RULE-MAKING ORDER
PERMANENT RULE ONLY

CR-103P (December 2017)
(Implements RCW 34.05.360)

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STATE OF WASHINGTON
FILED

DATE: August 29, 2024
TIME: 3:06 PM

WSR 24-18-081

Agency: Health Care Authority, Public Employees Benefits Board (PEBB) Admin #2024-01.05

Effective date of rule:

Permanent Rules

☐ 31 days after filing.

☒ Other (specify) January 1, 2025 **(If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)**

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?

☐ Yes ☒ No If Yes, explain:

Purpose: The purpose of this proposal is to amend rules to support the Public Employees Benefits Board (PEBB) Program:

1. Implement statutory changes in response to SHB 1804, Section 1, Chapter 312, Laws of 2023:

- Amended WAC 182-08-245 to include a new subsection
- Amended WAC 182-12-146 by updating a subsection and adding a new subsection
- Created WAC 182-12-232
- Amended WAC 182-12-262 to add a reference to WAC 182-12-232

2. Implement the following PEB Board Policy resolutions:

- PEBB 2024-14 Non-Medicare Retiree Enrollment Requirement
- PEBB 2024-19 UMP Classic Medicare Enrollment
- PEBB 2024-20 UMP Classic Medicare Plan Enrollment During Gap Month(s)
- PEBB 2024-21 Amending 2022-03 Medicare Advantage Prescription drug plan

3. Make other technical amendments:

- Amended WAC 182-08-198 to include Uniform Medical Plan (UMP) Classic Medicare plan disenrollment procedures.
- Amended WAC 182-08-245 to remove board members of school districts or educational service districts, clarified employer group for the PEBB Program, and updated a WAC reference.
- Amended WAC 182-12-146 to include PEBB vision, removed a subsection that applies to board member who no longer qualifies as described in WAC 182-12-111 (4)(c), added an exception to the first premium payment and applicable premium surcharges requirement, and added an exception to when a subscriber or their dependent will be disenrolled from a Medicare Advantage plan, a Medicare Advantage-Prescription Drug plan, or the UMP Classic Medicare plan
  Amended WAC 182-12-262 to update the language that describe a dependent must be enrolled in the same health plan coverage as the subscriber, added PEBB vision and the disenrollment process for UMP Classic Medicare plan, and updated the description of any other subscriber must submit the required forms to the PEBB Program.

4. Implement emergency rules:

- This permanent filing includes the information in the emergency rules filed under WSR 24-11-151 primarily for WAC 182-12-5120. Once the permanent rules take effect, the emergency rule will no longer be needed and the temporary WAC number 182-12-5120 will not be retained.

Citation of rules affected by this order:

New: WAC 182-12-232
Repealed:
Amended: WAC 182-08-198, 182-08-245, 182-12-146, and 182-12-262

Suspended:

Statutory authority for adoption: RCW 41.05.021, 41.05.065, and 41.05.160, HB 1008, Section 1, Chapter 164, Laws of 2023, SHB 1804, Section 1, Chapter 312, Laws of 2023, SSB 5275, Section 5, Chapter 13, Laws of 2023

Other authority: Policy Resolutions PEBB 2024-14, 2024-19, 2024-20, and 2024-21

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 24-14-131 on July 2, 2024 (date).

Describe any changes other than editing from proposed to adopted version: None

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

Name:
Address:
Phone:
Fax:
TTY:
Email:
Web site:
Other:

Note: If any category is left blank, it will be calculated as zero. No descriptive text.

Count by whole WAC sections only, from the WAC number through the history note. A section may be counted in more than one category.

The number of sections adopted in order to comply with:

Federal statute:	New		Amended		Repealed	
Federal rules or standards:	New		Amended		Repealed	
Recently enacted state statutes:	New	1	Amended	3	Repealed	

The number of sections adopted at the request of a nongovernmental entity:

	New		Amended		Repealed	

The number of sections adopted on the agency's own initiative:

	New	1	Amended	3	Repealed	

The number of sections adopted in order to clarify, streamline, or reform agency procedures:

	New	1	Amended	3	Repealed	

The number of sections adopted using:

Negotiated rule making:	New		Amended		Repealed	
Pilot rule making:	New		Amended		Repealed	
Other alternative rule making:	New	1	Amended	3	Repealed	

Date Adopted: August 29, 2024	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

AMENDATORY SECTION (Amending WSR 23-14-016, filed 6/23/23, effective 1/1/24)

WAC 182-08-198 When may a subscriber change health plans? A subscriber may change health plans at the following times:

(1) **During the annual open enrollment:** A subscriber may change health plans during the public employees benefits board (PEBB) annual open enrollment period. A subscriber must submit the required enrollment forms to change their health plan. An employee submits the enrollment forms to their employing agency. Any other subscriber submits the enrollment forms to the PEBB program. The required enrollment forms must be received no later than the last day of the annual open enrollment. Enrollment in the new health plan will begin January 1st of the following year.

