Washington State
Health Care Authority
Public Employees Benefits Board

Introduction

This manual is intended for use as a training document only. The purpose of this manual is to assist you with understanding the eligibility rules for subscribers and their dependents. If there is any inconsistency between information in this manual and the Revised Code of Washington (RCW) and Washington Administrative Code (WAC), RCW and WAC take precedence. If you have any questions about eligibility rules, please contact:

PEBB Outreach and Training
1-800-700-1555
www.fuzeqna.com/perspay/consumer/question.asp

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Employee Eligibility, Premiums, and Premium Surcharges

Employee Eligibility, Premiums, and Premium Surcharges

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Eligible Entities

State agencies and higher education institutions are required to participate in all PEBB benefits. Insurance and health care contributions for ferry employees are governed by RCW 47.64.270.

Employer groups may participate in PEBB insurance coverage through a medical-only benefits package or a full benefits package that includes medical, dental, basic life, and basic long-term disability (LTD), provided all requirements are met. Employer groups are defined as those employee organizations representing state civil service employees, counties, municipalities, political subdivisions, the Washington Health Benefit Exchange, tribal governments, school districts, and educational service districts participating in PEBB coverage under contractual agreement as described in 182-08-245.

Eligible Non-Employees

Blind vendors mean "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 may voluntarily participate in PEBB insurance coverage. Vendors who do not enroll when first eligible can enroll during annual open enrollment or the first day of the month following the loss of other insurance coverage.

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.

School board members or students eligible to participate under RCW 28A.400.305 may participate in PEBB insurance coverage as long as they remain eligible under that section.

Individuals Who Are Not Eligible

The following individuals are not eligible for PEBB benefits:

- Adult family home providers as defined in RCW 70.128.010
- Unpaid volunteers
- Patients of state hospitals
- Inmates in work programs offered by the WA State Department of Corrections as described in RCW 72.09.100 or an equivalent program administered by a local government
- 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 institutions
- Any others not expressly defined as employees under RCW 41.05.011

See WAC 182-12-111 for more details.

Employee Eligibility

Employees must establish eligibility based on the work circumstances described in WAC 182-12-114. Eligibility is determined solely by the criteria of the category that most closely describes the employee's work circumstances.

Hours that are excluded in determining eligibility include standby hours and any temporary increases in work hours, of six months or less, caused by training or emergencies that have not been or are not anticipated to be part of the employee's regular work schedule or pattern. The employer must request PEBB approval to include temporary training or emergency hours in determining eligibility.

PEBB has developed a method to help agencies determine eligibility. State agencies and higher education institutions are required to use the method outlined below per WAC 182-12-113, RCW 41.05.008, and RCW 41.05.009. Employer groups, K-12 school districts, and educational service districts are encouraged to use this method, but are not required to do so.

Method for Determining Eligibility

PEBB provides worksheets as the method for determining eligibility for the employer contribution toward benefits for employees of state agencies and higher education institutions. The method facilitates decisions compliant with RCW and WAC, provides required notice and information to employees, confirms receipt of the required notice and information, and provides guidance and suggestions for the employer and employee.

Worksheets are available on the Perspay website. Worksheet series "A" through "D" address specific employee scenarios, such as when a new employee is hired or returns to work. The "E" series provide additional information on dependent eligibility.

- "A" Series: For new hires
- "B" Series: For existing employees who have a change in employment status
- "C" Series: For benefits-eligible employee who are leaving work
- "D" Series: For employees who are returning to work
- "E" Series: For eligible dependents

1. Follow these steps:

Step 1	Choose the worksheet that describes the employee's situation. Additional information is provided to guide you to other worksheets that may be more appropriate for the employee's situation.
Step 2	Click on the title of the specific worksheet that describes the employee or employee's situation. The worksheet will display in Excel.
Step 3	Complete the worksheet electronically. Do not save worksheets to your computer, as they are updated often and employees may be issued outdated information.
Step 4	With the exception of the A-5 worksheet, the employee must sign their completed worksheet. If the employee is not with you to sign their worksheet, send them a completed worksheet and request a returned, signed copy or an email confirming receipt. A representative from the agency must also sign and date the worksheet. Include the agency and sub-agency number as applicable.
Step 5	File the worksheet electronically or as a hard copy for your use and review by PEBB.

2. PEBB requires employee signature to provide confirmation of the required information and notice. If the employee is not available to sign the worksheet:
    a. PEBB will accept an email, email read receipt, or any other written response from the employee acknowledging receipt of their worksheet. If the employee receives their worksheet through the mail, a copy of the tracking information (which shows the date and time the worksheet was delivered to the employee's address) can serve as the employee's signature.
    b. Electronic signatures are acceptable, if your agency accepts electronic signatures.
    c. If the employee is unwilling or unavailable to sign the worksheet, make a note on the worksheet.
3. Worksheets are required for all state agencies and higher education institutions when determining eligibility. Employer groups are encouraged, but not required, to use this method. Higher education institutions can use a different method of notification with PEBB Outreach and Training approval.

Affordable Care Act (ACA) Codes

In addition to PEBB eligibility, the worksheets also include a section for eligibility under the Affordable Care Act (ACA). The information captured in this section is used to meet the federal annual reporting requirement.

The ACA definition of an employee is different than the PEBB definition and **does not determine an employee's eligibility for PEBB benefits.** To help identify the correct ACA status code for each employee, definitions and code examples are included on the worksheets. An ACA code must be assigned to every new employee, returning employee, and an employee with a change in employment status beginning January 1, 2014.

