ble premium surcharge as would be charged to state employees for each participating school district or educational service district.

(b) The HCA may collect these amounts in accordance with the district fiscal year, as described in RCW 28A.505.030.

(4) **The Washington health benefit exchange.** In addition to subsection (2) of this section, the following provisions apply:

(a) The Washington health benefit exchange is subject to the same rules as an employing agency in chapters 182-08, 182-12 and 182-16 WAC.

(b) ~~((An))~~ Employees of the Washington health benefit exchange ~~((is))~~ are subject to the same rules as ~~((an))~~ employees of an employing agency in chapters 182-08, 182-12 and 182-16 WAC.

(5) **Eligible nonemployees.**

~~(a) Blind vendors ((means a "licensee" as defined in RCW 74.18.200: Vendors))~~ actively operating a business enterprise program facility in the state of Washington and deemed eligible by the department of services for the blind (DSB) may voluntarily participate in PEBB medical. Dependents of blind vendors are eligible as described in WAC 182-12-260. Eligible blind vendors and their dependents may enroll during the following times:

~~(i) ((Vendors that do not enroll when first eligible may enroll only during the annual open enrollment period offered by the HCA or the first day of the month following loss of other insurance coverage.~~

~~(ii) Department of services for the blind))~~ When newly eligible: The DSB will notify eligible blind vendors of their eligibility in advance of the date ((that)) they are eligible ((to apply)) for enrollment in PEBB medical.

~~((iii) The eligibility requirements for dependents of blind vendors shall be the same as the requirements for dependents of the state employees in WAC 182-12-260.~~

~~(iv) An individual licensee or))~~ To enroll, blind vendors must submit the required forms to the DSB. The forms must be received by the DSB no later than thirty-one days after the blind vendor becomes eligible for PEBB medical.

(ii) During the annual open enrollment: Blind vendors may enroll during the annual open enrollment. The required form must be received by the DSB before the end of the annual open enrollment. Enrollment will begin January 1st of the following year.

(iii) Following loss of other medical insurance coverage: Blind vendors may enroll following loss of other medical insurance coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA). To enroll, blind vendors must submit the required forms to the DSB. The forms must be received by the DSB no later than sixty days after the loss of other medical insurance coverage. In addition to the required forms, the DSB will require blind vendors to provide evidence of loss of other medical insurance coverage.

(iv) Blind vendors who cease((s)) to actively operate a facility become((s)) ineligible to participate in PEBB medical as described in (a) of this subsection. ((Individuals losing)) Enrollees who lose eligibility for coverage may continue enrollment in PEBB medical on a self-pay basis under COBRA coverage as described in WAC 182-12-146(5).

~~(v) ((An individual licensee or vendor is))~~ Blind vendors are not eligible for PEBB retiree insurance coverage.

(b) Dislocated forest products workers enrolled in the employment and career orientation program pursuant to chapter 50.70 RCW shall be eligible for PEBB health plans while enrolled in that program.

(c) School board members or students eligible to participate under RCW 28A.400.350 may participate in insurance coverage as long as they remain eligible under that section.

(6) **Individuals and entities not eligible as employees include:**

- (a) Adult family home providers as defined in RCW 70.128.010;
- (b) Unpaid volunteers;
- (c) Patients of state hospitals;
- (d) Inmates in work programs offered by the Washington state department of corrections as described in RCW 72.09.100 or an equivalent program administered by a local government;
- (e) Employees of the Washington state convention and trade center as provided in RCW 41.05.110;
- (f) Students of institutions of higher education as determined by their institutions; and
- (g) Any others not expressly defined as an employee(~~s~~ under RCW 41.05.011)).

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-12-123 Dual enrollment is prohibited. Public employees benefits board (PEBB) health plan coverage is limited to a single enrollment per individual.

(1) Effective January 1, 2002, an individual(~~s~~) who (~~have~~) has more than one source of eligibility for enrollment in PEBB health plan coverage (called "dual eligibility") (~~are~~) is limited to one enrollment.

(2) An eligible employee may waive PEBB medical and enroll as a dependent under the health plan of his or her spouse, registered domestic partner, or parent as stated in WAC 182-12-128.

(3) A dependent enrolled in a PEBB health plan who becomes eligible for PEBB benefits as an employee must elect to enroll in PEBB benefits as described in WAC 182-08-197 (1) or (3). This includes making an election to enroll in or waive enrollment in PEBB medical as described in WAC 182-12-128 (1)(a).

(a) If the employee does not waive enrollment in PEBB medical, the employee is not eligible to remain enrolled in his or her spouse's, registered domestic partner's, or parent's PEBB health plan as a dependent. If the employee's spouse, registered domestic partner, or parent does not remove the employee (who is enrolled as a dependent) from his or her subscriber account, the PEBB program will terminate the employee's enrollment as a dependent the last day of the month before the employee's employer-paid coverage begins.

Exception: An enrolled dependent who becomes newly eligible for PEBB benefits as an employee (~~as described in WAC 182-12-114~~) may be dual-enrolled in PEBB coverage for one month. This exception is only allowed for the first month the dependent is enrolled as an employee, and only if the dependent becomes enrolled as an employee on the first working day of a month that is not the first day of the month.

~~((2) An eligible employee may waive medical and enroll as a dependent on the coverage of his or her eligible spouse, eligible registered domestic partner, or eligible parent as stated in WAC 182-12-128.~~

~~(3) Children)) (b) If the employee elects to waive his or her enrollment in PEBB medical, the employee will remain enrolled in PEBB~~

medical under his or her spouse's, registered domestic partner's, or parent's PEBB health plan as a dependent.

(4) A child who is eligible for medical and dental under two subscribers may be enrolled as a dependent under the health plan of only one subscriber.

~~((4))~~ (5) When an employee ((who)) is eligible for the employer contribution towards insurance coverage due to employment in more than one PEBB-participating employing agency the following provisions apply:

(a) The employee must choose to enroll under only one employing agency.

Exception: Faculty who seek to establish or maintain eligibility under WAC 182-12-114(3) with two or more state institutions of higher education will be enrolled under the employing agency responsible to pay the employer contribution according to WAC 182-08-200(2).

(b) If the employee loses eligibility under the employing agency he or she chose to enroll under as described in subsection (5)(a) of this section, the employee must notify his or her other employing agency no later than sixty days from the date PEBB coverage ends through the employing agency described in (a) of this subsection to transfer coverage.

(c) The employee's insurance coverage elections remain the same when an employee transfers from enrollment under one employing agency to another employing agency without a break in PEBB coverage, as described in (b) of this subsection.

(6) A retiree who defers enrollment in a PEBB health plan as described in WAC 182-12-200 by enrolling as an eligible dependent in a health plan sponsored by PEBB, a Washington state school district, or a Washington state education service district and who loses the employer contribution for such coverage must enroll in PEBB retiree insurance coverage as described in WAC 182-12-171 or defer enrollment as described in WAC 182-12-205.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-12-128 When may an employee((s)) waive ((or enroll)) enrollment in public employees benefits board (PEBB) medical and when may he or she enroll in PEBB medical after having waived enrollment?

~~((Employees))~~ An employee may waive enrollment in public employees benefits board (PEBB) medical if he or she is enrolled in other employer-based group medical insurance, TRICARE, or medicare. An employee who waives enrollment in PEBB medical must enroll in dental, basic life, and basic long-term disability insurance (unless the employing agency does not participate in these ((public employees benefits board +))PEBB((+)) insurance coverages). ((However, employees may waive PEBB medical if they are enrolled in other employer-based group medical insurance.))

~~((Employees may))~~ To waive enrollment in PEBB medical ((by submitting)), the employee must submit the required ((enrollment)) form to ((their)) his or her employing agency ((during)) at one of the following times:

(a) When the employee becomes eligible: An employee((s)) may waive PEBB medical when ((they)) he or she becomes eligible for PEBB benefits. The employee((s)) must indicate ((they are waiving)) his or her election to waive enrollment in PEBB medical on the required ((en-

~~rollment form they submit to their~~) form and submit the form to his or her employing agency. The ((enrollment)) form must be received by the employing agency no later than thirty-one days after the date ((they)) the employee becomes eligible (see WAC 182-08-197). PEBB medical will be waived as of the date the employee becomes eligible for PEBB benefits.

(b) **During the annual open enrollment:** An employee((s)) may waive PEBB medical during the annual open enrollment ((period)). The required ((enrollment)) form must be received by ((their)) the employee's employing agency before the end of the annual open enrollment. PEBB medical will be waived beginning January 1st of the following year.

(c) **During a special open enrollment:** An employee((s)) may waive PEBB medical during a special open enrollment as described in subsection (4) of this section.

The employee must submit the required form to his or her employing agency. The form must be received no later than sixty days after the event that creates the special open enrollment. In addition to the required form, the employee must provide evidence of the event that creates the special open enrollment.

PEBB medical will be waived the last day of the month following the later of the event date or the date the required form is received. If that day is the first of the month, PEBB medical will be waived the last day of the previous month. If the special open enrollment is due to the birth, adoption or assumption of legal obligation for total or partial support in anticipation of adoption of a child, PEBB medical will be waived the last day of the previous month.

(2) If an employee waives PEBB medical, the employee's eligible dependents may not be enrolled in medical.

(3) Once PEBB medical is waived, ~~((enrollment))~~ the employee is only allowed ((during)) to enroll in PEBB medical at the following times:

(a) During the annual open enrollment((+)). The required form must be received by the employee's employing agency before the end of the annual open enrollment. PEBB medical will begin January 1st of the following year.

(b) ~~During a special open enrollment ((created by an event that allows for enrollment outside of the annual open enrollment as described in subsection (4) of this section. In addition to the required forms, the PEBB program will require the employee to provide evidence of eligibility and evidence of the event that creates a special open enrollment)).~~ A special open enrollment allows an employee to change his or her enrollment outside of the annual open enrollment. A special open enrollment may be created when one of the events described in subsection (4) of this section occurs.

The employee must submit the required form to his or her employing agency. The form must be received no later than sixty days after the event that creates the special open enrollment. In addition to the required form, the employee must provide evidence of the event that creates the special open enrollment.

PEBB medical will begin the first day of the month following the later of the event date or the date the required form is received. If that day is the first of the month, coverage is effective on that day. If the special open enrollment is due to the birth, adoption or assumption of legal obligation for total or partial support in anticipation of adoption of a child, PEBB medical will begin the first of the month in which the event occurs.