(2) **During a special open enrollment:** A subscriber may revoke their health plan election and make a new election outside of the annual open enrollment if a special open enrollment event occurs. A special open enrollment event must be an event other than an employee gaining initial eligibility for PEBB benefits as described in WAC 182-12-114 or regaining eligibility for PEBB benefits as described in WAC 182-08-197. The change in enrollment must be allowable under Internal Revenue Code and Treasury regulations, and correspond to and be consistent with the event that creates the special open enrollment for the subscriber, the subscriber's dependent, or both.

A subscriber may not change their health plan during a special open enrollment if their state registered domestic partner or state registered domestic partner's child is not a tax dependent. A subscriber may change their health plan as described in subsection (1) of this section.

To disenroll from a medicare advantage (MA) plan ((~~or~~)), medicare advantage-prescription drug (MA-PD) plan, or the Uniform Medical Plan (UMP) Classic medicare plan, the change in enrollment must be allowable under 42 C.F.R. Secs. 422.62(b) and 423.38(c). To make a health plan change, a subscriber must submit the required enrollment forms (and a completed disenrollment form, if required). The forms must be received no later than 60 days after the event occurs, except as described in (i) of this subsection. An employee submits the enrollment forms to their employing agency. Any other subscriber submits the enrollment forms to the PEBB program. In addition to the required forms, a subscriber must provide evidence of the event that created the special open enrollment. New health plan coverage 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, the change in enrollment begins on that day except for a MA ((~~or~~)) plan, a MA-PD plan, or the UMP Classic medicare plan which will begin the first day of the month following the date the form is received.

Exception: When a subscriber or their dependent is enrolled in a MA ((~~or~~)) plan, a MA-PD plan, or the UMP Classic medicare plan, they may disenroll during a special enrollment period as allowed under 42 C.F.R. Secs. 422.62(b) and 423.38(c). The new medical plan coverage will begin the first day of the month following the date the ((~~medicare advantage~~)) plan disenrollment form is received.

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, health plan coverage will begin the month in which the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption occurs. If the special open enrollment is due to the enrollment of an extended dependent or a dependent with a disability, the change in health plan

coverage will begin the first day of the month following the later of the event date or eligibility certification. 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 state registered domestic partnership;

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

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

(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 has a change in employment status that affects the subscriber's eligibility for their employer contribution toward their employer-based group health plan;

(d) The subscriber's dependent has a change in their own employment status that affects their eligibility or their dependent's eligibility for the employer contribution under their employer-based group health plan;

Note: As used in (d) of this subsection, "employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 26 C.F.R. 54.9801-6.

(e) Subscriber or a subscriber's dependent has a change in residence that affects health plan availability.

(i) If the subscriber has a change in residence and the subscriber's current medical plan is no longer available, the subscriber must select a new medical plan as described in WAC 182-08-196(3);

(ii) If the subscriber or the subscriber's dependent has a change in residence and the subscriber's current dental plan does not have available providers within 50 miles of the subscriber or the subscriber's dependent's new residence, the subscriber may select a new dental plan;

(f) A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state registered domestic partner is not an eligible dependent);

(g) Subscriber or a subscriber's dependent enrolls in 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 CHIP;

(i) Subscriber or a subscriber's dependent enrolls in coverage under medicare, or the subscriber or a subscriber's dependent loses eligibility for coverage under medicare, or enrolls in or terminates enrollment in a ((~~medicare advantage prescription drug~~)) MA-PD or a Part D plan. If the subscriber's current medical plan becomes unavailable due to the subscriber's or a subscriber's dependent's enrollment in medicare, the subscriber must select a new medical plan as described in WAC 182-08-196(2).