Based on the method of notification chosen by the agency, record the ACA code in your system of record (HRMS, PPMS, etc.). Instructions for determining the ACA status code is available on the PersPay website.

Regaining Eligibility for Employer Contribution

- Employees regain eligibility for the employer contribution when they return to work from approved leave without pay, approved educational leave, layoff, time-loss benefits under workers' compensation, or active military duty and are in pay status eight or more hours in a month.
- Seasonal employees who work less than nine months regain eligibility for the employer contribution when they return for the next season with at least eight hours of pay status in a month.
- Faculty who return after a gap in employer contribution regain eligibility for the employer contribution when they return for a quarter/semester at half-time or more no later than the 12th month after they lose eligibility for the employer contribution.

When an employee loses and later regains eligibility for the employer contribution for insurance coverage, the employee must complete and return the *Employee/Enrollment Change* form and *Life Insurance Enrollment/Change* form **no later than 31 days** after the date he/she regains eligibility If the forms are not received within 31 days, the employee will default to Uniform Medical Plan Classic, Uniform Dental Plan, basic life, and basic LTD insurance as a single subscriber (no dependents will be enrolled). In addition, the employee will incur the tobacco use premium surcharge (WAC 182-08-197 and WAC 182-08-198(2)).

Regaining eligibility for the employer contribution also triggers a special open enrollment event. The employee has 60 days from the date they regain eligibility to make allowable changes to medical and dental (Policy 45-2, Addendum 45-2A). ***Note:*** *The 60 days for the special open enrollment event begins the same day the 31-day period begins, which gives the employee an additional 29 days (60 days total) to make changes to medical and dental. Changes made after the initial 31-day period are effective the first of the month following the day the employer receives the form. If the form is received on the first day of the month, the changes are effective that day.*

Medical/Dental: Refer to Policy 45-2, Addendum 45-2A for guidance on changes employees may make when they regain eligibility for the employer contribution for benefits. Employees who choose to make allowable changes must submit an *Employee Enrollment/Change* form no later than **60 days** after the date the employee returns to work with eight or more hours of pay status per month.

If the employee does not submit the form within their first **31 days** of gaining eligibility, they are defaulted (see above). However, employees who are defaulted have an additional 29 days (60 days total, which begins the same day as the 31-day period) to submit the form (including tobacco use attestation) and enroll themselves and/or eligible dependents in PEBB coverage. Plan changes are effective the first of the month following receipt of the form. See the Premium Surcharge section of this chapter for the tobacco use and/or spousal premium surcharge attestation effective dates.

Life Insurance: The employee is enrolled in basic coverage and the amount of supplemental life insurance that was self-paid. The employee must submit a *Life Insurance Enrollment/Change* form no later than **31 days** after the date the employee regains eligibility for the employer contribution—even if the employee is not making changes to the amount of life insurance.

If the employee does not submit the form within 31 days of gaining eligibility, they are defaulted to basic life and must submit an *Evidence of Insurability* form for carrier approval for any supplemental coverage.

LTD Insurance: Most employees who leave work on approved leave (and not using eight hours of pay status (5% of full-time for faculty) to maintain their benefits) are not eligible to continue LTD while on leave. However, there are two exceptions:

- Employees on approved educational leave
- Employees called to active military duty (USERRA leave)

These employees are eligible to continue their LTD insurance while on leave. If they do not self-pay coverage while on leave, they will be required to submit an *Evidence of Insurability* form for carrier approval to reinstate their optional LTD coverage upon return.

All other employees, including employees who self-paid their LTD coverage (if eligible), are enrolled in the same waiting period they had prior to leave, effective first of the month in which the employee has at least eight hours of pay status.

Reference Guides

WAC References for Effective Dates of Coverage

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<tr><th colspan="2">When PEBB benefits begin (WAC 182-12-114)</th></tr>
<tr><td>Newly eligible employees
Medical
Dental
Basic LTD
Basic life</td><td>

Salaried and hourly employees (WAC 182-12-114(1))
PEBB benefits begin on the first day of the month following the date an employee becomes eligible. If the employee becomes eligible on the first working day of a month, then insurance coverage begins on that date.
Seasonal employees (WAC 182-12-114(2))
PEBB benefits begin on the first day of the month following the day the employee becomes eligible. If the employee becomes eligible on the first working day of a month, then insurance coverage begins on that date.
Faculty (WAC 182-12-114(3))
Faculty who the employing agency anticipates will work half-time or more for the entire instructional year or equivalent nine-month period, are eligible from the date of employment.
For faculty hired on quarter/semester to quarter/semester basis: Faculty who the employing agency anticipates will not work for the entire instructional year, or equivalent nine-month period, are eligible at the beginning of the second consecutive quarter or semester of employment in which he or she is anticipated to work, or has actually worked, half-time or more. Spring and fall are considered consecutive quarters/semesters when first establishing eligibility for faculty that work less than half-time during the summer quarter/semester.
Elected and full-time appointed officials of the legislative and executive branches of state government (WAC 182-12-114(4)
PEBB benefits for an eligible employee begin on the first day of the month following the day he or she becomes eligible. If the employee becomes eligible on the first working day of a month, then insurance coverage begins on that date.
Judges and Justices (WAC 182-12-114(5))
PEBB benefits for an eligible employee begin on the first day of the month following the day he or she becomes eligible. If the employee becomes eligible on the first working day of a month, then insurance coverage begins on that date.