(4) **Special open enrollment:** ~~((Employees may waive enrollment in medical or enroll in medical if a special open enrollment event occurs. The change in enrollment must be allowable under the Internal Revenue Code (IRC) and correspond to and be consistent with the event that creates the special open enrollment for the employee, the employee's dependent, or both. Employees must provide evidence of the event that created the special open enrollment.)) Any one of the ((following)) events in (a) through (j) of this subsection may create a special open enrollment((+)). The change in enrollment must be allowable under the Internal Revenue Code (IRC) and correspond to and be consistent with the event that creates the special open enrollment for the employee, the employee's dependent, or both.~~

(a) Employee acquires a new dependent due to:

(i) Marriage or registering a domestic partnership;

(ii) Birth, adoption or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption;

(iii) A child becoming eligible as an extended dependent through legal custody or legal guardianship; or

(iv) A child becoming eligible as a dependent with a disability;

(b) Employee or an employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);

(c) Employee or an employee's dependent has a change in employment status that affects the employee's or employee's dependent's eligibility for their employer contribution toward employer-based group medical insurance;

(d) Employee or an employee's dependent has a change in enrollment under another employer-based group medical insurance plan during its annual open enrollment that does not align with the PEBB program's annual open enrollment;

(e) Employee's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States;

(f) A court order or national medical support notice (see also WAC 182-12-263) requires the employee or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former registered domestic partner is not an eligible dependent);

(g) Employee or an employee's dependent becomes entitled to coverage under medicaid or a state children's health insurance program (CHIP), or the employee or an employee's dependent loses eligibility for coverage under medicaid or CHIP;

(h) Employee or an employee's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from medicaid or a state children's health insurance program (CHIP)((-

~~To waive or enroll during a special open enrollment, the employee must submit the required forms to his or her employing agency. The forms must be received by the employing agency no later than sixty days after the event that creates the special open enrollment.~~

~~Medical will be waived the end of the month following the later of the event date or the date the form is received. If the later day is the first of the month, medical will be waived the last day of the previous month. If the special open enrollment is due to the birth, adoption or assumption of legal obligation for total or partial support in anticipation of adoption of a child, medical will be waived the first of the month in which the event occurs.~~

~~Enrollment in medical will begin the first day of the month following the later of the event date or the date the form is received. If that day is the first of the month, coverage is effective on that day. If the special open enrollment is due to the birth, adoption or assumption of legal obligation for total or partial support in anticipation of adoption of a child, enrollment in medical will begin the first of the month in which the event occurs.));~~

(i) Employee or employee's dependent becomes eligible and enrolls in TRICARE, or loses eligibility for TRICARE;

(j) Employee becomes eligible and enrolls in medicare, or loses eligibility for medicare.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-12-131 How do eligible employees maintain the employer contribution toward insurance coverage? The employer contribution toward insurance coverage begins on the day that public employees benefits board (PEBB) benefits begin under WAC 182-12-114. This section describes under what circumstances employees maintain eligibility for the employer contribution toward insurance coverage.

(1) **Maintaining the employer contribution.** Except as described in subsections (2), (3), and (4) of this section, employees who have established eligibility for benefits under WAC 182-12-114 are eligible for the employer contribution each month in which they are in pay status eight or more hours per month.

(2) **Maintaining the employer contribution - Benefits-eligible seasonal employees.**

(a) Benefits-eligible seasonal employees (eligible under WAC 182-12-114(2)) who work a season of less than nine months are eligible for the employer contribution in any month of the season in which they are in pay status eight or more hours during that month. The employer contribution toward insurance coverage for seasonal employees returning after their off season begins on the first day of the first month of the season in which they are in pay status eight hours or more.

(b) Benefits-eligible seasonal employees (eligible under WAC 182-12-114(2)) who work a season of nine months or more are eligible for the employer contribution:

(i) In any month of the season in which they are in pay status eight or more hours during that month; and

(ii) Through the off season following each season worked.

(3) **Maintaining the employer contribution - Eligible faculty.**

(a) Benefits-eligible faculty anticipated to work half time or more the entire instructional year or equivalent nine-month period (eligible under WAC 182-12-114 (3)(a)(i)) are eligible for the employer contribution each month of the instructional year, except as described in subsection (7) of this section.

(b) Benefits-eligible faculty who are hired on a quarter/semester to quarter/semester basis (eligible under WAC 182-12-114 (3)(a)(ii)) are eligible for the employer contribution each quarter or semester in which employees work half-time or more.

(c) Summer or off-quarter/semester coverage: All benefits-eligible faculty (eligible under WAC 182-12-114(3)) who work an average of half-time or more throughout the entire instructional year or equiva-

lent nine-month period and work each quarter/semester of the instructional year or equivalent nine-month period are eligible for the employer contribution toward summer or off-quarter/semester insurance coverage.

Exception: Eligibility for the employer contribution toward summer or off-quarter/semester insurance coverage ends on the end date specified in an employing agency's termination notice or an employee's resignation letter, whichever is earlier, if the employing agency has no anticipation that the employee will be returning as faculty at any institution of higher education where the employee has employment. If the employing agency deducted the employee's premium for insurance coverage after the employee was no longer eligible for the employer contribution, insurance coverage ends the last day of the month for which employee premiums were deducted.

(d) **Two-year averaging:** All benefits-eligible faculty (eligible under WAC 182-12-114(3)) who worked an average of half-time or more in each of the two preceding academic years are potentially eligible to receive uninterrupted employer contribution to insurance coverage. "Academic year" means summer, fall, winter, and spring quarters or summer, fall, and spring semesters and begins with summer quarter/semester. In order to be eligible for the employer contribution through two-year averaging, the faculty must provide written notification of his or her potential eligibility to his or her employing agency or agencies within the deadlines established by the employing agency or agencies. Faculty continue to receive uninterrupted employer contribution for each academic year in which they:

(i) Are employed on a quarter/semester to quarter/semester basis and work at least two quarters or two semesters; and

(ii) Have an average workload of half-time or more for three quarters or two semesters.

Eligibility for the employer contribution under two-year averaging ceases immediately if the eligibility criteria is not met or if the eligibility criteria becomes impossible to meet.

(e) Faculty who lose eligibility for the employer contribution: All benefits-eligible faculty (eligible under WAC 182-12-114(3)) who lose eligibility for the employer contribution will regain it if they return to a faculty position where it is anticipated that they will work half-time or more for the quarter/semester no later than the twelfth month after the month in which they lost eligibility for the employer contribution. The employer contribution begins on the first day of the month in which the quarter/semester begins.

(4) Maintaining the employer contribution - Employees on leave and under the special circumstances listed below.

(a) Employees who are on approved leave under the federal Family and Medical Leave Act (FMLA) continue to receive the employer contribution as long as they are approved under the act.

(b) Unless otherwise indicated in this section, employees in the following circumstances receive the employer contribution only for the months they are in pay status eight hours or more:

(i) Employees on authorized leave without pay;

(ii) Employees on approved educational leave;

(iii) Employees receiving time-loss benefits under workers' compensation;

(iv) Employees called to active duty in the uniformed services as defined under the Uniformed Services Employment and Reemployment Rights Act (USERRA); or

(v) Employees applying for disability retirement.

(5) Maintaining the employer contribution - Employees who move from an eligible to an otherwise ineligible position due to a layoff maintain the employer contribution toward insurance coverage under the criteria in WAC 182-12-129.

(6) Employees who are in pay status less than eight hours in a month. Unless otherwise indicated in this section, when there is a

month in which employees are not in pay status for at least eight hours, employees:

(a) Lose eligibility for the employer contribution for that month; and

(b) Must reestablish eligibility for PEBB benefits under WAC 182-12-114 in order to be eligible for the employer contribution again.

(7) **The employer contribution toward insurance coverage ends** in any one of these circumstances for all employees:

(a) When employees fail to maintain eligibility for the employer contribution as indicated in the criteria in subsection (1) through (6) of this section.

(b) When the employment relationship is terminated. As long as the employing agency has no anticipation that the employee will be re-hired, the employment relationship is terminated:

(i) On the date specified in an employee's letter of resignation; or

(ii) On the date specified in any contract or hire letter or on the effective date of an employer-initiated termination notice.

(c) When employees move to a position that is not anticipated to be eligible for benefits under WAC 182-12-114, not including changes in position due to a layoff.

The employer contribution toward PEBB benefits cease for employees and their enrolled dependents the last day of the month in which employees are eligible for the employer contribution under this section.

Exception: If the employing agency deducted the employee's premium for insurance coverage after the employee was no longer eligible for the employer contribution, insurance coverage ends the last day of the month for which employee premiums were deducted.

(8) **Options for continuation coverage by self-paying.** During temporary or permanent loss of the employer contribution toward insurance coverage, employees have options for providing continuation coverage for themselves and their dependents by self-paying the full premium set by the health care authority (HCA). These options are available according to WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, and 182-12-270.

AMENDATORY SECTION (Amending WSR 13-22-019, filed 10/28/13, effective 1/1/14)

WAC 182-12-133 What options for continuation coverage are available to employees ~~((on))~~ and their dependents during certain types of leave or ~~((whose work))~~ when employment ends due to a layoff? Employees who have established eligibility for public employees benefits board (PEBB) benefits under WAC 182-12-114 ~~((have options for providing continuation))~~ may continue coverage for themselves and their dependents ~~((by self-paying the full premium set by the health care authority (HCA) during temporary or permanent loss of the employer contribution toward insurance coverage))~~ during certain types of leave or when their employment ends due to a layoff.

(1) ~~((When an employee is))~~ Employees who are no longer eligible for the employer contribution toward insurance coverage due to an event described in ~~((a) through (f))~~ (c)(i) through (vi) of this subsection ~~((, insurance coverage may be continued))~~ may continue insurance coverage by self-paying the full premium set by the ~~((HCA,~~

~~with no contribution from the employer.))~~ health care authority (HCA) from the date the employer contribution is lost:

(a) Employees may self-pay for a maximum of twenty-nine months. The employee must pay the premium amounts for insurance coverage as premiums become due. If premiums are more than sixty days delinquent, insurance coverage will end as of the last day of the month for which a full premium was paid.