(j) A subscriber enrolled in PEBB retiree insurance coverage, a retired employee, a retired school employee, or a survivor enrolled in PEBB health plan coverage after their employer group ceased participation, or an eligible subscriber enrolled in Consolidated Omnibus Budg-

et Reconciliation Act (COBRA) coverage has six months from the date of their or their dependent's enrollment in medicare Part B to enroll in a PEBB medicare supplement plan for which they or their dependent is eligible. The forms must be received by the PEBB program no later than six months after the enrollment in medicare Part B for either the subscriber or the subscriber's dependent;

(ii) A subscriber enrolled in PEBB retiree insurance coverage, a retired employee, a retired school employee, or a survivor enrolled in PEBB health plan coverage after their employer group ceased participation, or an eligible subscriber enrolled in ((~~Consolidated Omnibus Budget Reconciliation Act (COBRA)~~)) COBRA coverage has seven months to enroll in a ((~~medicare advantage or medicare advantage-prescription drug~~)) MA plan, MA-PD plan, or the UMP Classic medicare plan that begins three months before they or their dependent first enrolled in both medicare Part A and Part B and ends three months after the month of medicare eligibility. A subscriber may also enroll themselves or their dependent in a ((~~medicare advantage or medicare advantage-prescription drug~~)) MA plan, MA-PD plan, or the UMP Classic medicare plan before their last day of the medicare Part B initial enrollment period. The forms must be received by the PEBB program no later than the last day of the month prior to the month the subscriber or the subscriber's dependent enrolls in the ((~~medicare advantage or medicare advantage-prescription drug~~)) MA plan, MA-PD plan, or the UMP Classic medicare plan.

(j) Subscriber or a subscriber's dependent's current medical plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA). The authority may require evidence that the subscriber or subscriber's dependent is no longer eligible for an HSA;

(k) Subscriber or a subscriber's dependent experiences a disruption of care for active and ongoing treatment, that could function as a reduction in benefits for the subscriber or the subscriber's dependent. A subscriber may not change their health plan election if the subscriber's or dependent's physician stops participation with the subscriber'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:

(i) Active cancer treatment such as chemotherapy or radiation therapy;

(ii) Treatment following a recent organ transplant;

(iii) A scheduled surgery;

(iv) Recent major surgery still within the postoperative period; or

(v) Treatment for a high-risk pregnancy;

(l) The PEBB program determines that there has been a substantial decrease in the providers available under a PEBB medical plan.

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

AMENDATORY SECTION (Amending WSR 23-14-015, filed 6/23/23, effective 1/1/24)

WAC 182-08-245 Employer group ((~~and board members of school districts and educational service districts~~)) participation requirements. This section applies to an employer group for the public employees benefits board (PEBB) program as defined in WAC 182-08-015 ((~~or board members of school districts or educational service districts~~)) 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)~~)) PEBB insurance coverage, the employer group ((~~or board members of school districts or educational service districts~~)) 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 PEBB insurance coverage by the criteria outlined in this chapter and chapter 182-12 WAC unless otherwise approved by the authority 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 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 to be eligible; and

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

(2) Pay premiums under its contract with the authority. The premium rate structure for employer groups ((~~and board members of school districts and educational service districts~~)) will be a tiered rate based on health plan election and family enrollment. Employer groups must collect an amount equal to the premium surcharges 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~~)) 90 days advance written notice.

(3) Counties, municipalities, political subdivisions, and tribal governments must pay the monthly employer group rate surcharge in the amount invoiced by the authority.

(4) If an employer group ((~~or board member of school districts and educational service districts~~)) wants to make subsequent changes to the contract, the changes must be submitted to the authority for approval.

(5) The employer group ((~~or board members of school districts and educational service districts~~)) must maintain participation in PEBB insurance coverage for at least one full year. An employer group ((~~or board members of school districts and educational service districts~~)) 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 ((~~or board members of school districts and educational~~

~~service districts~~)) must provide written notice to the PEBB program at least 60 days before the requested termination date. If an employer group terminates participation in PEBB insurance coverage, they must:

(a) Notify all their employees, dependents, or retirees who are enrolled in PEBB insurance coverage 45 days prior to the employer group's date of termination; and

(b) Provide assistance to retirees as described in RCW 41.04.208(12).

(6) 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 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 a PEBB health plan as COBRA subscribers for the remainder of the months available to them based on their qualifying event.