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Supplemental life not requiring carrier approval	**Newly eligible employees only** Coverage is effective the first of the month following the signature date on the form, even if the form is signed on the first day of the month.
Supplemental life requiring carrier approval	Coverage is effective the first of the month following the approval date on the Final Action Notice (FAN).
Optional LTD	**Newly eligible employees only** Coverage is effective the first of the month following the signature date on the form, even if the form is signed on the first of the month.

When Do PEBB Benefits Begin?

PEBB benefits begin on the first day of the month following the date an employee becomes eligible. If the employee becomes eligible on the first working day of the month, PEBB benefits begin on that date (WAC 182-12-114).

2016 First Day of Work/Effective Date

Use the table to determine the effective date of medical and dental coverage based on the employee's first day of work.

First Day of Work	Medical/Dental Effective Date	First Day of Work	Medical/Dental Effective Date
January		**July**	
1-January	1-January	1-July	1-July
2-January	2-January	2-July and After	1-August
3-January	3-January		
4-January	4-January		
5-January and After	1-February		
February		**August**	
1-February	1-February	1-August	1-August
2-February and After	1-March	2-August and After	1-September
March		**September**	
1-March	1-March	1-September	1-September
2-March	1-April	2-September and After	1-October
April		**October**	
1-April	1-April	1-October	1-October
2-April and After	1-May	2-October	2-October
		3-October	3-October
		4-October and After	1-November
May		**November**	
1-May	1-May	1-November	1-November
2-May	2-May	2-November and After	1-December
3-May and After	1-June		
June		**December**	
1-June	1-June	1-December	1-December
2-June and After	1-July	2-December and After	1-January

Dependent Eligibility

Eligible dependents include:

- Employee's lawful spouse
- Employee's registered domestic partner*
- Children through age 25
- Children of any age with developmental or physical disabilities, as long as the disability occurred before age 26
- Extended dependents in the legal custody or legal guardianship of the employee or the employee's spouse or registered domestic partner

*For purposes of PEBB benefits, spouses are eligible for benefits, regardless of gender.

To enroll a dependent, the employee must complete the *Employee Enrollment/Change* form no later than 31 days after the date of eligibility. Additional documentation is required as follows:

- **Spouse and children through age 25**—Dependent verification documents are required and a *Declaration of Tax Status* form is required for dependents who do not qualify as a dependent for tax purposes under IRC Section 152, as modified by IRC Section 105(b).
- **Registered domestic partner and their children through age 25**—*Declaration of Tax Status* form is required for dependents who do not qualify as a dependent for tax purposes under IRC Section 152, as modified by IRC Section 105(b). Dependent verification documents are required.
- **Extended dependents**—*Extended Dependent Certification* form is required.
- Dependent with disabilities age 26 or older –*Dependent with Disabilities Certification* form is required.

See WAC 182-12-260 for details.

Enrolling Dependents

New employees may enroll their eligible dependents during their initial enrollment period. The effective date of coverage is the same as the new employee's effective date of coverage. Dependents may also be added during annual open enrollment or during a special open enrollment.

All employees enrolling a dependent are required to submit dependent verification documents within the required timeframe. Failure to submit these documents will result in the dependent not being enrolled in PEBB coverage. A list of acceptable dependent

verification documents and all dependent certification forms for extended dependents and dependents with disabilities are available below and on the PEBB website.

You may download the forms or order hard copies on the PersPay website under the *Forms and Publications* menu.

Required Forms

Dependent	Required Forms:
Spouse	• *Employee Enrollment/Change* form (50-400) • Dependent verification documents • *Declaration of Tax Status* form (50-704) (determining dependent tax status) Required when enrolling a dependent who does not qualify as a dependent for tax purposes under IRC Section 152, as modified by IRC Section 105(b) • Dependent verification documents must be submitted to HCA through FUZE for processing*
Registered domestic partner	• *Employee Enrollment/Change* form (50-400) • Dependent verification documents • *Declaration of Tax Status* form (50-704) (determining dependent tax status) Required when enrolling a dependent who does not qualify as a dependent for tax purposes under IRC Section 152, as modified by IRC Section 105(b) • Dependent verification documents must be submitted to HCA through FUZE for processing*
Dependents up to age 26	**Required Forms:**
Children	• *Employee Enrollment/Change* form (50-400) • Dependent verification documents • *Declaration of Tax Status* form (50-704) (determining dependent tax status) Required when enrolling a dependent who does not qualify as a dependent for tax purposes under IRC Section 152, as modified by IRC Section 105(b) • Dependent verification documents must be submitted to HCA through FUZE for processing*
Extended dependents	• *Employee Enrollment/Change* form (50-400) • *Extended Dependent Certification* (50-500) • A copy of legal custody, guardianship, or temporary guardianship signed by a judge or the officer of the court for the child(ren) • Forms must be submitted to HCA through FUZE for approval
Dependents over age 26	**Required Forms:**
Dependents with disabilities age 26 and older	• *Employee Enrollment/Change* form (50-400) • *Dependent with Disabilities Certification* (50-142) • Certification form must be submitted to the employee's medical plan for approval

*Except agencies who key their own dependent verification.

