Title: Subscriber Mistake – Factor Test

PEBB Program Administrative Policy 94-3

Contact:	Policy and Rules Coordinator, ERB Division	**Effective:**	January 1, ~~2024~~2025
Associated RCW:		**Owner:**	Policy, Rules, & Compliance Manager, ERB Division
Associated PEB Board Policy Resolutions:		**Approved by:**	
Associated WAC:		**Position:**	Director of the PEBB Program
Assoc. fed law/reg:	Section 125 of the Internal Revenue Code	**Date approved:**	
Associated Forms & Communication	State of Washington Salary Reduction Plan PEBB Policy 94-1 Accessing PEBB Program salary reduction plan document		

Purpose:

This policy applies whenever:

- An employee makes a mistake electing a ~~medical~~ flexible spending arrangement (FSA), a limited purpose FSA, or a dependent care assistance program (DCAP); or
- ~~An employee, continuation coverage subscriber, or retiree~~A subscriber ~~-~~requests a health plan change when they or their dependent experiences a disruption of medical care because of a mistake, which impacts a documented, on-going course of treatment.

This policy does not apply to a subscriber's initial enrollment or disenrollment in a Public Employees Benefits Board (PEBB) health plan and does not supplement any existing special open enrollment events or add new events not otherwise specified in chapters 182-08 and 182-12 WAC.

The mistake factors listed in this policy are intended to be used in conjunction with Exhibit A in the PEBB Program salary reduction plan. The Health Care Authority's Office of Legal Affairs (OLA) is responsible for determining if a mistake has been made as described in this policy and in Exhibit A of the salary reduction plan.

Policy:

1. The following factors will be used by OLA to determine if a mistake was made by the subscriber. Each factor must provide clear and convincing evidence:

    a. **Impossibility** – Is it impossible for the subscriber or their dependent to use the elected benefit?
    b. **Timeliness of request** - Did the subscriber discover the mistake and appeal within a reasonable period?
    c. **Triggering event** – If the request was not timely, did a triggering event (i.e., an annual visit to a provider) alert the subscriber they had made a mistake?
    d. **History** - Does the history of the subscriber's past elections make the current election seem consistent with their pattern of coverage?

e. **Consequence of election** – Would no reasonable person have consciously chosen to make that election in consideration of the consequences?
f. **Use of benefit** – Has the subscriber or their dependent been using the mistakenly elected benefits during the plan year?
g. **Notice to the subscriber** – Was the subscriber given ample notice of their election and they failed to act on it?
h. **Diagnosis and disruption of care** – Will the subscriber or their dependent's treatment be available based on the election?

2. If OLA determines that a mistake was made, any necessary changes to the employee's ~~medical~~ FSA, limited purpose FSA, DCAP, or a subscriber's health plan coverage will be made retroactively to return the subscriber to the same position they would be in had the mistake not been made.