(v) Is included in a college or university degree program that pertains to the individual's current assignment, or potential future assignment, as a certified instructional staff.

[Statutory Authority: RCW 28A.410.010. 99-14-010, § 180-85-075, filed 6/24/99, effective 7/25/99. Statutory Authority: RCW 28A.305.130 (1) and (2), 28A.410.010 and 28A.150.220(4). 99-01-174, § 180-85-075, filed 12/23/98, effective 1/23/99. Statutory Authority: RCW 28A.70.005. 89-01-043 (Order 28-88), § 180-85-075, filed 12/14/88; 86-13-018 (Order 8-86), § 180-85-075, filed 6/10/86.]

Title 182 WAC

HEALTH CARE AUTHORITY

Chapters

Chapter 182-08 WAC
PROCEDURES

WAC

WAC 182-08-095 Waiver of coverage. Employees eligible for PEBB health care coverage have the option of waiving medical coverage for themselves and any or all dependents if they are covered by another medical plan. In order to waive medical coverage, the employee must complete an enrollment form that identifies the individuals for whom coverage is being waived. If an employee waives medical coverage for him/herself, coverage is automatically waived for all eligible dependents. An employee may choose to enroll only him/herself, and waive medical coverage for any or all dependents.

Employees and dependents whose medical coverage is waived will remain enrolled in a PEBB dental plan. Employees will also remain enrolled in PEBB life and long term disability coverage.

If PEBB medical coverage is waived, an otherwise eligible person may not enroll in a PEBB plan until the next open enrollment period, or within 31 days of loss of other medical coverage. Proof of other medical coverage is required to demonstrate that: 1) Coverage was continuous from the date PEBB coverage was waived; and 2) the period between loss of coverage and application for PEBB coverage is 31 days or less. The employee and dependents may have an additional opportunity to enroll in the event of acquisition of a new dependent as a result of marriage, birth, adoption, or placement for adoption, provided that enrollment is requested within 31 days of marriage or within 60 days of birth, adoption or placement for adoption.

[Statutory Authority: RCW 41.05.160. 99-19-029 (Order 99-03), § 182-08-095, filed 9/8/99, effective 10/9/99; 97-21-126, § 182-08-095, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-095, filed 3/29/96, effective 4/29/96.]

Chapter 182-12 WAC
ELIGIBLE AND NONELIGIBLE EMPLOYEES

WAC

WAC 182-12-111 Eligible entities and individuals. The following entities and individuals shall be eligible to participate in PEBB insurance plans subject to the terms and conditions set forth below:

(1) State agencies. Every department, division, or separate agency of state government, including all state higher education institutions, including the higher education coordinating board, and the state board for community and technical colleges is eligible and required to participate in all PEBB approved plans. Insurance and health care contributions for ferry employees shall be governed by RCW 47.64.270.

Employees of technical colleges previously enrolled in a benefits trust may terminate PEBB coverage by January 1, 1996, or the expiration of the current collective bargaining agreements, whichever is later. Employees electing to terminate PEBB coverage have a one-time re-enrollment option after a five year wait. Employees of a bargaining unit may terminate only as an entire bargaining unit. All administrative or managerial employees may terminate only as an entire unit.

Technical colleges with employees enrolled in a benefits trust shall remit to the HCA a retiree remittance as specified in the omnibus appropriations act, for each full-time employee equivalent. The remittance may be prorated for employees receiving a prorated portion of benefits.

(2) Employees of employee organizations representing state civil service employees, at the option of each employee organization, and, effective October 1, 1995, employees of employee organizations currently pooled with employees of school districts for the purpose of purchasing insurance benefits, at the option of such employee organization.

(3) Employees of a school district, educational service district, county, municipality, or other political subdivision of the state may participate in PEBB insurance programs provided:

(a) All eligible employees of the entity transfer to PEBB plan coverage as a unit. If the employer group meets the minimum size standards established by HCA, bargaining units may elect to participate separately from the whole group, and the nonrepresented employees may elect to participate separately from the whole group provided all nonrepresented employees join as a group.

(b) The legislative authority or the board of directors obligates itself to participate in all PEBB insurance plans. The PEBB medical must be the only employer sponsored medical plans available to all eligible employees.