Dependent Verification

Employees are required to verify all dependents added to their account during the following times:

- When the employee is first eligible for benefits
- Annual open enrollment
- Special open enrollment

Extended dependents and dependents with disabilities are excluded from the dependent verification process, but must be certified (see the Dependent Certification Process section of this chapter). Verification documents must be submitted within the following timelines:

- New employee—Within the first 31 days of eligibility
- Annual open enrollment—Within the annual open enrollment period
- Special open enrollment event—Within 60 days of the date of the event

Valid Documents for Dependent Verification

	Documents
Spouse (including same-sex spouse)	• The most recent year's Federal Tax Return filed jointly that lists the spouse *(black out financial information)*; OR • The most recent subscriber's and spouse's Federal Tax Return if filed separately *(black out financial information);* OR • Proof of common residence (e.g. a utility bill) and Marriage certificate;* OR • Proof of financial interdependency (e.g. bank statement – *black out financial information*) and Marriage certificate;* OR • Petition for Dissolution of Marriage (Divorce); OR • Legal Separation notice; OR • Defense Enrollment Eligibility Reporting System (DEERS) registration
Registered domestic partner	• Proof of common residence (e.g. a utility bill) and certificate/card of state-registered domestic partnership or legal union;* OR • Proof of financial interdependency (e.g. bank statement) *(black out financial information)* and certificate/card of state-registered domestic partnership or legal unions;* OR • Petition for invalidity (annulment) of a domestic partnership or legal union; OR • Petition for dissolution of domestic partnership or legal union; OR • Legal separation notice of domestic partnership or legal union

Children**	• The most recent Federal Tax Return that includes the child(ren) as a dependent and listed as a son or daughter *(black out financial information);* OR • Birth certificate (or hospital certificate with the child's footprints on it) showing the name of parent who is the subscriber, the subscriber's spouse, or the subscriber's registered domestic partner;** OR • Certificate or decree of adoption; OR • Court ordered parenting plan; OR • National Medical Support Notice; OR • Defense Enrollment Eligibility Reporting System (DEERS) registration

*If within 2 years of marriage, state-registered domestic partnership, or establishment of a legal union then only the marriage certificate or certificate/card of state-registered domestic partnership or legal union is required.

** Newborns—If a subscriber submits acceptable verification documentation for a newborn (or newly adopted child) who is the first child on their account, you can accept the documentation and submit the documentation to HCA through FUZE for verification or verify and enroll that child (if you key your own dependent verification) any time within 12 months of the birth (or adoption). If the subscriber has received the "Your Opportunity to Enroll Has Ended" letter (i.e., they missed the window to submit verification materials) from HCA, the employee must appeal to PEBB. If you receive an appeal from the employee, review for agency error and forward to PEBB Appeals.
*****If dependent is stepchild of the subscriber, the spouse/partner must also be verified in order to enroll the child even though the spouse/partner may not be enrolling in coverage.

Dependent Certification Process

- Children may remain on the employee's account until the end of the month in which the dependent turns age 26.
- Extended dependents require PEBB certification to be enrolled.
- Dependents with disabilities are required to be certified at age 26. Proof the disability occurred prior to age 26 is required.

Extended Dependents

To add an extended dependent:

Newly eligible employees: The employee must submit the required forms no later than **31 days** after their date of eligibility. The personnel, payroll, or benefits office will key the extended dependent into the PAY1 insurance system with the same effective date as the new employee.

Annual open enrollment: The employee must submit the required forms no later than the end of the annual open enrollment period (November 30). The personnel, payroll, or benefits office will key the extended dependent into the PAY1 insurance system, effective January 1 of the following year.

Special open enrollment: The employee must submit the required forms no later than 60 days after the date of the event. The personnel, payroll, or benefits office will key the extended dependent into the PAY1 insurance system, effective the first of the month following the signature date on the form.
Note: *This date will be adjusted to the first of the month following the eligibility certification once the dependent is certified.*

In all situations, the dependent's enrollment will pend approval from HCA. The employer must submit a copy of the required paperwork to PEBB for processing.

Approval: If the dependent meets the eligibility requirements, PEBB will notify the employee and employer in writing. The copy of the approval letter sent to the agency should be placed in the employee's file.

Denial: If the dependent does not meet eligibility requirements, PEBB will notify the employee and employer in writing. A copy of the denial letter sent to the agency should be placed in the employee's file. If the denial is because of recertification, the PEBB Program will also send a *Continuation of Coverage Election Notice* to the dependent.

Recertification: Eligibility will be recertified annually. The subscriber will receive a letter from PEBB with instructions to submit all recertification information directly to PEBB.

Dependents with Disabilities Age 26 and Older

A disabled child is defined by WAC 182-12-260 as a child 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 26 (WAC 182-12-260).

To add a dependent with disabilities age 26 or older, the subscriber must submit the required forms and evidence that the condition occurred prior to age 26 no later than 60 days after the child turns 26 or no later than 31 days after the date of initial eligibility.

The dependent's enrollment will pend approval. The employee must submit a copy of the required paperwork per instructions on the form for processing, based on their plan enrollment. The request will be reviewed.

Approval: A medical review will be conducted to determine if the dependent meets the medical requirements of a dependent with a disability. If the employee changes health plans, the new health plan will conduct a medical review to continue the dependent's certification.

Denial: Dependents who fail the medical review may appeal to the entity that made the determination. If the denial is due to recertification, PEBB will send a *Continuation of Coverage Election Notice.*

Recertification: Dependents given a permanently disabled certification status will not be asked to recertify unless the employee changes health plans. Dependents given a temporarily disabled certification status will be asked to periodically recertify their dependent. The employee will be contacted when recertification is required.