(7) 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 ends participation, retired and disabled employees who began participation before September 15, 1991, are eligible to continue enrollment in PEBB retiree insurance coverage if they continue 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 ((~~on the same terms and conditions as retirees who are eligible under COBRA (see WAC 182-12-146)~~)) as described in WAC 182-12-232.

(8) Employer groups that enter into a contractual agreement with the authority on or after May 4, 2023, and whose contractual agreement is subsequently terminated, shall make a one-time payment to the authority for each of the employer group's retired or disabled employees who continue their participation in insurance plans and contracts under WAC 182-12-232.

(a) For each of the employer group's retired or disabled employees who will be continuing their participation, the authority shall determine the one-time payment by:

(i) Calculating the difference in cost between the rate charged to retired or disabled employees as described in RCW 41.05.080(2); and

(ii) The actuarially determined value of the medical benefits for retired and disabled employees who are not eligible for parts A and B of medicare; and

(iii) Multiplying that difference by the number of months until the retired or disabled employee would become eligible for medicare.

(b) Employer groups shall not be entitled to any refund of the amount paid to the authority as described in this subsection.

AMENDATORY SECTION (Amending WSR 23-14-015, filed 6/23/23, effective 1/1/24)

WAC 182-12-146 When is an enrollee eligible to continue public employees benefits board (PEBB) benefits under Consolidated Omnibus Budget Reconciliation Act (COBRA)? (1) An employee or an employee's dependent who loses eligibility for the employer contribution toward public employees benefits board (PEBB) benefits and who qualifies for continuation coverage under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) may continue coverage for all or any combination of PEBB medical, dental, or ((~~both~~)) vision.

(2) An employee or an employee's dependent who loses eligibility for continuation coverage described in WAC 182-12-133, 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 any combination of PEBB medical, dental, or ((~~both~~)) vision for the remaining difference in months.

(3) A retired employee, a retired school employee, or survivor who loses eligibility for PEBB retiree insurance coverage because ((~~an~~)) their employer group ceases participation ((~~in PEBB insurance coverage~~)) with the authority may continue PEBB medical, dental, or ((~~both on the same terms and conditions as retirees who are eligible under COBRA~~)) vision as described in WAC 182-12-232.

(4) A dependent of a subscriber enrolled as described in WAC 182-12-232 who is no longer eligible as described in WAC 182-12-260 may continue any combination of PEBB medical, dental, or vision.

(5) A retiree or a dependent of a retiree, who is no longer eligible as described in WAC 182-12-171, 182-12-180, or 182-12-260 may continue any combination of PEBB medical, dental, or ((~~both~~)) vision.

((~~(5)~~)) (6) A blind vendor who ceases to actively operate a facility as described in WAC 182-12-111 (4)(a) may continue enrollment in PEBB medical for the maximum number of months allowed under COBRA as described in this section.

((~~(6) A board member who no longer qualifies as described in WAC 182-12-111 (4)(c) may continue enrollment in PEBB medical, dental, or both for the maximum number of months allowed under COBRA as described in this section.~~))

(7) An enrollee may continue any combination of PEBB medical, dental, or ((~~both~~)) vision under COBRA by self-paying the premium and applicable premium surcharges set by the health care authority (HCA):

(a) The election must be received by the PEBB program no later than 60 days from the date the enrollee's PEBB health plan coverage ended or from the postmark date on the election notice sent by the PEBB program, whichever is later;

(b) The first premium payment under COBRA coverage and applicable premium surcharges are due to the HCA no later than 45 days after the election period ends as described in (a) of this subsection, except as described in WAC 182-08-180 (1)(a). Following the enrollee's first premium payment, premiums and applicable premium surcharges must be paid as described in WAC 182-08-180 (1)(c);

(c) COBRA continuation coverage enrollees who voluntarily terminate their COBRA coverage will not be eligible to reenroll in COBRA coverage unless they regain eligibility as described in WAC 182-12-114. Those who request to terminate their COBRA coverage must do so in writing. COBRA coverage will end on the last day of the month in which the PEBB program receives the termination request or on the

last day of the month specified in the COBRA enrollee's termination request, whichever is later. If the termination request is received on the first day of the month, COBRA coverage will end on the last day of the previous month;

Exception: When a subscriber or their dependent is enrolled in a medicare advantage plan, a medicare advantage-prescription drug plan, or the Uniform Medical Plan Classic medicare plan, the enrollment will terminate on the last day of the month when the plan disenrollment form is received.