(b) Employees may continue any combination of medical, dental and life insurance; however, only employees on approved educational leave or called in to active duty in the uniformed services as defined under the Uniformed Services Employment and Reemployment Rights Act (USERRA) may continue either basic or both basic and optional long-term disability insurance.

(c) Employees in the following circumstances qualify to continue coverage under this subsection:

~~((a) The employee is))~~ (i) Employees who are on authorized leave without pay;

~~((b) The employee is))~~ (ii) Employees who are on approved educational leave;

~~((c) The employee is))~~ (iii) Employees who are receiving time-loss benefits under workers' compensation;

~~((d) The employee is))~~ (iv) Employees who are called to active duty in the uniformed services as defined under the Uniformed Services Employment and Reemployment Rights Act (USERRA);

~~((e) The employee's))~~ (v) Employees whose employment ends due to a layoff as defined in WAC 182-12-109; or

~~((f) The employee is))~~ (vi) Employees who are applying for disability retirement.

(2) The number of months that ~~((an))~~ employees self-pay~~((s))~~ the premium while eligible ~~((under))~~ as described in subsection (1) of this section will count toward the total months of continuation coverage allowed under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). ~~((An employee who is))~~ Employees who are no longer eligible for continuation coverage as described in subsection (1) of this section but who ~~((has))~~ have not used the maximum number of months allowed under COBRA coverage may continue medical and dental for the remaining difference in months by self-paying the premium ~~((under COBRA))~~ as described in WAC 182-12-146.

AMENDATORY SECTION (Amending WSR 12-20-022, filed 9/25/12, effective 11/1/12)

WAC 182-12-138 What options are available if an employee is approved for the federal Family and Medical Leave Act (FMLA)? (1) An ~~employee((s))~~ on approved leave under the federal Family and Medical Leave Act (FMLA) may continue to receive the employer contribution toward insurance coverage in accordance with the federal FMLA. ~~((These))~~ The ~~employee((s))~~ may also continue current optional life and optional long-term disability. The employee's employing agency is responsible for determining if the employee is eligible for leave under FMLA and the duration of such leave.

(2) If ~~((the))~~ an employee's contribution toward premiums is more than sixty days delinquent, insurance coverage will end as of the last day of the month for which a full premium was paid.

~~((2))~~ (3) If an employee exhausts the period of leave approved under FMLA, insurance coverage may be continued by self-paying the full premium set by the HCA, with no contribution from the employer, under WAC 182-12-133(1) while on approved leave.

AMENDATORY SECTION (Amending WSR 13-22-019, filed 10/28/13, effective 1/1/14)

WAC 182-12-146 ~~((What options for continuation coverage are available to subscribers and dependents who become eligible under COBRA?))~~ When is an enrollee eligible to continue public employee's benefits board (PEBB) health plan coverage under Consolidated Omnibus Budget Reconciliation Act (COBRA)? An enrollee ~~((ean))~~ may continue public employee's benefits board (PEBB) health plan coverage under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) by self-paying the full premium set by the health care authority (HCA) ~~((in accordance with Consolidated Omnibus Budget Reconciliation Act (COBRA) regulations in the following circumstances:)).~~ Premiums must be paid as described in WAC 182-08-180(b).

(1) An employee or an employee's dependent who loses eligibility for the employer contribution toward insurance coverage and who qualifies for continuation coverage under COBRA may continue medical, dental, or both.

(2) An employee or an employee's dependent who loses eligibility for continuation coverage described in WAC 182-12-133, 182-12-138, 182-12-141, 182-12-142, or 182-12-148 but who has not used the maximum number of months allowed under COBRA may continue medical, dental, or both for the remaining difference in months.

(3) A retired ~~((or disabled))~~ employee who loses eligibility for PEBB retiree insurance because an employer group, with the exception of school districts and educational service districts, ceases participation in PEBB insurance coverage may continue medical, dental, or both.

(4) A retired ~~((or disabled))~~ employee, or a dependent of a retired ~~((or disabled))~~ employee, who is no longer eligible to continue coverage under WAC 182-12-171 may continue medical, dental, or both.

(5) ~~((An individual licensee or))~~ A blind vendor who ceases to actively operate a facility as described in WAC 182-12-111 (5)(a) may continue enrollment in public employees benefits board (PEBB) medical for the maximum number of months allowed under COBRA as described in this section.

~~((An individual licensee or))~~ A blind vendor is not eligible for PEBB retiree insurance coverage.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-12-171 When ((are)) is a retiring employee((s)) eligible to enroll in public employees benefits board (PEBB) retiree insurance coverage? A retiring employee is eligible to continue enrollment or defer enrollment in public employees benefits board (PEBB) insurance

coverage as a retiree if he or she meets procedural and substantive eligibility requirements as described in subsections (1) and (2) of this section.

~~(1) Procedural requirements. A retiring employee((s)) must ((meet these procedural requirements to)) enroll or defer enrollment in ((public employees benefits board (-))PEBB((+)) retiree insurance coverage(, as well as have substantive eligibility under subsection (2) or (3)) as described in (a) and (b) of this ((section)) subsection:~~

~~(a) ((The employee's form to enroll or defer enrollment)) To enroll in PEBB retiree insurance coverage, the required form must be received by the PEBB program no later than sixty days after the employee's employer-paid ((or)) coverage, Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage, or continuation coverage ends. The effective date of ((health plan enrollment will be)) PEBB retiree insurance coverage is the first day of the month ((following the loss of)) after the employee's employer-paid ((or)) coverage, COBRA coverage, or continuation coverage ends.~~

~~(Exception: The effective dates of health plan enrollment for retirees who defer enrollment in a PEBB health plan at or after retirement are identified in WAC 182-12-200 and 182-12-205.~~

~~Employees who do not enroll in a PEBB health plan at retirement are only eligible to enroll at a later date if they have deferred enrollment and maintained continuous enrollment in other coverage)) (b) To defer enrollment in a PEBB health plan, the employee must defer enrollment as described in WAC 182-12-200 or 182-12-205.~~

~~((b) Employees and)) (c) A retiring employee and his or her enrolled dependents who are entitled to medicare must enroll and maintain enrollment in both medicare parts A and B if the employee retired after July 1, 1991. If ((the employee)) a retiree or an enrolled dependent becomes entitled to medicare after enrollment in PEBB retiree insurance coverage, he or she must enroll and maintain enrollment in medicare parts A and B to remain enrolled in PEBB retiree insurance coverage.~~

~~Note: If an enrollee who is entitled to medicare does not meet this procedural requirement, the enrollee is no longer eligible for enrollment in PEBB retiree insurance coverage. The enrollee may continue PEBB health plan enrollment ((under COBRA (see)) as described in WAC 182-12-146((9))).~~

~~(2) Substantive eligibility requirements. ((Eligible employees (as described in WAC 182-12-114 and 182-12-131) who end))~~

~~(a) An employee as defined in WAC 182-12-109 who is enrolled in PEBB benefits or an employee who is enrolled in basic benefits through a Washington state school district or educational service district as defined in RCW 28A.400.270 and ends public employment after becoming vested in a Washington state-sponsored retirement plan ((as described in subsection (4) of this section) are eligible to continue)) may enroll or defer enrollment in PEBB retiree insurance coverage ((as a retiree if they)) if he or she meets procedural and substantive eligibility requirements.~~

~~(i) To be eligible to continue enrollment or defer enrollment insurance coverage as a retiree, the employee must be eligible to retire under a Washington state-sponsored retirement plan when the employee's employer-paid ((or)) coverage, COBRA coverage, or continuation coverage ends.~~

~~(ii) A retiring employee((s)) who ((do)) does not meet ((their)) his or her Washington state-sponsored retirement plan's age requirement when ((their employer paid)) his or her employer-paid coverage or COBRA coverage, or continuation coverage ends, but who meets the age requirement within sixty days of coverage ending, may request ((that their)) an appeal as described in WAC 182-16-032. His or her eligibil-~~

ity will be reviewed by the PEBB appeals committee ~~((to determine eligibility (see WAC 182-16-032)))~~. An employee((s)) must meet PEBB retiree insurance coverage ((election)) procedural requirements as described in subsection (1) of this section.

~~((Employees))~~ (b) A retiring employee of a state agency must immediately begin to receive a monthly retirement plan payment, with exceptions described below:

~~((•))~~ (i) A retiring employee((s)) who receives a lump-sum payment instead of a monthly retirement plan payment ((are)) is only eligible if the department of retirement systems offered the employee the choice between a lump sum actuarially equivalent payment and the ongoing monthly payment, as allowed by the plan; or

~~((•))~~ (ii) A retiring employee((s)) who ((are)) is a member((s)) of a Plan 3 retirement plan, also called a separated employee((s)) (defined in RCW 41.05.011(20)), ((are eligible if they meet their)) must meet his or her Plan 3 retirement ((plan's)) eligibility criteria. ((They do)) The employee does not have to receive a retirement plan payment to enroll in retiree insurance coverage;

~~((• Employees who are members))~~ (c) A retiring employee of a Washington higher education institution who is a member of a higher education retirement plan ((are eligible if they)) (HERP) must immediately begin to receive a monthly retirement plan payment, or meet ((their)) his or her HERP plan's retirement eligibility criteria, or ((are)) be at least age fifty-five with ten years of state service;

~~((• Employees not retiring under a))~~ (d) A retiring employee of an employer group participating in PEBB insurance coverage under contractual agreement with the authority must be eligible to retire as described in (i) or (ii) of this subsection to be eligible to continue PEBB insurance coverage as a retiree, except for a school district or educational service district employee who must meet the requirements as described in subsection (2)(e) of this section.

(i) A retiring employee who is eligible to retire under a retirement plan sponsored by an employer group or tribal government that is not a Washington state-sponsored retirement plan must meet the same age and years of service requirements as if ((the person had been employed as)) he or she was a member of ((either)) public employees retirement system Plan 1 or Plan 2 ((for the same period of employment; or

~~• Employees who retire from a local government or tribal government that participates in PEBB insurance coverage for their employees are eligible to continue PEBB insurance coverage as retirees if the employees meet the procedural and eligibility requirements under this section.~~

~~(a) Local government employees. If the local government)) during his or her employment.~~

(ii) A retiring employee who is eligible to retire under a Washington state-sponsored retirement plan must immediately begin to receive a monthly retirement plan payment, with exceptions described in subsection (2)(b)(i) and (ii) of this section.