Note: *If the employee is enrolling the dependent in dental only, the required forms and evidence that the condition occurred prior to age 26 are submitted to PEBB within the same timeframes as above.*

Premiums

Employer Contribution

State agencies and employer groups that participate in the PEBB Program under contract with HCA must pay premium contributions to HCA for insurance coverage for all eligible employees and their dependents.

Each employee of a state agency eligible under WAC 182-12-131 or each eligible employee on leave under FMLA is eligible for the employer contribution. The entire employer contribution is payable to HCA, even if medical is waived. Employees of employer groups are eligible under criteria stipulated under their contract with HCA. Refer to WAC 182-08-190 for details.

Faculty Employed at More Than One Institution of Higher Education

Faculty eligible for the employer contribution during an anticipated work period under WAC 182-12-131, one institution will pay the entire cost of the employer contribution if the employee is eligible by virtue of employment at that single institution.

Otherwise, each institution contributes based on its percentage of the employee's total work at all institutions during the anticipated work period. The institution with the greatest

percentage coordinates with the other institution(s) and is responsible for sending the total payment to HCA (WAC 182-08-200(2)(a)).

Faculty During Summer or Off-Quarter/Semester

For faculty eligible for the employer contribution during the summer or off-quarter/semester under WAC 182-12-131, one institution will pay the entire cost of the employer contribution if the employee is eligible by virtue of employment at that single institution.

Otherwise, each institution contributes based on its percentage of the employee's total work at all institutions throughout the instructional year or equivalent nine-month period. The institution with the greatest percentage coordinates with the other institution(s) and is responsible for sending the total payment to HCA (WAC 182-08-200(2)(b)).

Faculty Using Two-Year Averaging

For faculty eligible for the employer contribution through two-year averaging under WAC 182-12-131, one institution will pay the entire cost of the employer contribution if the employee is eligible by virtue of employment at that single institution.

Otherwise, each institution contributes based on its percentage of the employee's total work at all institutions through the two preceding academic years. The institution with the greatest percentage coordinates with the other institution(s) and is responsible for sending the total payment to HCA (WAC 182-08-200(2)(c)).

Payments and Refunds

Premiums

PEBB insurance coverage premiums become due the first of the month in which insurance coverage is effective. Premium is due from the subscriber for the entire month of insurance coverage and will not be prorated during any month.

If an employee elects optional coverage as described in WAC 182-08-197 (1)(a) or (3)(a), the employee is responsible for payment of premiums from the month that the optional coverage begins.

Unpaid or underpaid accounts must be paid, and are due from the employing agency, subscriber, or beneficiary to HCA. If a subscriber's account is past due and it is determined by HCA that full payment of the unpaid balance in a lump sum would be considered a hardship, HCA may develop a reasonable repayment plan with the subscriber or beneficiary upon request. Refer to WAC 182-08-180 for more details.

Refunds

PEBB premiums will be refunded using the following method:

When a subscriber submits an enrollment change affecting subscriber or dependent eligibility, HCA may allow up to three months of accounting adjustments. HCA will refund to the individual or the employing agency any excess premium paid during the three month adjustment period, except as indicated in WAC 182-12-148(4).

If a PEBB subscriber, dependent, or beneficiary submits a written appeal as described in WAC 182-16-025, showing proof of extraordinary circumstances beyond his or her control such that it was effectively impossible to submit the necessary information to accomplish an enrollment change within 60 days after the event that created a change of premium occurred, the PEBB deputy director or the PEBB appeals committee may approve a refund which does not exceed 12 months of premium.

If a federal government entity determines that an enrollee is retroactively enrolled in coverage (for example, Medicare) the subscriber or beneficiary may be eligible for a refund of all premiums paid during the time he or she was enrolled under the federal program if approved by the PEBB deputy director or designee.

HCA errors will be corrected by returning all excess premiums paid by the employing agency, subscriber, or beneficiary. Employing agency errors will be corrected by returning all excess premiums paid by the employee or beneficiary.

Refer to WAC 182-08-180 for more details.

Correcting Enrollment Errors

An employing agency that fails to timely enroll an employee, or his or her dependent, in PEBB benefits must correct the error. An agency must correct a failure to notify an employee timely of his or her eligibility for PEBB benefits and the employer contribution; or a failure to accurately enroll insurance coverage; 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, reconcile premium payments and premium surcharges, and provide recourse.

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 31-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).

Medical and Dental: Enrollment is effective the first day of the month following the date the enrollment error is identified, unless HCA determines additional recourse is warranted. If the enrollment error is identified on the first day of the month, the enrollment correction is effective that day.

Basic Life and LTD: 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.

Supplemental Life and Optional LTD: Enrollment 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).

FSA/DCAP: If the employee is eligible and elects (or elected) to enroll in the medical Flexible Spending 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.

Error in Enrollment Following a Period of Leave

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):

- 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.
- 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.

- 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.

Reconcile Premium Payments

Medical, Dental, and Basic Life and LTD:

The employing agency must remit to HCA the employer contribution and the employee contribution for health plan premiums, premium surcharges, basic life, and basic LTD from the date insurance coverage begins. If a state agency failed to notify a newly eligible employee of his or her eligibility for PEBB benefits, the 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.

Supplemental Life and Optional LTD:

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:

- 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.
- 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.

Recourse

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:

- Retroactive enrollment in a PEBB health plan;
- Reimbursement of claims paid;

- Reimbursement of amounts paid for medical and dental premiums; or
- Other recourse, upon approval by the authority.

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

Paying for Premiums with Pre-Tax Dollars (IRC Section 125)

Note: This section applies to state agencies and higher education institutions only.