(d) An employee enrolled in a ((~~medical~~)) flexible spending arrangement (FSA) or limited purpose FSA and the employee's dependents will have an opportunity to continue making contributions to their ((~~medical~~)) FSA or limited purpose FSA by electing COBRA if on the date of the qualifying event, as described under 42 U.S.C. Sec. 300bb-3, the employee's ((~~medical~~)) FSA or limited purpose FSA has a greater amount in remaining benefits than remaining contribution payments for the current year. The election must be received by the contracted vendor no later than 60 days from the date the PEBB health plan coverage ended or from the postmark date on the election notice sent by the contracted vendor, whichever is later. The first premium payment under COBRA coverage is due to the contracted vendor no later than 45 days after the election period ends as described above.

(8) A subscriber's state registered domestic partner and the state registered domestic partner's children may continue any combination of PEBB medical, dental, or ((~~both~~)) vision on the same terms and conditions as spouses and other eligible dependents under COBRA as described under RCW 26.60.015.

(9) Medical ((~~and~~)), dental, and vision coverage under COBRA begin on the first day of the month following the day the COBRA enrollee loses eligibility for PEBB health plan coverage as described in WAC 182-12-131, 182-12-133, 182-12-141, 182-12-142, 182-12-148, 182-12-171, 182-12-180, 182-12-250, 182-12-260, or 182-12-265.

NEW SECTION

WAC 182-12-232 What options for continuing health plan enrollment are available to a retiree of an employer group that ended participation in public employees benefits board (PEBB) or school employees benefits board (SEBB) insurance coverage? (1) A retired employee, a retired school employee, or an eligible survivor of an employee, school employee, or retiree of an employer group as defined in WAC 182-12-109 who loses eligibility for public employees benefits board (PEBB) retiree insurance coverage due to the employer group ending participation in PEBB or school employees benefits board (SEBB) insurance coverage may continue enrollment in PEBB health plan coverage by self-paying the premium and applicable premium surcharges set by the health care authority (HCA). A retired employee, a retired school employee, or a survivor enrolled under this section is not eligible for any subsidy provided under RCW 41.05.085.

(2) A retired employee, a retired school employee, or a survivor as described in subsection (1) of this section may enroll in PEBB medical, dental, or vision.

(a) The required forms must be received by the PEBB program no later than 60 days after the employer group's date of termination. The effective date of enrollment in PEBB health plan coverage will be the

first day of the month following the day eligibility for PEBB retiree insurance coverage ended.

Note: Enrollment in the PEBB program's medicare advantage (MA) plan, medicare advantage prescription-drug (MA-PD) plan, or the Uniform Medical Plan (UMP) Classic medicare plan may not be retroactive.
(1) If a subscriber elects to enroll in a MA plan, and the required forms are received by the PEBB program after the date the PEBB health plan coverage is to begin, the subscriber and their enrolled dependents will be enrolled in a plan with the same contracted vendor during the gap month(s) prior to when the MA coverage begins.
(2) If a subscriber elects to enroll in a MA-PD plan, and the required forms are received by the PEBB program after the date the PEBB health plan coverage is to begin, the subscriber and their enrolled dependents will be enrolled in transitional coverage as designated by the director or designee during the gap month(s) prior to when the MA-PD coverage begins.
(3) If a subscriber elects to enroll in the UMP Classic medicare plan, and the required forms are received by the PEBB program after the date the PEBB health plan coverage is to begin, the subscriber and their enrolled dependents will be enrolled in transitional UMP coverage during the gap month(s) prior to when the UMP Classic medicare plan begins.

(b) The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends as described in (a) of this subsection. Following the first premium payment, premiums and applicable premium surcharges must be paid as described in WAC 182-08-180 (1)(c).

Note: An employer group as defined in WAC 182-12-109 that enters into a contractual agreement with the HCA on or after May 4, 2023, and whose contractual agreement is subsequently terminated, shall make a one-time payment to the HCA for each of the employer group's retired or disabled employees who continue participation under this section as described in RCW 41.05.083.

(c) If a retired employee, a retired school employee, or a survivor elects to enroll a dependent in PEBB health plan coverage, the dependent must be enrolled in the same PEBB medical and PEBB dental plan as the retired employee, retired school employee, or survivor.