(iii) A retired employee of an employer group, except a Washington state school district or educational service district, that ends participation in PEBB insurance coverage((, employees who enrolled after September 15, 1991, are)) is no longer eligible ((for)) to continue enrollment in PEBB retiree insurance coverage((. These employees may continue health plan coverage under COBRA (see WAC 182-12-146).

~~(b) Tribal government employees.~~ If)) if he or she enrolled after September 15, 1991. Any retiree who loses eligibility for this reason may continue health plan enrollment as described in WAC 182-12-146.

~~(iv) A retired employee of a tribal government employer that ends participation in PEBB insurance coverage((, its employees are)) is no longer eligible ((for)) to continue enrollment in PEBB retiree insurance coverage. ((These employees)) Any retiree who loses eligibility for this reason may continue health plan ((coverage under COBRA (see)) enrollment as described in WAC 182-12-146((+)).~~

~~((e)) (e) A retiring employee of a Washington state school district ((and)) or educational service district ((employees for districts that do not participate in PEBB insurance coverage. Employees of Washington state school districts and educational service districts who separate from employment after becoming vested in a Washington state sponsored retirement system are eligible to enroll in PEBB health plans as a retiree when retired or permanently and totally disabled.~~

~~Except for employees who are members of a retirement Plan 3, employees who separate on or after October 1, 1993, must immediately begin to receive a monthly retirement plan payment from a Washington state sponsored retirement system.) must immediately begin to receive a monthly retirement plan payment, with exceptions described below:~~

~~(i) A retiring employee who ends employment before October 1, 1993; or~~

~~(ii) A retiring employee((s)) who receives a lump-sum payment instead of a monthly retirement plan payment ((are)) is only eligible if the department of retirement systems offered the employee the choice between a lump sum actuarially equivalent payment and the ongoing monthly payment, as allowed by the plan, or the employee enrolled before 1995((-)); or~~

~~(iii) A retiring employee((s)) who ((are)) is a member((s)) of a Plan 3 retirement system, also called a separated employee((s)) (defined in RCW 41.05.011(20)), ((are eligible if they meet their Plan 3 retirement plan's eligibility criteria. They do not have to receive a retirement plan payment to enroll in PEBB retiree insurance coverage.) must meet his or her Plan 3 retirement eligibility criteria; or~~

~~(iv) An employee((s)) who retired as of September 30, 1993, and began receiving a monthly retirement ((allowance)) plan payment from a Washington state-sponsored retirement system (as defined in chapters 41.32, 41.35 or 41.40 RCW) ((are)) is eligible if ((they)) he or she enrolled in a PEBB health plan ((not)) no later than the ((HCA's)) health care authority's (HCA's) annual open enrollment period for the year beginning January 1, 1995.~~

~~(3) ((Substantive eligibility for)) An elected ((and)) or a full-time appointed state official((s)) of the legislative ((and executive branches. Employees who are elected and full-time appointed state officials (as defined under WAC 182-12-114(4))) or executive branch of state government who voluntarily or involuntarily leave public office ((are)) is eligible to continue insurance coverage as a retiree if ((they)) he or she meets procedural requirements of subsection (1) of this section.~~

~~(4) Washington state-sponsored retirement ((systems)) plans include:~~

~~((•)) (a) Higher education retirement plans;~~

~~((•)) (b) Law enforcement officers' and firefighters' retirement system;~~

~~((•)) (c) Public employees' retirement system;~~

- ((•)) (d) Public safety employees' retirement system;
- ((•)) (e) School employees' retirement system;
- ((•)) (f) State judges/judicial retirement system;
- ((•)) (g) Teachers' retirement system; and
- ((•)) (h) State patrol retirement system.

(i) The two federal retirement systems, Civil Service Retirement System and Federal Employees' Retirement System, are considered ((a)) Washington state-sponsored retirement systems for Washington State University Extension for an employee((s)) covered under PEBB insurance coverage at the time of retirement ((~~or disability~~)).

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-12-200 ((May)) How does a retiree((s)) who ((are)) is enrolled as a dependent in a health plan sponsored by public employees benefits board (PEBB), a Washington state school district, or a Washington state educational service district ((sponsored health plan)) defer enrollment under PEBB retiree insurance coverage? ((The following provisions apply when retirees defer enrollment under public employees benefits board (PEBB) retiree insurance coverage when enrolled as a dependent in a PEBB, Washington state school district, or Washington state education service district sponsored health plan:

~~(1) Retirees who are enrolled in a PEBB, Washington state school district, or Washington state educational service district sponsored medical plan as a dependent may defer enrollment in a PEBB health plan. Retirees who defer enrollment in medical cannot remain enrolled in dental.~~

~~(2) Retirees who defer may later enroll themselves and their dependents in medical, or medical and dental, if they provide evidence of continuous enrollment in a PEBB, Washington state school district, or Washington state educational service district sponsored medical plan. Continuous enrollment must be from the date the retiree deferred enrollment in PEBB retiree insurance coverage. Retirees may enroll:~~

~~(a) During the PEBB annual open enrollment period. The required enrollment form must be received by the PEBB program no later than the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or~~

~~(b) When enrollment in the PEBB, Washington state school district, or Washington state educational service district sponsored medical plan ends or such coverage under COBRA ends. The required enrollment form and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after such coverage ends. PEBB health plan coverage begins the first day of the month after the PEBB, Washington state school district, or Washington state educational service district sponsored medical plan ends.)~~ (1) A retiree may defer enrollment in a public employees benefits board (PEBB) health plan during the period of time he or she is enrolled as a dependent in a health plan sponsored by PEBB, a Washington state school district, or a Washington state education service district, including such coverage under Consolidated Omnibus Budget Reconciliation Act (COBRA) or continuation coverage.

(2) A retiree who defers enrollment in medical must defer enrollment in dental. Retirees must be enrolled in medical to enroll in dental.

(3) A retiree who defers coverage may later enroll in a PEBB health plan if he or she provides evidence of continuous enrollment in a health plan sponsored by PEBB, a Washington state school district, or a Washington state educational service district and submits the required form as described in (a) and (b) of this subsection:

(a) During the PEBB annual open enrollment period. The required form must be received by the PEBB program no later than the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or

(b) When enrollment in a health plan sponsored by PEBB, a Washington state school district, or a Washington state educational service district ends, or such coverage under COBRA or continuation coverage ends. The retiree must submit the required form to enroll or defer enrollment as described in WAC 182-12-171 (1)(a). The required form must be received by the PEBB program no later than sixty days after coverage ends. PEBB health plan coverage begins the first day of the month following the date the other coverage ends.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-12-205 May retirees defer enrollment under public employees benefits board (PEBB) retiree insurance coverage at or after retirement? The following provisions apply when retirees defer enrollment under public employees benefits board (PEBB) retiree insurance coverage when enrolled in other coverage:

(1) Retirees who defer enrollment in a PEBB health plan also defer enrollment for all eligible dependents, except as ~~((stated))~~ described in subsection (2)(c) of this section.

(2) Retirees may defer enrollment in a PEBB health plan at or after retirement if continuously enrolled in other medical as described in this ~~((subsection))~~ section or WAC 182-12-200. Retirees who defer enrollment in medical ~~((automatically))~~ must defer enrollment in dental. Retirees must ~~((enroll))~~ be enrolled in medical to enroll in dental.

(a) Beginning January 1, 2001, retirees may defer enrollment in a PEBB health plan if they are enrolled in employer-based group medical insurance as an employee or the dependent of an employee, or such medical insurance continued under ~~((COBRA))~~ Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage or continuation coverage.

(b) Beginning January 1, 2001, retirees may defer enrollment in a PEBB health plan if they are enrolled ~~((in medical))~~ as a retiree or the dependent of a retiree ~~((enrolled))~~ in a federal retiree medical plan.

(c) Beginning January 1, 2006, retirees may defer enrollment in a PEBB health plan if they are enrolled in medicare Parts A and B and a medicaid program that provides creditable coverage as described in this chapter. The retiree's dependents may continue their PEBB health plan enrollment if they meet PEBB eligibility criteria and are not eligible for creditable coverage under a medicaid program.

(d) Beginning January 1, 2014, retirees who are not eligible for Parts A and B of Medicare may defer enrollment in a PEBB health plan if they are enrolled in exchange coverage.

(3) To defer PEBB health plan enrollment, retiring employees or enrolled subscribers must submit the required forms to the PEBB program (~~(requesting to defer)~~).

(a) If retiring employees submit the required forms to defer enrollment in a PEBB health plan after their employer-paid (~~(or)~~) coverage, COBRA coverage, or continuation coverage ends as described in WAC 182-12-171 (1)(~~(a)~~) (b), enrollment will be deferred the first of the month following the date their employer-paid (~~(or)~~) coverage, COBRA coverage, or continuation coverage ends. The forms must be received by the PEBB program no later than sixty days after the employer-paid (~~(or)~~) coverage, COBRA coverage, or continuation coverage ends.

(b) If enrolled subscribers submit the required forms to defer enrollment in a PEBB health plan, enrollment will be deferred effective the first of the month following the date (~~(their deferral)~~) the required form is received by the PEBB program. If the form is received on the first day of the month, coverage will end on the last day of the previous month.

(4) Retirees who defer enrollment while enrolled in coverage described in subsection (2)(a) through (d) of this section and lose such coverage must enroll in a PEBB retiree health plan as described in WAC 182-12-171 or defer enrollment as described in this section or WAC 182-12-200.

(5) Retirees who meet substantive eligibility requirements in WAC 182-12-171(2) and whose employer-paid coverage, COBRA coverage, or continuation coverage ended between January 1, 2001, and December 31, 2001, was not required to submit the deferral form at that time, but must have met all procedural requirements as stated in this section, WAC 182-12-171, and 182-12-200.

(~~(4)~~) (6) Retirees who defer may later enroll themselves and their dependents in a PEBB health plan as follows:

(a) Retirees who defer enrollment while enrolled in employer-based group medical insurance, or such medical insurance continued under COBRA coverage or continuation coverage may enroll in a PEBB health plan by submitting the required forms and evidence of continuous enrollment in such coverage to the PEBB program:

(i) During the PEBB annual open enrollment period. The required (~~(enrollment)~~) form must be received by the PEBB program no later than the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or

(ii) When their employer-based group medical insurance or such coverage under COBRA coverage or continuation coverage ends. The required (~~(enrollment)~~) form and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after such coverage ends. PEBB health plan coverage begins the first day of the month after the employer-based group medical insurance (~~(or)~~) coverage, COBRA coverage, or continuation coverage ends.