Section 125 of the Internal Revenue Service code allows the employer to deduct money from the employee's paycheck before certain payroll taxes and income taxes are calculated. This rule allows for deductions including monthly premiums for medical coverage and for the state's Medical FSA and DCAP programs.

If employees have questions on how this will affect their future social security benefits, they should contact the Social Security Administration and request an estimate. For further information, refer to the *Employee Enrollment Guide* "Enrollment Summary" section. The *Premium Payment Plan Election/Change* form is available on the PEBB and PersPay websites.

Subscribers may change their premium payment status during annual open enrollment or if a qualifying event triggers a special open enrollment.

Premium Payment Plan (IRC Section 125) State of Washington Payroll Rules FAQ

1. **How will an employee on paid annual or medical leave be handled under the premium payment plan?**

   Payroll contributions for employees on annual or medical leave will be treated no differently than other active employees.

2. **How will employees on LWOP be treated?**

   Employees who self-pay for coverage while on leave status will be covered under the employer coverage upon the date of return. The employee contribution will begin the first of the month in which the employee returns to work with eight or more hours of pay status. The employee will be reimbursed any self-pay premium paid for that month.

3. **How will premium deductions for employees on FMLA be handled?**

   Employees may pre-pay to employers, but pre-payment should not cross plan years. Employer contributions will continue up to the first 12 weeks of approved family leave. Employees must also continue to pay the employee premium contribution to maintain

eligibility. HCA cannot track prepayment on an employee-by-employee basis. Arrangements for pre-payment will be made between the employer's payroll office and the employee. The HCA's eligibility system will not reflect the arrangement.

4. **What will be the effective date of transfers between employers?**

   The employer losing an employee will use an effective date of the last day of the month in which the transfer occurred. The losing agency is responsible for the employer contribution for the entire month. The gaining agency will use the first of the month following the transfer.

5. **How will the higher education institutions handle employee premium deductions for summer coverage?**

   The method used will be driven by the employer. The payroll contribution system will be that used for FMLA.

6. **How will employee's (on workers compensation) active claims be treated for payroll contributions and the premium payment plan?**

   Implementation of payroll contributions will have no impact on the rules for eligibility for those on worker's compensation coverage.

7. **Will we need to track whether people elected the premium payment plan on the insurance system?**

   The intention is to track people only on payroll systems. This means that when the HCA's insurance system creates payroll contribution levels for payroll systems, it cannot indicate which of these payroll contributions are for non-premium payment plan contributions.

8. **What are the rules for when an employee can change premium payment plan status, and how will the employee make the change?**

   An employee can only change his or her premium payment plan status during annual open enrollment each year, unless there is a qualifying event that triggers a special open enrollment. PEBB may also remove an employee from the premium payment plan deduction, with notice, when it is necessary to prevent excess tax deferral.

9. **Will premium payment plan benefits affect deferred compensation allowable maximums?**

   Maximum allowable deferred compensation levels for certain employees at the lower end of compensation levels may be reduced under various pre-tax deferral programs such as Sections 457 and 403B.

Personal Checks Considered Taxed Employee Contributions

Even though an employee chooses the pre-tax option for health insurance payroll deductions, if the employee is not on an active payroll (which can sustain the pre-tax deductions), personal check payments will be treated as taxed employee contributions.

Examples of this include:

- An employee remains on pay status while on leave, using eight hours of paid status per month to maintain benefits. If the employee's pay does not cover the pre-tax insurance deduction, the employee needs to send a personal check to maintain the insurance. This personal check will be considered an after-tax employee contribution.
- An employee is on the employer's payroll for nine months (for example, faculty or a seasonal employee), and the employee authorizes pre-tax premiums to be collected in advance by payroll deduction for the summer months. (**Note:** *Prepayment of health coverage by payroll deduction cannot cross the plan year.)* However, the payroll office forgets to take the deductions. In this case, when the employee sends a personal check to pay for his or her coverage, adjustments should be made in the payroll system to convert the personal check to pre-tax status.

De Minimis Default Policy for Terminated Employees

When a pre-tax health insurance payroll deduction has been improperly taken from a terminated employee no longer on an agency's payroll, this deduction should be refunded at the deduction gross amount.

For example: A pre-tax deduction of $16 may only cost the employee $10.30 after saving income tax, OASI, and Medicare. Agencies may refund the entire $16 and not change the pre-tax federal reporting already completed. Refund this amount from the account that retains health insurance deductions until paid to HCA.

The administrative costs to make extensive corrections and complete changes for federal depositing and reporting outweigh the very minimal future benefits for employees and lost tax revenue to IRS. This policy has been reviewed by the IRS and is in compliance with IRC Section 125.

FMLA Premium Payment Options and Tax Treatments

In conjunction with IRS proposed regulations payment options may be offered under an IRC Section 125 to an employee who chooses to continue group health coverage while on unpaid FMLA leave. These are pre-pay, pay-as-you-go, and catch-up. For purposes of PEBB benefits, employers may offer either the pre-pay or pay-as-you-go option.

Pre-Pay: This option allows the employee to pay the insurance premiums due during the FMLA leave in advance. These may be made on a pre-tax or after-tax basis, depending on the employee's premium payment plan status for the plan year. No pre-tax advance payments may be made for any time period in the next plan year (plan year runs January—December), nor may an employer require an employee pre-pay for the leave period.

Pay-As-You-Go: Under this option, employees may make premium payments on the same schedule as if they were not on leave or by the date premiums are due to HCA. These contributions are made on an after-tax basis unless they are taken from any taxable compensation paid the employee during the leave period.