(c) The legislative authority of the entity or the board of directors submits an application together with employee census data and, if available, prior claims experience of the entity to the HCA. The application to participate in the PEBB plans is subject to the approval of the HCA.

(d) The legislative authority or the board of directors agrees to maintain its PEBB plan participation for a mini-

mum of one full year, and then through the end of the plan year.

(e) The terms and conditions for the payment of the insurance premiums shall be set forth in the provisions of the bargaining agreement or terms of employment and shall comply with the employer contribution requirements specified in the governing statute. These provisions, including eligibility, shall be subject to review and approval by the HCA at the time of application for participation. Any substantive changes will be submitted to HCA.

(f) The eligibility requirements for dependents shall be the same as the requirements for dependents of the state employees and retirees as defined in WAC 182-12-119.

(g) The legislative authority or the board of directors shall provide the HCA written notice of its intent to terminate PEBB plan participation no later than thirty days prior to the effective date of termination. If a county, municipality, or political subdivision, or employees of employee organizations as defined in WAC 182-12-111(2) terminates coverage in PEBB insurance plans, retired and disabled employees who began participating after September 15, 1991, will no longer be eligible to participate in PEBB insurance plans beyond the mandatory extension requirements specified in WAC 182-12-215.

(4) Eligible nonemployees:

(a) Dislocated forest products workers enrolled in the employment and career orientation program pursuant to chapter 50.70 RCW shall be eligible for PEBB medical and dental plan coverage while enrolled in that program.

(b) School board members or students eligible to participate under RCW 28A.400.350.

[Statutory Authority: RCW 41.05.160. 99-19-028 (Order 99-04), § 182-12-111, filed 9/8/99, effective 10/9/99; 97-21-127, § 182-12-111, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-111, filed 3/29/96, effective 4/29/96. Statutory Authority: RCW 41.04.205, 41.05.065, 41.05.011, 41.05.080 and chapter 41.05 RCW. 92-03-040, § 182-12-111, filed 1/10/92, effective 1/10/92. Statutory Authority: Chapter 41.05 RCW. 78-02-015 (Order 2-78), § 182-12-111, filed 1/10/78.]

WAC 182-12-119 Eligible dependents. "Eligible dependents." The following are eligible as dependents under the PEBB eligibility rules:

(1) Lawful spouse.

(2) Dependent children through age nineteen. The term "children" includes the subscriber's natural children, stepchildren, legally adopted children, children for whom the subscriber has assumed a legal obligation for total or partial support of a child in anticipation of adoption of the child, or children specified in a court order or divorce decree. Married children who qualify as dependents of the subscriber under the Internal Revenue Code, and extended dependents approved by the HCA are included. To qualify for HCA approval, the subscriber must demonstrate legal custody for the child with a court order, and:

(a) Be living with the subscriber in a parent-child relationship;

(b) Be dependent upon the subscriber for financial support;

(c) Not be eligible for coverage under Medicare, Medicaid, or similar government entitlement programs; and

(d) Not be a foster child for whom support payments are made to the subscriber through the state department of social and health services (DSHS) foster care program.

(3) Dependent children age twenty through age twenty-three who are dependent upon the employee/retiree for maintenance and support, and who are registered students in full-time attendance at an accredited secondary school, college, university, vocational school, or school of nursing. Dependent student eligibility continues year-round for those who attend three of the four school quarters or two semesters and for the quarter following graduation provided the employee/retiree is covered at the same time; the dependent limiting age has not been exceeded; and the dependent meets all other eligibility requirements.

(4) Dependent children of any age who are incapable of self-support due to developmental or physical disability, provided such condition occurs prior to age twenty or during the time the dependent was covered under a PEBB plan as a full-time student. Proof of such disability and dependency must be furnished prior to the dependent's attainment of age twenty or loss of eligibility for student coverage, and as periodically requested thereafter.

(5) Dependent parents. Dependent parents covered under a PEBB medical plan before July 1, 1990, may continue enrollment on a self-pay basis as long as:

(a) The parent maintains continuous coverage in a PEBB-sponsored medical plan;

(b) The parent continues to qualify under the Internal Revenue Code as a dependent of an eligible subscriber;

(c) The subscriber who claimed the parent as a dependent continues enrollment in a PEBB program; and

(d) The parent is not covered by any other group medical insurance. Dependent parents may be enrolled in a different PEBB plan than that selected by the eligible subscriber; however, dependent parents may not add additional family members to their coverage.