(b) Retirees who defer enrollment while enrolled as a retiree or dependent of a retiree in a federal retiree medical plan will have a one-time opportunity to enroll in a PEBB health plan by submitting the required forms and evidence of continuous enrollment in such coverage to the PEBB program:

(i) During the PEBB annual open enrollment period. The required (~~(enrollment)~~) form must be received by the PEBB program no later than

the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or

(ii) When the federal retiree medical plan coverage ends. The required (~~enrollment~~) form and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after such coverage ends. PEBB health plan coverage begins the first day of the month after coverage under the federal retiree medical plan ends.

(c) Retirees who defer enrollment while enrolled in medicare Parts A and B and a medicaid program that provides creditable coverage as described in this chapter may enroll in a PEBB health plan by submitting the required forms and evidence of continuous enrollment in (~~creditable~~) such coverage to the PEBB program:

(i) During the PEBB annual open enrollment period. The required (~~enrollment~~) form must be received by the PEBB program no later than the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or

(ii) When their medicaid coverage ends. The required (~~enrollment~~) form and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after such coverage ends. PEBB health plan coverage begins the first day of the month after the medicaid coverage ends; or

(iii) No later than the end of the calendar year when their medicaid coverage ends if the retiree was also determined eligible under 42 U.S.C. § 1395w-114 and subsequently enrolled in a medicare Part D plan. Enrollment in the PEBB health plan will begin January 1st following the end of the calendar year when the medicaid coverage ends. The required (~~enrollment~~) form must be received by the PEBB program no later than the last day of the calendar year (~~when~~) in which the retiree's medicaid coverage ends.

(d) Retirees who defer enrollment while enrolled in exchange coverage will have a one-time opportunity to enroll or reenroll in a PEBB health plan by submitting the required forms and evidence of continuous enrollment in such coverage to the PEBB program:

(i) During the PEBB annual open enrollment period. The required (~~enrollment~~) form must be received by the PEBB program no later than the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or

(ii) When exchange coverage ends. The required (~~enrollment~~) form and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after such coverage ends. PEBB health plan coverage begins the first day of the month after exchange coverage ends.

(e) Retirees who defer enrollment may enroll in a PEBB health plan if the retiree receives formal notice that the authority has determined it is more cost-effective to enroll the retiree or the retiree's eligible (~~dependent(s)~~) dependents in PEBB medical than a medical assistance program.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-12-208 What are the requirements regarding enrollment in dental under public employees benefits board (PEBB) retiree insurance coverage? The following provisions apply to a subscriber and his or

her dependents enrolled under public employees benefits board (PEBB) retiree insurance coverage:

(1) A subscriber and his or her dependents enrolling in dental must meet procedural requirements (as described in WAC 182-12-171(1) and 182-12-262) and eligibility requirements (as described in WAC 182-12-171(2) and 182-12-260).

(2) A subscriber and his or her dependents must be enrolled in medical to enroll in dental.

(3) A subscriber enrolling in dental must stay enrolled for at least two years before dental can be dropped unless he or she defers medical and dental coverage as described in WAC 182-12-200 or 182-12-205, or drops dental as described in subsection (4) of this section.

(4) A subscriber enrolled in PEBB dental who becomes eligible for, and enrolls in, employer-based group dental insurance as an employee or the dependent of an employee, or such coverage ((continued)) under ((COBRA,)) Consolidated Omnibus Budget Reconciliation Act (COBRA) or continuation coverage may drop PEBB dental, before completing the two-year enrollment requirement. ((The subscriber and enrolled dependents will be removed from PEBB dental)) Coverage will end on the last day of the month ((following the date)) in which the required ((enrollment)) form is received by the PEBB program. If that day is the first of the month, the change in enrollment will be made the last day of the previous month.

(a) A subscriber may enroll in PEBB dental during the PEBB annual open enrollment period. The required ((enrollment)) form must be received by the PEBB program no later than the last day of the open enrollment period. PEBB dental begins January 1st of the following year.

(b) A subscriber may enroll in PEBB dental after his or her employer-based group dental insurance or such coverage under COBRA coverage or continuation coverage ends. The required ((enrollment)) form must be received by the PEBB program no later than sixty days after such coverage ends. PEBB dental begins the first day of the month after the employer-based group dental insurance or coverage under COBRA ends.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-12-211 May an employee who is determined to be retroactively eligible for disability retirement enroll in public employees benefits board (PEBB) retiree insurance coverage? (1) An employee who is determined to be retroactively eligible for a disability retirement is eligible to enroll or defer enrollment (as described in WAC 182-12-200 or 182-12-205) in public employees benefits board (PEBB) retiree insurance coverage if:

(a) The employee submits the required form and a copy of the formal determination letter he or she received from the Washington state department of retirement systems (DRS) or the appropriate higher education authority;

(b) The employee's ((enrollment)) form and a copy of his or her Washington state-sponsored retirement system's formal determination letter are received by the PEBB program no later than sixty days after the date on the determination letter; and

(c) The employee immediately begins to receive a monthly pension benefit or a supplemental retirement plan benefit under his or her higher education retirement plan (HERP), with exceptions described in WAC 182-12-171 (2)(b).

(2) Premiums are due from the effective date of enrollment in PEBB retiree insurance coverage. The employee, at his or her option, must indicate the effective date of PEBB retiree insurance coverage on the ((enrollment)) form. The employee may choose from the following dates:

(a) The employee's retirement date as stated in the formal determination letter; or

(b) The first day of the month following the date the formal determination letter was written.

(3) The director may make an exception to the date PEBB retiree insurance coverage begins; however, such request must demonstrate extraordinary circumstances beyond the control of the retiree.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-12-250 Insurance coverage eligibility for survivors of emergency service personnel killed in the line of duty. Surviving spouses, state registered domestic partners, and dependent children of emergency service personnel who are killed in the line of duty are eligible to enroll in public employees benefits board (PEBB) retiree insurance coverage.

(1) This section applies to the surviving spouse, the surviving state registered domestic partner, and dependent children of emergency service personnel "killed in the line of duty" as determined by the Washington state department of labor and industries.

(2) "Emergency service personnel" means law enforcement officers and firefighters as defined in RCW 41.26.030, members of the Washington state patrol retirement fund as defined in RCW 43.43.120, and reserve officers and firefighters as defined in RCW 41.24.010.

(3) "Surviving spouse, state registered domestic partner, and dependent children" means:

(a) A lawful spouse;

(b) An ex-spouse as defined in RCW 41.26.162;

(c) A state registered domestic partner as defined in RCW 26.60.020(1); and

(d) Children. The term "children" includes children of the emergency service worker up to age twenty-six. Children with disabilities as defined in RCW 41.26.030(6) are eligible at any age. "Children" is defined as:

(i) Biological children (including the emergency service worker's posthumous children);

(ii) Stepchildren or children of a state registered domestic partner;

(iii) Legally adopted children;

(iv) Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child;

(v) Children specified in a court order or divorce decree; or

(vi) Children as defined in RCW 26.26.101.

(4) Surviving spouses, state registered domestic partners, and children who are entitled to medicare must enroll in both parts A and B of medicare.

(5) The survivor (or agent acting on his or her behalf) must submit the required forms to the PEBB program to either enroll or defer enrollment in retiree insurance coverage as described in subsection (7) of this section. The forms must be received by the PEBB program no later than one hundred eighty days after the later of:

(a) The death of the emergency service worker;

(b) The date on the letter from the department of retirement systems or the board for volunteer firefighters and reserve officers that informs the survivor that he or she is determined to be an eligible survivor;

(c) The last day the surviving spouse, state registered domestic partner, or child was covered under any health plan through the emergency service worker's employer; or

(d) The last day the surviving spouse, state registered domestic partner, or child was covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage from the emergency service worker's employer.

(6) Survivors who do not choose to defer enrollment in retiree insurance coverage may choose among the following options for when their enrollment in a PEBB health plan will begin:

(a) June 1, 2006, for survivors whose required forms are received by the PEBB program no later than September 1, 2006;

(b) The first of the month that is not earlier than sixty days before the date that the PEBB program receives the required forms (for example, if the PEBB program receives the required forms on August 29, the survivor may request health plan enrollment to begin on July 1); or

(c) The first of the month after the date that the PEBB program receives the required forms.

For surviving spouses, state registered domestic partners, and children who enroll, monthly health plan premiums must be paid by the survivor except as provided in RCW 41.26.510(5) and 43.43.285 (2)(b).

(7) Survivors must choose one of the following two options to maintain eligibility for retiree insurance coverage:

(a) Enroll in a PEBB health plan:

(i) Enroll in medical; or

(ii) Enroll in medical and dental.

(iii) Survivors enrolling in dental must stay enrolled for at least two years before dental can be dropped, unless they defer medical and dental coverage as described in WAC 182-12-205, or drop dental as described in WAC 182-12-208(4).

(iv) Dental only is not an option.

(b) Defer enrollment:

(i) Survivors may defer enrollment in a PEBB health plan if continuously enrolled in other coverage as described in WAC 182-12-205 (2).

(ii) Survivors may enroll in a PEBB health plan as described in WAC 182-12-205(4) when they lose other coverage. Survivors must provide evidence that they were continuously enrolled in other such coverage when enrolling in a PEBB health plan. The required (~~enrollment~~) form and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after such coverage ends.

(iii) PEBB health plan enrollment and premiums will begin the first day of the month following the day that the other coverage ended for eligible spouses and children who enroll.

(8) Survivors may change their health plan during annual open enrollment. In addition to annual open enrollment, survivors may change health plans as described in WAC 182-08-198.

(9) Survivors will lose their right to enroll in retiree insurance coverage if they:

(a) Do not apply to enroll or defer PEBB health plan enrollment within the timelines (~~stated~~) as described in subsection (5) of this section; or

(b) Do not maintain continuous enrollment in other coverage during the deferral period, as (~~provided~~) described in subsection (7)(b)(i) of this section.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-12-260 Who are eligible dependents? To be enrolled in a health plan, a dependent must be eligible under this section and the subscriber must comply with enrollment procedures outlined in WAC 182-12-262.