Delinquent Payment of FMLA Employee Contributions

During FMLA leave, employee contributions are due to the employer on the first calendar day of the month of coverage. The employer's obligation to maintain health insurance coverage ceases under FMLA if an employee's premium payment is more than 60 days late. To drop the coverage for an employee whose premium payment is late, the employer must provide written notice to the employee that the payment has not been received.

This notice shall state that unless payment is received by the final day of the month, insurance coverage will be terminated retroactive to the last day of the month in which payment was received. The notice must be mailed to the employee at least 15 days before the end of the month. If payment has not been received by the final day of the month, the coverage should be terminated and a letter sent to the employee confirming the termination.

Reporting on Premium Payment Plan Participation

Individual payroll systems are responsible for submitting information to HCA on an annual basis, which will comprise form 5500, Annual Return/Report of Employee Benefit Plan to the Internal Revenue Service (IRS). HCA compiles information from all payroll systems to submit on form 5500 report to the IRS.

Your agency's information will be submitted on an input form provided by HCA. It will summarize data for those employees whose premium payment plan payroll contributions are processed through each respective payroll system. The HCA input form will require the following information:

- Number of total employees
- Number of employees eligible to participate in the plan
- Number who actually participated

- Total cost of the fringe benefit plan (total payroll contributions qualifying under the plan)

Forms and instructions for input will be distributed by HCA to payroll system offices by October 31 of each plan year. Copies of the completed input forms from each payroll office will be due to HCA by January 31 for the prior calendar (plan) year.

Premium Payment Plan Brochure

Paying for your premiums with pretax dollars

If you're an eligible state agency or higher-education institution employee enrolling in a PEBB medical plan, your employer may deduct your medical premium from your paycheck before calculating federal withholding, Social Security, and Medicare taxes. This is allowed under the state's premium payment plan.

If you are not a state agency or higher-education institution employee, ask your employer's personnel, payroll, or benefits office if they offer this benefit.

Why should I pay my monthly medical premiums with pretax dollars?
You take home more money because taxes are calculated *after* the premium is deducted. This reduces your taxable income, which lowers your taxes and saves you money.

Do I need to complete a form to have my medical premiums withheld pretax?
No. If you are a new employee who enrolls in a medical plan, and your employer offers this benefit, your payroll office may automatically have the premiums deducted before calculating taxes.

If you do not want to pay your medical premiums with pretax earnings, you must complete and submit a *Premium Payment Plan Election/Change Form* to waive (opt out of) participation in the premium payment plan **no later than 31 days** after you become eligible for PEBB benefits (generally the first day of employment; check with your personnel, payroll, or benefits office or see WAC 182-12-114 for more information).

Can I change my mind about having my medical premiums withheld pretax?
You may change your participation under the state's premium payment plan (enroll, decline enrollment, or change election) during an annual open enrollment or a special open enrollment as described in WAC 182-08-199.

When would it benefit me *not* to have a pretax deduction?
If you have your medical premiums deducted pretax, it may also affect the following benefits:

- **Social Security**—If your base salary is under the $113,700 annual maximum in 2013, participation in the premium payment plan saves you money now by reducing your Social Security taxes. However, your lifetime Social Security benefit would be calculated using the lower salary.
- **Unemployment compensation**—Participation in the premium payment plan also reduces your base salary used to calculate unemployment compensation.

Your employer may also remove you from the premium payment plan, with notice, if necessary to prevent excess tax deferral.

HCA 50-580 (5/13)

Premium Surcharges

In 2013, the Washington State Legislature established two premium surcharges, effective July 1, 2014. These surcharges are related to tobacco use and whether an employee's spouse or registered domestic partner enrolled in PEBB medical qualifies for health coverage comparable to UMP Classic through his or her employer.

Tobacco Use Premium Surcharge

Employees will pay a monthly $25-per-account premium surcharge, in addition to their premium, if they or any dependent (age 13 or older) enrolled on their PEBB medical coverage uses a tobacco product.

Newly eligible employees and employees regaining eligibility, returning from waived status, or enrolling a dependent in PEBB medical (age 13 or older) must attest on the *Employee Enrollment/Change* form. Existing employees who need to re-attest can complete the *Premium Surcharge Change* form or attest through *My Account*.

Defaulting in PAY1

The employee will be defaulted to incur the premium surcharge if:

- Employee does not include an attestation for a dependent, age 13 or older.
- Employee does not attest, submits an incomplete attestation form, or attests after their initial date of eligibility (if newly eligible or regaining eligibility), annual open enrollment, or a special open enrollment event occurring.

When Premium Surcharge Does Not Apply

An employee **does not** have to attest for themselves and/or their dependents if:

- Employee is waiving PEBB medical
- Dependents are not enrolled in PEBB medical
- Dependents are enrolled in PEBB medical but **under the age the 13**

If the employee or dependent is a tobacco user but is enrolled in their PEBB medical plan's smoking cessation program, they can attest "no." If a dependent is a tobacco user and between the ages of 13 and 17, they are not old enough to participate in a smoking cessation program, but can access information about tobacco use at teen.smokefree.gov and attest "no."

Re-Attesting

An employee can re-attest to the tobacco use premium surcharge at any time.

- If the re-attestation results in the employee **incurring** the premium surcharge, the change is effective the first of the month following the status change. If that day is the first of the month, then the change begins on that day.
- If the re-attestation results in **removal** of the premium surcharge, the change is effective the first of the month following receipt of the form. If that day is the first of the month, then the change begins on that day.
- If an employee requests reimbursement for the incurred premium surcharge from previous months, the employee has the right to appeal.