(6) Surviving dependents.

(a) The following surviving dependents may continue their medical and dental coverages on a self-pay basis:

(i) If a dependent loses eligibility under a PEBB plan due to the death of the employee, the dependent(s) may continue coverage under a retiree plan provided the dependent(s) will immediately begin receiving a monthly benefit from any state of Washington-sponsored retirement system (the Federal Civil Service Retirement System shall be considered a Washington sponsored retirement system for Washington State University cooperative extension service employees who held a federal civil service appointment and who were covered under the PEBB program at the time of death).

(ii) If a surviving dependent of a PEBB employee is not eligible for a monthly retirement income benefit, or lump-sum payment because the monthly pension payment would be less than $50, the dependent may be eligible for continued coverage under COBRA.

(iii) Dependents of retirees covered under a PEBB plan at the time of the retiree's death are eligible to continue PEBB retiree coverage.

(iv) Surviving spouses and/or eligible dependent children of a deceased school district or educational service district employee who were not enrolled in a PEBB plan at the

time of death may continue coverage provided the employee died on or after October 1, 1993 and the dependent(s) immediately began receiving a retirement benefit allowance under chapter 41.32 or 41.40 RCW.

(b) Application for surviving dependent(s) coverage must be made in writing on the enrollment form approved by the health care authority within sixty days from the date of death of the employee or retiree. Coverage is retroactive to the date the employee or retiree coverage terminated subject to the payment of the premium. The employee's or retiree's spouse may continue coverage indefinitely; other dependents may continue coverage until they lose eligibility under PEBB rules.

[Statutory Authority: RCW 41.05.160. 99-19-028 (Order 99-04), § 182-12-119, filed 9/8/99, effective 10/9/99; 97-21-127, § 182-12-119, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-119, filed 3/29/96, effective 4/29/96.]

Chapter 182-25 WAC
WASHINGTON BASIC HEALTH PLAN

WAC

WAC 182-25-010 Definitions. The following definitions apply throughout these rules.

(1) "Administrator" means the administrator of the Washington state health care authority (HCA) or designee.

(2) "Appeal procedure" means a formal written procedure for resolution of problems or concerns raised by enrollees which cannot be resolved in an informal manner to the enrollee's satisfaction.

(3) "Basic health plan" (or BHP) means the system of enrollment and payment on a prepaid capitated basis for basic health care services administered by the administrator through managed health care systems.

(4) "BHP plus" means the program of expanded benefits available to children through coordination between the department of social and health services (DSHS) and basic health plan. Eligibility for BHP Plus is determined by the department of social and health services, based on Medicaid eligibility criteria. To be eligible for the program children must be under age nineteen, with a family income at or below two hundred percent of federal poverty level, as defined by the United States Department of Health and Human Services. They must be Washington state residents, not eligible for Medicare, and may be required to meet additional DSHS eligibility requirements.

(5) "Co-payment" means a payment indicated in the schedule of benefits which is made by an enrollee to a health care provider or to the MHCS.

(6) "Covered services" means those services and benefits in the BHP schedule of benefits (as outlined in the member handbook issued to the enrollee, or to a subscriber on behalf of the enrollee), which an enrollee shall be entitled to receive from a managed health care system in exchange for payment of premium and applicable co-payments.

(7) "Disenrollment" means the termination of covered services in BHP for a subscriber and dependents, if any.

(8) "Effective date of enrollment" means the first date, as established by BHP, on which an enrollee is entitled to receive covered services from the enrollee's respective managed health care system.

(9) "Dependent" means:

(a) The subscriber's lawful spouse, not legally separated, who resides with the subscriber; or

(b) The unmarried child of the subscriber or the subscriber's dependent spouse, whether by birth, adoption, legal guardianship, or placement pending adoption, who is:

(i) Younger than age nineteen, and who has not been relinquished for adoption by the subscriber or the subscriber's dependent spouse; or

(ii) Younger than age twenty-three, and a registered student at an accredited secondary school, college, university, technical college, or school of nursing, attending full time, other than during holidays, summer and scheduled breaks; or

(c) A person of any age who is under legal guardianship of the subscriber or the subscriber's dependent spouse, and who is incapable of self-support due to disability.