The public employees benefits board (PEBB) program verifies the eligibility of all dependents and (~~reserves the right to~~) will request documents from subscribers that provide evidence of a dependent's eligibility. The PEBB program will remove a subscriber's enrolled dependents from health plan enrollment if the PEBB program is unable to verify a dependent's eligibility. The PEBB program will not enroll or reenroll dependents into a health plan if the PEBB program is unable to verify a dependent's eligibility.

The subscriber must notify the PEBB program, in writing, when his or her dependent is not eligible under this section. The notification must be received by the PEBB program no later than sixty days after the date his or her dependent is no longer eligible under this section. See WAC 182-12-262 (2)(a) for the consequences of not removing an ineligible dependent from insurance coverage.

The following are eligible as dependents:

(1) Lawful spouse. Former spouses are not eligible dependents upon finalization of a divorce or annulment, even if a court order requires the subscriber to provide health insurance for the former spouse.

(2) Registered domestic partner is defined to include the following:

(a) Effective January 1, 2010, a state registered domestic partner, as defined in RCW 26.60.020(1);

(b) A domestic partner who was qualified under PEBB eligibility criteria as a domestic partner before January 1, 2010, and was continuously enrolled under the subscriber in a PEBB health plan or life insurance; and

(c) Former registered domestic partners are not eligible dependents upon dissolution or termination of a partnership, even if a court order requires the subscriber to provide health insurance for the former partner.

(3) Children. Children are eligible up to (~~age twenty-six~~) the last day of the month in which their twenty-sixth birthday occurred except as described in (i) of this subsection. Children are defined as the subscriber's:

(a) Children as defined in RCW 26.26.101 establishment of parent-child relationship;

(b) Biological children, where parental rights have not been terminated;

(c) Stepchildren. The stepchild's relationship to a subscriber (and eligibility as a PEBB dependent) ends, for purposes of this rule, on the same date the subscriber's legal relationship with the spouse or registered domestic partner ends through divorce, annulment, dissolution, termination, or death;

(d) Legally adopted children;

(e) Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child;

(f) Children of the subscriber's registered domestic partner;

(g) Children specified in a court order or divorce decree;

(h) Extended dependents in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or subscriber's registered domestic partner. The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. "Children" does not include foster children for whom support payments are made to the subscriber through the state department of social and health services foster care program; and

(i) Children of any age with a developmental disability or physical handicap that renders the child incapable of self-sustaining employment and chiefly dependent upon the subscriber for support and maintenance provided such condition occurs before the age twenty-six:

(i) The subscriber must provide evidence of the disability and evidence that the condition occurred before age twenty-six;

(ii) The subscriber must notify the PEBB program, in writing, when his or her dependent is not eligible under this section. The notification must be received by the PEBB program no later than sixty days after the date that a child age twenty-six or older no longer qualifies under this subsection;

(iii) A child with a developmental disability or physical handicap who becomes self-supporting is not eligible under this subsection as of the last day of the month in which he or she becomes capable of self-support;

(iv) A child with a developmental disability or physical handicap age twenty-six and older who becomes capable of self-support does not regain eligibility under (i) of this subsection if he or she later becomes incapable of self-support;

(v) The PEBB program will periodically certify the eligibility of a dependent child with a disability beginning at age twenty-six, but no more frequently than annually after the two-year period following the child's twenty-sixth birthday.

(4) Parents.

(a) Parents covered under PEBB medical before July 1, 1990, may continue enrollment on a self-pay basis as long as:

(i) The parent maintains continuous enrollment in PEBB medical;

(ii) The parent qualifies under the Internal Revenue Code as a dependent of the subscriber;

(iii) The subscriber continues enrollment in insurance coverage; and

(iv) The parent is not covered by any other group medical plan.

(b) Parents eligible under this subsection may be enrolled with a different health plan than that selected by the subscriber. Parents may not add additional dependents to their insurance coverage.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-12-262 When may subscribers enroll or remove eligible dependents? (1) **Enrolling dependents in public employees benefits board (PEBB) benefits.** A dependent must be enrolled in the same health plan coverage as the subscriber, and the subscriber must be enrolled to enroll his or her dependent except as provided in WAC 182-12-205 (2)(c). Subscribers may enroll eligible dependents at the following times:

(a) **When the subscriber becomes eligible** and enrolls in public employees benefits board (PEBB) benefits. If eligibility is verified and the dependent is enrolled, the dependent's effective date will be the same as the subscriber's effective date.

(b) **During the annual open enrollment.** PEBB health plan coverage begins January 1st of the following year.

(c) **During special open enrollment.** Subscribers may enroll dependents during a special open enrollment as described in subsection (3) of this section. The subscriber must satisfy the enrollment requirements as described in subsection (4) of this section.

(2) **Removing dependents from a subscriber's health plan coverage.**

(a) **A dependent's eligibility for enrollment in health plan coverage ends the last day of the month the dependent** meets the eligibility criteria in WAC 182-12-250 or 182-12-260. Employees must notify their employing agency when a dependent is no longer eligible. All other subscribers must notify the PEBB program when a dependent is no longer eligible. Consequences for not submitting notice within sixty days of the last day of the month the dependent loses eligibility for health plan coverage may include, but are not limited to:

(i) The dependent may lose eligibility to continue health plan coverage under one of the continuation coverage options described in WAC 182-12-270;

(ii) The subscriber may be billed for claims paid by the health plan for services that were rendered after the dependent lost eligibility;

(iii) The subscriber may not be able to recover subscriber-paid insurance premiums for dependents that lost their eligibility; and

(iv) The subscriber may be responsible for premiums paid by the state for the dependent's health plan coverage after the dependent lost eligibility.

(b) **Employees have the opportunity to remove dependents:**

(i) During the annual open enrollment. The dependent will be removed the last day of December; or

(ii) During a special open enrollment as described in subsections (3) and (4)(f) of this section.

(c) **Retirees, survivors, and enrollees with PEBB continuation coverage under WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, or 182-12-148 may remove dependents** from their insurance coverage outside of the annual open enrollment or a special open enrollment by provid-

ing written notice to the PEBB program. Unless otherwise approved by the PEBB program, the dependent will be removed from the subscriber's insurance coverage prospectively. Insurance coverage will end on the last day of the month in which the written notice is received by the PEBB program. If the written notice is received on the first day of the month, coverage will end on the last day of the previous month.

(3) **Special open enrollment.** Subscribers may enroll or remove their dependents outside of the annual open enrollment if a special open enrollment event occurs. The change in enrollment must correspond to and be consistent with the event that creates the special open enrollment for the subscriber, the subscriber's dependents, or both.

- Health plan coverage will begin the first of the month following the later of the event date or the date the required form is received. If that day is the first of the month, the change in enrollment begins on that day.

- Enrollment of an extended dependent((s)) or a dependent((s)) with a disability will be the first day of the month following eligibility certification.

- The dependent((s)) will be removed from the subscriber's health plan coverage the last day of the month following the later of the event date or the date the required form is received. If that day is the first of the month, the change in enrollment will be made the last day of the previous month.

- If the special open enrollment is due to the birth or adoption of a child, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of a child, health plan coverage will begin or end the month in which the event occurs.

Any one of the following events may create a special open enrollment:

- (a) Subscriber acquires a new dependent due to:
 - (i) Marriage or registering a domestic partnership;
 - (ii) Birth, adoption, or when a subscriber has assumed a legal obligation for total or partial support in anticipation of adoption;
 - (iii) A child becoming eligible as an extended dependent through legal custody or legal guardianship; or
 - (iv) A child becoming eligible as a dependent with a disability;
- (b) Subscriber or a subscriber's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);

- (c) Subscriber or a subscriber's dependent has a change in employment status that affects the subscriber's or the subscriber's dependent's eligibility for their employer contribution toward employer-based group health insurance;

- (d) Subscriber or a subscriber's dependent has a change in enrollment under another employer-based group health insurance plan during its annual open enrollment that does not align with the PEBB program's annual open enrollment;

- (e) Subscriber's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States;

- (f) A court order or national medical support notice (see also WAC 182-12-263) requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former registered domestic partner is not an eligible dependent);

(g) Subscriber or a subscriber's dependent becomes entitled to coverage under medicaid or a state children's health insurance program (CHIP), or the subscriber or a subscriber's dependent loses eligibility for coverage under medicaid or CHIP;

(h) Subscriber or a subscriber's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from medicaid or a state children's health insurance program (CHIP).

(4) Enrollment requirements. A subscriber((s)) must submit the required ((enrollment)) forms within the time frames described in this subsection. Employees submit the required forms to their employing agency. All other subscribers submit the required forms to the PEBB program. In addition to the required forms indicating dependent enrollment, the subscriber must provide the required documents as evidence of the dependent's eligibility; or as evidence of the event that created the special open enrollment.

(a) If a subscriber wants to enroll his or her eligible ((depend-ent(s))) dependents when the subscriber becomes eligible to enroll in PEBB benefits, the subscriber must include the dependent's enrollment information on the required forms that the subscriber submits within the relevant time frame described in WAC 182-08-197, 182-08-187, 182-12-171, or 182-12-250.

(b) If a subscriber wants to enroll eligible dependents during the PEBB annual open enrollment period, the required forms must be received no later than the last day of the annual open enrollment.

(c) If a subscriber wants to enroll newly eligible dependents, the required ((enrollment)) forms must be received no later than sixty days after the dependent becomes eligible except as provided in (d) of this subsection.

(d) If a subscriber wants to enroll a newborn or child whom the subscriber has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption, the subscriber should notify the PEBB program by submitting ((an-enrollment)) the required form as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the required ((enrollment)) form must be received no later than twelve months after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption.

(e) If the subscriber wants to enroll a child age twenty-six or older as a child with a disability, the required ((form(s))) forms must be received no later than sixty days after the last day of the month in which the child reaches age twenty-six or within the relevant time frame described in WAC 182-12-262 (4)(a), (b), and (f).

(f) If the subscriber wants to change a dependent's enrollment status during a special open enrollment, required forms must be received no later than sixty days after the event that creates the special open enrollment.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-12-263 National Medical Support Notice (NMSN) ((or-court-order)). When a National Medical Support Notice (NMSN) ((or-court-order)) requires a subscriber to provide health plan coverage for a dependent child the following provisions apply:

(1) The subscriber may enroll his or her dependent child and request changes to his or her health plan coverage as described under subsection (3) of this section. Employees submit the required forms to their employing agency. All other subscribers submit the required forms to the public employees benefits board (PEBB) program.