Exceptions: (1) If a retired employee, a retired school employee, or a survivor selects a medicare supplement plan, a MA-PD plan, or the UMP Classic medicare plan, nonmedicare enrollees will be enrolled in the UMP classic. If a retired employee, a retired school employee, or a survivor selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees.
(2) If a retired employee, a retired school employee, or a survivor selects a medicare supplement plan, MA-PD plan, or any other medicare plan, they may elect a PEBB vision plan available for any nonmedicare enrollees.

(3) A subscriber enrolled under this section may continue PEBB health plan coverage until they request to terminate enrollment as described in subsection (4) of this section, or premiums and applicable premium surcharges are no longer paid as described in WAC 182-08-180 (1)(c). If PEBB health plan coverage is terminated for these reasons, the subscriber and their enrolled dependents will not be eligible to reenroll under this section.

(4) A subscriber enrolled under this section who requests to voluntarily terminate their PEBB health plan coverage must do so in writing. PEBB health plan coverage will end on the last day of the month in which the PEBB program receives the termination request or on the last day of the month specified in the subscriber's termination request, whichever is later. If the termination request is received on the first day of the month, PEBB health plan coverage will end on the last day of the previous month.

Exception: When a subscriber or their dependent is enrolled in a MA plan, a MA-PD plan, or the UMP Classic medicare plan, the enrollment in PEBB health plan coverage will terminate on the last day of the month when the plan disenrollment form is received.

AMENDATORY SECTION (Amending WSR 23-14-015, filed 6/23/23, effective 1/1/24)

WAC 182-12-262 When may subscribers enroll or remove eligible dependents? (1) **Enrolling dependents in public employees benefits board (PEBB) health plan coverage, supplemental dependent life insurance, and accidental death and dismemberment (AD&D) insurance.** A dependent must be enrolled in the same health plan coverage as the subscriber ((~~except as described in WAC 182-12-171 (1)(c)~~)) unless otherwise described in the Washington Administrative Code applicable to the

subscriber. The subscriber must be enrolled in health plan coverage to enroll their dependent in health plan coverage except as provided in WAC 182-12-205 (3)(c). A dependent with more than one source of eligibility for enrollment in the PEBB and school employees benefits board (SEBB) programs is limited to a single enrollment in medical, dental, and vision plans in either the PEBB or SEBB program. Subscribers must satisfy the enrollment requirements as described in subsection (4) of this section and may enroll eligible dependents at the following times:

(a) **When the subscriber becomes eligible** and enrolls in PEBB benefits. If eligibility is verified the dependent's effective date will be as follows:

(i) PEBB health plan coverage will be the same as the subscriber's effective date;

(ii) Supplemental dependent life insurance or AD&D insurance, if elected, will be effective the first day of the month following the date the contracted vendor receives the required form or approves the enrollment. A newly born child must be at least 14 days old before supplemental dependent life insurance or AD&D insurance coverage is effective.

(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;

(d) **When a National Medical Support Notice (NMSN)** requires a subscriber to cover a dependent child in health plan coverage as described in WAC 182-12-263; or

(e) **Any time during the calendar year for supplemental dependent life insurance or AD&D insurance** by submitting the required form to the contracted vendor for approval. Evidence of insurability may be required for supplemental dependent life insurance but will not be required for supplemental AD&D insurance. Supplemental dependent life insurance or AD&D insurance will be effective the first day of the month following the date the contracted vendor receives the required form or approves the enrollment. A newly born child must be at least 14 days old before supplemental dependent life insurance or AD&D insurance coverage is effective.

(2) **Removing dependents from a subscriber's PEBB health plan coverage or supplemental dependent life insurance or AD&D insurance.**

(a) **A dependent's eligibility for enrollment in PEBB health plan coverage or supplemental dependent life insurance or AD&D insurance ends the last day of the month the dependent** meets the eligibility criteria as described in WAC 182-12-250 or 182-12-260. Subscribers must provide notice when a dependent is no longer eligible due to divorce, annulment, dissolution, or qualifying event of a dependent ceasing to be eligible as a dependent child, as described in WAC 182-12-260(3). For supplemental dependent life insurance or AD&D insurance, subscribers must notify the contracted vendor on the required form, in writing, or by telephone when a dependent is no longer eligible. Contact information for the contracted vendor may be found at hca.wa.gov/employees-contact-plan. For PEBB health plan coverage, the notice must be received within 60 days of the last day of the month the dependent loses eligibility. Employees must notify their employing agency when a dependent is no longer eligible for PEBB health plan coverage, except as required under WAC 182-12-260 (3)(g)(ii). All other subscribers must notify the PEBB program. Consequences for not sub-

mitting notice within the required 60 days include, but are not limited to:

(i) The dependent may lose eligibility to continue PEBB medical ((~~or~~)), dental, or vision 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 as described in WAC 182-12-270;

(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 eligible dependents:**

(i) During the annual open enrollment. The dependent will be removed from PEBB health plan coverage the last day of December;

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

(iii) When a NMSN requires a spouse, former spouse, or other individual to provide health plan coverage for a dependent who is already enrolled in PEBB coverage, and that health plan coverage is in fact provided as described in WAC 182-12-263(2); or

(iv) Any time during the calendar year from supplemental dependent life insurance or AD&D insurance by submitting a request to the contracted vendor on the required form, in writing, or by telephone. Contact information for the contracted vendor may be found at hca.wa.gov/employees-contact-plan.

(c) **Retirees (see WAC 182-12-171, 182-12-180, or 182-12-211), survivors (see WAC 182-12-180, 182-12-250, or 182-12-265), ((~~and~~)) PEBB continuation coverage enrollees (see WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, or 182-12-148), and retired employees, retired school employees, or survivors continuing PEBB health plan coverage after their employer group ceased participation (see WAC 182-12-232) may remove dependents** from their PEBB health plan coverage outside of the annual open enrollment or a special open enrollment by providing written notice to the PEBB program. The dependent will be removed from the subscriber's PEBB health plan coverage prospectively. PEBB health plan coverage will end on the last day of the month in which the written notice is received by the PEBB program or on the last day of the month specified in the subscriber's written notice, whichever is later. If the written notice is received on the first day of the month, PEBB health plan coverage will end on the last day of the previous month. PEBB continuation coverage enrollees may remove dependents from supplemental dependent life insurance or AD&D insurance any time during the calendar year by submitting a request to the contracted vendor on the required form, in writing, or by telephone. Contact information for the contracted vendor may be found at hca.wa.gov/employees-contact-plan.

(3) **Special open enrollment.**

(a) Subscribers may enroll or remove their eligible dependents outside of the annual open enrollment if a special open enrollment event occurs. The change in enrollment must be allowable under the Internal Revenue Code and Treasury Regulations, and correspond to and be consistent with the event that creates the special open enrollment for the subscriber, the subscriber's dependents, or both. To disenroll from a medicare advantage (MA) ((~~or~~)) plan, a medicare advantage-prescription drug (MA-PD) plan, or the Uniform Medical Plan (UMP) Classic

medicare plan, the change in enrollment must be allowable under 42 C.F.R. Secs. 422.62(b) and 423.38(c).

(i) PEBB 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 except for a MA ((~~or~~)) plan, a MA-PD plan, or the UMP Classic medicare plan, which will begin the first day of the month following the date the form is received.

(ii) PEBB health plan coverage for an extended dependent or a dependent with a disability will begin the first day of the month following the later of the event date or eligibility certification.

(iii) The dependent will be removed from the subscriber's PEBB health plan coverage the last day of the month following the later of the event date or the date the required form and proof of the event 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.

(iv) 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, PEBB health plan coverage will begin or end as follows:

• For the newly born child, PEBB health plan coverage will begin the date of birth;

• For a newly adopted child, PEBB health plan coverage will begin on the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier;

• For a spouse or state registered domestic partner of a subscriber, PEBB health plan coverage will begin the first day of the month in which the event occurs. The spouse or state registered domestic partner will be removed from PEBB health plan coverage the last day of the month in which the event occurred.

(v) Supplemental dependent life insurance or AD&D insurance will begin the first day of the month following the date the contracted vendor receives the required form or approves the enrollment. A newly born child must be at least 14 days old before supplemental dependent life insurance or AD&D insurance coverage is effective.