For more information about the tobacco use premium surcharge, view the *Premium Surcharge Help Sheet*, visit the PEBB website, or see WAC 182-08-185.

Spousal Premium Surcharge

Employees may pay a $50-per-month surcharge, in addition to their premium, if covering a spouse or registered domestic partner in PEBB medical who has chosen not to enroll in medical coverage comparable to UMP Classic through his or her employer. All employees who enroll a spouse or registered domestic partner on their PEBB medical coverage must attest.

Newly eligible employees and employees regaining eligibility or enrolling a spouse or registered domestic partner in PEBB medical must attest on the *Employee Enrollment/Change* form. Existing employees re-attest by completing the *Premium Surcharge Change* form.

Defaulting in PAY1

An employee will be defaulted to incur the premium surcharge if they have a spouse or registered domestic partner on their PEBB medical coverage and:

- Does not attest
- Submits an incomplete attestation form
- Attests after 31 days of their date of eligibility or 60 days of a special open enrollment event occurring

When Premium Surcharge Does Not Apply

An employee **does not** have to attest if their spouse or registered domestic partner is not enrolled in PEBB medical.

Re-Attesting

Employees can only re-attest during specific times of the year:

a) When adding a spouse or registered domestic partner to PEBB medical
b) During annual open enrollment
c) When there is a change to the spouse or registered domestic partner's employer-based group medical insurance

Re-Attestation Results

- If the re-attestation results in the employee **incurring** the premium surcharge, the change is effective the first of the month following the status change. If that day is the first of the month, then the change begins on that day.
- If the re-attestation results in **removal** of the premium surcharge, the change is effective the first of the month following receipt of the form. If that day is the first of the month, then the change begins on that day.
- If an employee requests reimbursement for the incurred premium surcharge from previous months, the employee has the right to appeal.

Determining the Spousal Premium Surcharge

The *Premium Surcharge Help Sheet* is used to determine if the surcharge applies to the employee. On page two of the *Premium Surcharge Help Sheet,* the employee must answer the following six questions.

	Questions	YES	NO
1	Are you covering your spouse or registered domestic partner in Public Employees Benefits Board (PEBB) medical coverage under your account in 2016?		
2	Will your spouse or registered domestic partner be eligible for medical coverage through his or her employer in 2016? (If your spouse or registered domestic partner will not be employed in 2016, answer NO.)		
3	Will your spouse's or registered domestic partner's employer offer at least one medical plan that serves your spouse's or registered domestic partner's county of residence in 2016?		
4	Has your spouse or registered domestic partner elected not to enroll in his or her employer's medical coverage in 2016?		
5	Will the coverage offered by your spouse's or registered domestic partner's employer in 2016 NOT be through the PEBB Program or TRICARE? Answer YES if your spouse's or registered domestic partner's employer **does not** offer PEBB or TRICARE coverage. Answer NO if your spouse's or registered domestic partner's employer **does** offer PEBB or TRICARE coverage.		
6	Will your spouse's or registered domestic partner's share of the medical premium through his or her employer be less than $89.31 per month in 2016?		

If the employee answers "no" to any of the questions, they do **not** have to pay the premium surcharge. If they answer "yes" to all the questions, the employee will be directed to the spousal plan calculator, which is available on the PEBB website. The spousal plan calculator

determines if the employee will incur the premium surcharge. The employee can complete an online calculator or fill out a paper calculator by hand and submit to their agency's personnel, payroll, or benefits office for a determination.

If the employee attests "no" based on a "no" response to one of the questions, they must include the number they answered "no" to from the six questions in the *Premium Surcharge Help Sheet*.

Does the spouse or registered domestic partner coverage surcharge apply to you?
If you enroll a spouse or registered domestic partner on your PEBB medical coverage and you check YES or leave the check boxes below blank, you will pay the monthly $50 surcharge.

☐ **YES:** I used the *2016 Premium Surcharge Help Sheet* and, if directed, completed the *2016 Spousal Plan Calculator* online.

☒ **NO:** I used the *2016 Premium Surcharge Help Sheet* and, if directed, completed the *2016 Spousal Plan Calculator* online.
Which questions, if any, on the *2016 Premium Surcharge Help Sheet* did you check NO? Check all that apply.
☐ Question 1 ☒ Question 2 ☐ Question 3 ☐ Question 4 ☐ Question 5 ☐ Question 6

☐ **Employer or PEBB Program to determine:** I used the *2016 Premium Surcharge Help Sheet* and I am completing and submitting a paper *2016 Spousal Plan Calculator* with this form. My employer or the PEBB Program will determine whether my spouse's or registered domestic partner's employer-based group medical insurance is comparable to UMP Classic.

The employee may choose to have their employer determine if they will incur the spousal premium surcharge by checking the "Employer or PEBB Program to Determine" checkbox. The employee is responsible for submitting a completed *Premium Surcharge Help Sheet* and a *Spousal Plan Calculator*. If they fail to provide or do not timely provide these items, they will incur the surcharge.

To learn more about the spousal premium surcharge, visit the PEBB website or see WAC 182-08-185 and Policy 31-3.

Resources

- Policy 45-2, Addendum 45-2A
- Chapter 182-08 WAC
- Chapter 182-12 WAC
- FUZE
- PersPay website (for agencies only)
- PEBB website (for employees)