(2) If the subscriber fails to request enrollment or health plan coverage changes as directed by the NMSN (~~(or court order)~~), the employing agency or the PEBB program may make enrollment or health plan coverage changes according to subsection (3) of this section upon request of:

- (a) The child's other parent; or
- (b) Child support enforcement program.

(3) Changes to health plan coverage or enrollment are allowed as directed by the NMSN (~~(or court order)~~):

(a) The dependent will be enrolled under the subscriber's health plan coverage as directed by the NMSN (~~(or court order)~~);

(b) An employee who has waived PEBB medical under WAC 182-12-128 will be enrolled in medical as directed by the NMSN (~~(or court order)~~), in order to enroll the dependent;

(c) The subscriber's selected health plan will be changed if directed by the NMSN (~~(or court order)~~);

(d) If the dependent is already enrolled under another PEBB subscriber, the dependent will be removed from the other health plan coverage and enrolled as directed by the NMSN (~~(or court order)~~).

(4) Changes to health plan coverage or enrollment as described in subsection (3)(a) through (c) of this section will begin the first day of the month following receipt of the NMSN (~~(or court order)~~). If the NMSN (~~(or court order)~~) is received on the first day of the month, the change to health plan coverage or enrollment begins on that day. A dependent will be removed from the subscriber's health plan coverage as described in subsection (3)(d) of this section the last day of the month the NMSN (~~(or court order)~~) is received. If that day is the first of the month, the change in enrollment will be made the last day of the previous month.

(5) The subscriber may be eligible to make changes to his or her health plan enrollment and salary reduction elections during a special open enrollment related to the NMSN as described in WAC 182-08-198(2), 182-08-199(3), 182-12-128(4), or 182-12-262(3).

AMENDATORY SECTION (Amending WSR 14-08-040, filed 3/26/14, effective 4/26/14)

WAC 182-12-300 Public employees benefits board (PEBB) wellness incentive program eligibility and procedural requirements. The public employees benefits board (PEBB) annually determines the design of the PEBB wellness incentive program.

(1) All subscribers, except PEBB subscribers who are enrolled in both medicare parts A and B, and in the medicare risk pool, are eligible to participate in the PEBB wellness incentive program.

(2) To receive a PEBB wellness incentive for the (~~(following)~~) 2016 plan year, eligible subscribers must complete PEBB wellness incentive program requirements during 2015 by the latest date below:

(a) For subscribers continuing enrollment in PEBB medical and subscribers enrolling in PEBB medical with an effective date in January, February, or March, the deadline is June 30th; or

(b) (~~Within sixty days after their effective date of PEBB medical, but no later than December 31st.~~

(~~3~~) For subscribers enrolling in PEBB medical with an effective date in April, May, June, July, or August, the deadline is one hundred twenty days from the subscriber's PEBB medical effective date; or

(c) For subscribers enrolling in PEBB medical with an effective date in September, October, November, or December, the deadline is December 31st.

(3) Effective January 1, 2016, to receive a PEBB wellness incentive for the following plan year, eligible subscribers must complete PEBB wellness incentive program requirements during the current plan year by the latest date below:

(a) For subscribers continuing enrollment in PEBB medical and subscribers enrolling in PEBB medical with an effective date in January, February, March, April, May, or June the deadline is September 30th; or

(b) For subscribers enrolling in PEBB medical with an effective date in July or August, the deadline is one hundred twenty days from the subscriber's PEBB medical effective date; or

(c) For subscribers enrolling in PEBB medical with an effective date in September, October, November, or December, the deadline is December 31st.

(4) Subscribers who do not complete the requirements (~~(e)~~) according to subsection (2) or (3) of this section, except as noted, within the time frame described are not eligible to receive a PEBB wellness incentive the following plan year.

Note: All eligible subscribers can earn a wellness incentive. Subscribers who cannot complete the wellness incentive program requirements may be able to earn the same incentive by different means. The PEBB program will work with enrollees (and their physician, if they wish) to define an individual wellness program that provides the opportunity to qualify for the same incentive in light of the enrollee's health status.

(~~(4)~~) (5) A PEBB wellness incentive will be provided only if:

(a) The subscriber is still eligible for the PEBB wellness incentive program in the year the incentive applies;

(b) The funding rate provided by the legislature is designed to provide a PEBB wellness incentive program or a PEBB wellness incentive, or both; or

(~~(b)~~) (c) Specific appropriations are provided for wellness incentives.

WAC 182-16-020 Definitions. As used in this chapter the term:

"Authority" or "HCA" means the health care authority.

"Business days" means all days except Saturdays, Sundays, and all legal holidays as set forth in RCW 1.16.050.

"Calendar days" or "days" means all days including Saturdays, Sundays, and all legal holidays as set forth in RCW 1.16.050.

"Continuance" means a change in the date or time of a hearing.

"Denial" or "denial notice" means an action by, or communication from, either an employing agency, or the PEBB program that aggrieves an employee, or his or her dependent, with regard to PEBB benefits including, but not limited to, actions or communications expressly designated as a "denial," "denial notice," or "cancellation notice."

"Dependent" means a person who meets eligibility requirements in WAC 182-12-260, except that "surviving spouses, state registered domestic partners, and dependent children" of emergency service personnel who are killed in the line of duty is defined in WAC 182-12-250.

"Dependent care assistance program" or "DCAP" means a benefit plan whereby state and public employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan authorized in chapter 41.05 RCW.

"Director" means the director of the authority.

"Documents" means papers, letters, writings, e-mails, electronic files, or other printed or written items.

"Employee" includes all employees of the state, whether or not covered by civil service; elected and appointed officials of the executive branch of government, including full-time members of boards, commissions, or committees; justices of the supreme court and judges of the court of appeals and the superior courts; and members of the state legislature. Pursuant to contractual agreement with the authority, "employee" may also include: (a) Employees of a county, municipality, or other political subdivision of the state and members of the legislative authority of any county, city, or town who are elected to office after February 20, 1970, if the legislative authority of the county, municipality, or other political subdivision of the state seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.04.205 and 41.05.021 (1)(g); (b) employees of employee organizations representing state civil service employees, at the option of each such employee organization, and, effective October 1, 1995, employees of employee organizations currently pooled with employees of school districts for the purpose of purchasing insurance benefits, at the option of each such employee organization; (c) employees of a school district if the authority agrees to provide any of the school districts' insurance programs by contract with the authority as provided in RCW 28A.400.350; (d) employees of a tribal government, if the governing body of the tribal government seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(f) and (g); (e) employees of the Washington health benefit exchange if the governing board of the exchange established in RCW 43.71.020 seeks and receives approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(g) and (n); and (f) employees of a charter school established un-

der chapter 28A.710 RCW. "Employee" does not include: Adult family home providers; unpaid volunteers; patients of state hospitals; inmates; employees of the Washington state convention and trade center as provided in RCW 41.05.110; students of institutions of higher education as determined by their institution; and any others not expressly defined as employees under this chapter or by the authority under this chapter.

"Employer-based group medical insurance" means group medical insurance coverage related to a current employment relationship. It does not include medical insurance coverage available to retired employees, individual market medical insurance coverage, or government-sponsored programs such as medicare or medicaid.

"Employer group" means those ((~~employee organizations representing state civil service employees,~~) counties, municipalities, political subdivisions, the Washington health benefit exchange, tribal governments, school districts, ((~~charter schools, and~~)) educational service districts ((~~participating in PEBB insurance coverage under contractual agreement~~)), and employee organizations representing state civil service employees, obtaining employee benefits through a contractual agreement with the authority as described in WAC 182-08-245.

"Employing agency" means a division, department, or separate agency of state government, including an institution of higher education; a county, municipality, school district, educational service district, or other political subdivision; charter school; or a tribal government covered by chapter 41.05 RCW.

"Enrollee" means a person who meets all eligibility requirements defined in chapter 182-12 WAC, who is enrolled in PEBB benefits, and for whom applicable premium payments have been made.

"Final order" means an order that is the final PEBB program decision.

"Health plan" means a plan offering medical or dental, or both, developed by the public employees benefits board and provided by a contracted vendor or self-insured plans administered by the HCA.

"Hearing" means a proceeding before a presiding officer that gives a party an opportunity to be heard in a dispute about a decision made by the PEBB appeals committee, including prehearing conferences, dispositive motion hearings, status conferences, and evidentiary hearings.

"Hearing representative" means a person who is authorized to represent the PEBB program in an administrative hearing. The person may be an assistant attorney general, a licensed attorney, or authorized HCA employee.

"Institutions of higher education" means the state public research universities, the public regional universities, The Evergreen State College, the community and technical colleges, and the state board for community and technical colleges.

"Insurance coverage" means any health plan, life insurance, long-term care insurance, long-term disability (LTD) insurance, or property and casualty insurance administered as a PEBB benefit.

"LTD insurance" includes basic long-term disability insurance paid for by the employing agency and long-term disability insurance offered to employees on an optional basis.

"Mail" or "mailing" means placing a document in the United States Postal system, commercial delivery service, or Washington state consolidated mail services properly addressed.

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby state and public employees may reduce their sal-

ary before taxes to pay for medical expenses not reimbursed by insurance as provided in the salary reduction plan authorized in chapter 41.05 RCW.

"PEBB" means the public employees benefits board.

"PEBB appeals committee" means the committee that considers appeals relating to the administration of PEBB benefits by the PEBB program. The director has delegated the authority to hear appeals at the level below an administrative hearing to the PEBB appeals committee.

"PEBB benefits" means one or more insurance coverages or other employee benefits administered by the PEBB program within the health care authority.

"PEBB program" means the program within the HCA (~~(which)~~) that administers insurance and other benefits for eligible employees (as ~~(defined)~~) described in WAC 182-12-114), eligible retired and disabled employees (as ~~(defined)~~) described in WAC 182-12-171), eligible dependents (as ~~(defined)~~) described in WAC 182-12-250 and 182-12-260), and others as defined in RCW 41.05.011.

"Prehearing conference" means a proceeding scheduled and conducted by a presiding officer to address issues in preparation for a hearing.