(b) The events described in this subsection (3)(b)(i) of this section create a special open enrollment to enroll eligible dependents in supplemental dependent life insurance or AD&D insurance. Any one of the following events may create a special open enrollment to enroll or remove eligible dependents from PEBB health plan coverage:

(i) Subscriber acquires a new dependent due to:

• Marriage or registering a state registered domestic partnership;

• Birth, adoption, or when a subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or

• A child becoming eligible as an extended dependent through legal custody or legal guardianship.

(ii) 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);

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

(iv) The subscriber's dependent has a change in their own employment status that affects their eligibility or their dependent's eligi-

bility for the employer contribution under their employer-based group health plan;

Note: As used in (iv) of this subsection, "employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 54.9801-6.

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

(vi) 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 and that change in residence resulted in the dependent losing their health insurance;

(vii) A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state registered domestic partner is not an eligible dependent);

(viii) Subscriber or a subscriber's dependent enrolls in 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;

(ix) Subscriber or a subscriber's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from medicaid or CHIP;

(x) Subscriber's dependent enrolls in medicare, or loses eligibility for medicare.

(4) **Enrollment requirements. A subscriber must submit the required forms within the time frames described in this subsection.** For PEBB health plan coverage, an employee must submit the required forms to their employing agency, ((~~a~~)) any other subscriber ((~~on continuation coverage or PEBB retiree insurance coverage~~)) must 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. All required forms and documents must be received within the required time frames. An employee enrolling a dependent in supplemental dependent life insurance or AD&D insurance must submit the required form to the contracted vendor for approval within the required time frames.

Note: When enrolling a state registered domestic partner or a state registered domestic partner's child, a subscriber must certify that the state registered domestic partner or state registered domestic partner's child is a tax dependent on the required form; otherwise, the PEBB program will assume the state registered domestic partner or state registered domestic partner's child is not a tax dependent.

(a) If a subscriber wants to enroll their eligible dependents in PEBB health plan coverage when the subscriber becomes eligible to enroll in PEBB benefits, the subscriber must include the dependent's enrollment information on the required forms and submit them within the required time frame described in WAC 182-08-197, 182-12-171, 182-12-180, 182-12-211, 182-12-232, or 182-12-250. If an employee enrolls a dependent in supplemental dependent life insurance or AD&D insurance, the required form must be submitted within the required time frame described in WAC 182-08-197.

(b) If a subscriber wants to enroll eligible dependents in PEBB health plan coverage 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 forms must be received no later than 60 days after the dependent becomes eligible. An employee enrolling a dependent in sup-

plemental dependent life insurance or AD&D insurance must submit the required form to the contracted vendor for approval. An employee may enroll a dependent in supplemental dependent life insurance up to the guaranteed issue coverage amount without evidence of insurability if the required form is submitted to the contracted vendor as required. Evidence of insurability will be required for supplemental dependent life insurance over the guaranteed issue coverage amount. Evidence of insurability is not required for supplemental AD&D insurance.

(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 in PEBB health plan coverage, the subscriber should notify the PEBB program by submitting the required forms as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the required forms must be received no later than 60 days after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption. An employee enrolling a dependent in supplemental dependent life insurance or AD&D insurance must submit the required form to the contracted vendor for approval no later than 60 days after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption. A newly born child must be at least 14 days old before supplemental dependent life insurance or AD&D insurance coverage can become effective.

(e) If the subscriber wants to enroll a child age 26 or older as a child with a disability in PEBB health plan coverage, the required forms must be received no later than 60 days after the child reaches age 26 or within the relevant time frame described in (a), (b), and (f) of this subsection. To recertify an enrolled child with a disability, the required forms must be received by the PEBB program or the contracted vendor by the child's scheduled PEBB health plan coverage termination date.

(f) If the subscriber wants to change a dependent's enrollment status in PEBB health plan coverage during a special open enrollment, the required forms must be received no later than 60 days after the event that creates the special open enrollment.

Exception: If the subscriber wants to change a dependent's enrollment or disenrollment in a ((~~medicare advantage or medicare advantage-preseription drug~~)) MA plan, a MA-PD plan, or the UMP Classic medicare plan, the required forms must be received during a special enrollment period as allowed under 42 C.F.R. Secs. 422.62(b) and 423.38(c).

(g) An employee may enroll a dependent in supplemental dependent life insurance or AD&D insurance at any time during the calendar year by submitting the required form to the contracted vendor for approval. Evidence of insurability may be required for supplemental dependent life insurance but will not be required for supplemental AD&D insurance.