"Premium payment plan" means a benefit plan whereby state and public employees may pay their share of group health plan premiums with pretax dollars as provided in the salary reduction plan.

"Premium surcharge" means a payment required from a subscriber, in addition to the subscriber's premium contribution, due to an enrollee's tobacco use or a subscriber's spouse or registered domestic partner choosing not to enroll in his or her employer-based group medical insurance when:

- Premiums are less than ninety-five percent of Uniform Medical Plan (UMP) Classic premiums; and
- The actuarial value of benefits is at least ninety-five percent of the actuarial value of UMP Classic benefits.

"Presiding officer" means an impartial decision maker who is an attorney, presides at an administrative hearing, and is either a director designated HCA employee or an administrative law judge employed by the office of administrative hearings.

"Record" means the official documentation of the hearing process. The record includes recordings or transcripts, admitted exhibits, decisions, briefs, notices, orders, and other filed documents.

"Salary reduction plan" means a benefit plan whereby state and public employees may agree to a reduction of salary on a pretax basis to participate in the DCAP, medical FSA, or premium payment plan as authorized in chapter 41.05 RCW.

"State agency" means an office, department, board, commission, institution, or other separate unit or division, however designated, of the state government and all personnel thereof. It includes the legislature, executive branch, and agencies or courts within the judicial branch, as well as institutions of higher education and any unit of state government established by law.

"Subscriber" means the employee, retiree, COBRA beneficiary or eligible survivor who has been designated by the HCA as the individual to whom the HCA and contracted vendors will issue all notices, information, requests and premium bills on behalf of enrollees.

"Tobacco products" means any product made with or derived from tobacco that is intended for human consumption, including any component, part, or accessory of a tobacco product. This includes, but is not limited to, cigars, cigarettes, chewing tobacco, snuff, and other

tobacco products. It does not include United States Food and Drug Administration (FDA) approved quit aids or e-cigarettes until their tobacco related status is determined by the FDA.

"Tobacco use" means any use of tobacco products within the past two months. Tobacco use, however, does not include the religious or ceremonial use of tobacco.

"Tribal government" means an Indian tribal government as defined in Section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, or an agency or instrumentality of the tribal government, that has government offices principally located in this state.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-16-036 How can an employee who is eligible to participate in the state's salary reduction plan appeal a decision regarding the administration of benefits offered under the state's salary reduction plan? (1) Any employee who is eligible to participate in the state's salary reduction plan who disagrees with a decision that denies eligibility for or enrollment in a benefit offered under the state's salary reduction plan may appeal that decision ((to the public employees benefits board (PEBB) appeals committee. The PEBB appeals manager)) by submitting a written request for review to his or her state agency. The state agency must receive the ((notice of appeal)) request for review no later than thirty days after the date of the initial denial notice ((by the PEBB program)). The contents of the ((notice of appeal)) request for review are to be provided ((in accordance with)) as described in WAC 182-16-040.

(a) Upon receiving the request for review, the state agency shall make a complete review of the initial denial by one or more staff who did not take part in the initial denial. As part of the review, the state agency may hold a formal meeting or hearing, but is not required to do so.

(b) The state agency shall render a written decision within thirty days of receiving the request for review. The written decision shall be sent to the employee.

(c) A copy of the state agency's written decision shall be sent to the state agency's administrator or designee and to the public employees benefits board (PEBB) appeals manager. The state agency's written decision shall become the state agency's final decision effective fifteen days after the date it is rendered.

(d) Any employee who disagrees with the state agency's decision in response to a request for review, as described in subsection (1) of this section, may appeal that decision by submitting a notice of appeal to the PEBB appeals committee. The PEBB appeals manager must receive the notice of appeal no later than thirty days after the date of the state agency's written decision on the request for review.

The contents of the notice of appeal are to be provided in accordance with WAC 182-16-040.

(e) The PEBB appeals manager shall notify the appellant in writing when the notice of appeal has been received.

((b)) (f) The PEBB appeals committee shall render a written decision to the appellant within thirty days of receiving the notice of

appeal. The committee may extend the thirty-day time requirement for rendering a decision upon issuing a written finding of a good reason explaining the cause for the delay.

~~((e))~~ (g) Any appellant who disagrees with the decision of the PEBB appeals committee may request an administrative hearing, as described in WAC 182-16-050.

(2) Any employee who is eligible to participate in the state's salary reduction plan aggrieved by a decision regarding a claim for benefits under the medical flexible spending arrangement (FSA) and dependent care assistance program (DCAP) offered under the state's salary reduction plan may appeal that decision to the third-party administrator contracted to administer the plan by following the appeal process of the third-party administrator.

Any employee who is eligible to participate in the state's salary reduction plan who disagrees with a decision in response to an appeal filed with the third-party administrator that administers the medical FSA and DCAP under the state's salary reduction plan may appeal to the PEBB appeals committee. The PEBB appeals manager must receive the notice of appeal no later than thirty days after the date of the appeal decision by the third-party administrator that administers the medical FSA and DCAP. The contents of the notice of appeal are to be provided in accordance with WAC 182-16-040.

(a) The PEBB appeals manager shall notify the appellant in writing when the notice of appeal has been received.

(b) The PEBB appeals committee shall render a written decision to the appellant within thirty days of receiving the notice of appeal. The committee may extend the thirty-day time requirement for rendering a decision upon issuing a written finding of a good reason explaining the cause for the delay.

(c) Any appellant who disagrees with the decision of the PEBB appeals committee may request an administrative hearing, as described in WAC 182-16-050.

(3) Any employee who is eligible to participate in the state's salary reduction plan aggrieved by a decision regarding the administration of the premium payment plan offered under the state's salary reduction plan may appeal that decision to the PEBB appeals committee. The PEBB appeals manager must receive the notice of appeal no later than thirty days after the date of the denial notice by the PEBB program. The contents of the notice of appeal are to be provided in accordance with WAC 182-16-040.

(a) The PEBB appeals manager shall notify the appellant in writing when the notice of appeal has been received.

(b) The PEBB appeals committee shall render a written decision to the appellant within thirty days of receiving the notice of appeal. The committee may extend the thirty-day time requirement for rendering a decision upon issuing a written finding of a good reason explaining the cause for the delay.

(c) Any appellant who disagrees with the decision of the PEBB appeals committee may request an administrative hearing, as described in WAC 182-16-050.

AMENDATORY SECTION (Amending WSR 08-20-128, filed 10/1/08, effective 1/1/09)

WAC 182-16-040 What should the request for review or notice of appeal contain? A request for review or notice of appeal ~~((is to))~~ should contain all of the following:

- (1) The name and mailing address of the appealing party;
- (2) The name and mailing address of the appealing party's representative, if any;
- (3) Documentation, or reference to documentation, of decisions previously rendered through the appeal process, if any;
- (4) A statement identifying the specific portion of the decision being appealed and clarifying what is believed to be unlawful or in error;
- (5) A statement of facts in support of the appealing party's position;
- (6) Any information or documentation that the appealing party would like considered and substantiates why the decision should be reversed. Information or documentation submitted at a later date, unless specifically requested by the PEBB appeals manager, may not be considered in the appeal decision;
- (7) The type of relief sought;
- (8) A statement that the appealing party has read the notice of appeal and believes the contents to be true and correct; and
- (9) The signature of the appealing party or the appealing party's representative.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-16-073 Rescheduling and continuances. (1) Any party may request the presiding officer to reschedule a hearing if a rule requires notice of a hearing and the amount of notice required was not provided.

(a) The presiding officer must reschedule the hearing under circumstances identified in this subsection (1) if requested by any party.

(b) The parties may agree to shorten the amount of notice required by any rule.

(2) Any party may request a continuance of a hearing either orally or in writing.

~~(a) ((Before contacting the presiding officer to request a continuance, the party seeking a continuance must contact the other parties, if possible, to find out if they will agree to a continuance.~~

~~(b) The party making the request for a continuance must let the presiding officer know whether the other parties agreed to the continuance. If the parties agree to a continuance, the presiding officer must grant the continuance. If the parties do not agree to a continuance, the presiding officer must schedule a prehearing conference in accordance with the requirements of WAC 182-16-071 to decide whether to grant the continuance.))~~ In each administrative hearing, the presiding officer must grant each party's first request for a continuance. The continuance may be up to thirty calendar days.

(b) The presiding officer may grant each party up to one additional continuance of up to thirty calendar days because of extraordinary circumstances.

(c) After granting a continuance, the presiding officer must mail a new hearing notice at least fourteen calendar days before the new hearing date unless the parties agree to a shorter time period.

(d) If the presiding officer denies the continuance request after a prehearing conference is held pursuant to (b) of this subsection, the presiding officer must mail a written order setting forth the basis for denying the continuance request and may proceed with the hearing on the originally scheduled hearing date) officer's office must:

(i) Immediately telephone all other parties to inform them the hearing was continued; and

(ii) Serve an order of continuance on the parties no later than fourteen days before the new hearing date. All orders of continuance must provide a new deadline for mailing documents to the presiding officer. The new mailing deadline can be no less than ten calendar days prior to the new hearing date. If the continuance is granted pursuant to (b) of this subsection, then the order of continuance must also include findings of fact that state with specificity the extraordinary circumstances for which the presiding officer granted the continuance.

(3) Regardless of whether a party has been granted a continuance as described in subsection (1) of this section, the presiding officer must grant a continuance if a new issue is raised during the hearing and a party requests a continuance.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-16-080 Determining if an administrative hearing right exists. (1) A party has a right to a hearing only if a law or program rule gives that right. If the party is not sure whether a hearing right exists, they may request a hearing to protect their rights.

(2) The right to a hearing does not exist unless:

(a) The public employees benefits board (PEBB) appeals committee has issued a written decision under WAC 182-16-030 (2)(b), 182-16-032(7), 182-16-035(4), 182-16-036 (1)((b), (3)(b), (4)) (f), (2)(b), (3)(b), or 182-16-038(2); and

(b) A hearing of the PEBB appeals committee's written decision has been timely requested pursuant to WAC 182-16-050.

(3) If the hearing representative or the presiding officer questions the right to a hearing, the presiding officer must decide whether a hearing right exists, in a written ruling, prior to reviewing and ruling on any other issues.

(4) If the presiding officer decides a person or entity does not have a right to a hearing, the matter must be dismissed.