(10) "Eligible full-time employee" means an employee who meets all eligibility requirements in WAC 182-25-030 and who is regularly scheduled to work thirty or more hours per week for an employer. The term includes a self-employed individual (including a sole proprietor or a partner of a partnership, and may include an independent contractor) if the individual:

(a) Is regularly scheduled to work thirty hours or more per week; and

(b) Derives at least seventy-five percent of his or her income from a trade or business that is licensed to do business in Washington.

Persons covered under a health benefit plan pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 shall not be considered eligible employees for purposes of minimum participation requirements.

(11) "Eligible part-time employee" means an employee who meets all the criteria in subsection (10) of this section, but who is regularly scheduled to work fewer than thirty hours per week for an employer.

(12) "Employee" means one who is in the employment of an employer, as defined by RCW 50.04.080.

(13) "Employer" means an enterprise licensed to do business in Washington state, as defined by RCW 50.04.080, with employees in addition to the employer, whose wages or salaries are paid by the employer.

(14) "Enrollee" means a person who meets all eligibility requirements, who is enrolled in BHP, and for whom applicable premium payments have been made.

(15) "Family" means an individual or an individual and spouse, if not legally separated, and dependents. For purposes of eligibility determination and enrollment in the plan, an individual cannot be a member of more than one family.

(16) "Financial sponsor" means a person, organization or other entity, approved by the administrator, that is responsi-

ble for payment of all or a designated portion of the monthly premiums on behalf of a subscriber and any dependents.

(17) "Gross family income" means total cash receipts, as defined in (a) of this subsection, before taxes, from all sources, for subscriber and dependents whether or not they are enrolled in BHP, with the exceptions noted in (b) of this subsection.

(a) Income includes:

(i) Money wages, tips and salaries before any deductions;

(ii) Net receipts from nonfarm self-employment (receipts from a person's own unincorporated business, professional enterprise, or partnership, after deductions for business expenses);

(iii) Net receipts from farm self-employment (receipts from a farm which one operates as an owner, renter, or sharecropper, after deductions for farm operating expenses);

(iv) Regular payments from Social Security, railroad retirement, unemployment compensation, strike benefits from union funds, workers' compensation, veterans' payments, public assistance, alimony, child support, military family allotments, private pensions, government employee pensions (including military retirement pay), and regular insurance or annuity payments;

(v) Work study or training stipends;

(vi) Dividends and interest accessible to the enrollee without a penalty;

(vii) Net rental income, net royalties, periodic receipts from estates or trusts, and net gambling or lottery winnings.

(b) Income does not include the following types of money received:

(i) Capital gains;

(ii) Any assets drawn down as withdrawals from a bank, the sale of property, a house or a car;

(iii) Tax refunds, gifts, loans, lump-sum inheritances, one-time insurance payments, or compensation for injury (except workers' compensation);

(iv) Noncash benefits, such as the employer-paid or union-paid portion of health insurance or other employee fringe benefits, food or housing received in lieu of wages, the value of food and fuel produced and consumed on farms, the imputed value of rent from owner-occupied nonfarm or farm housing, and such noncash benefit programs as Medicare, Medicaid, food stamps, school lunches, and housing assistance;

(v) Income earned by dependent children;

(vi) Income of a family member who resides in another household when such income is not available to the subscriber or dependents seeking enrollment in BHP;

(vii) College or university scholarships, grants, fellowships and assistantships;

(viii) Payments from the department of social and health services adoption support program authorized under RCW 26.33.320 and 74.13.100 through 74.13.145;

(ix) Documented child care expenses for the care of a dependent child of a subscriber may be deducted (at a rate set by the administrator and consistent with Internal Revenue Service requirements) when calculating gross family income. To qualify for this deduction, the subscriber must be employed during the time the child care expenses were paid, and payment may not be paid to a parent or step parent of the child or to a dependent child of the subscriber or his/her spouse.

(18) "Home care agency" means a private or public agency or organization that administers or provides home care services directly or through a contract arrangement to ill, disabled, or infirm persons in places of temporary or permanent residence, and is licensed by the department of social and health services (DSHS) as a home care agency. In order to qualify, the agency must be under contract with one of the following DSHS programs: Chore, Medicaid Personal Care, Community Options Program Entry System (COPES) or Respite Care (up to level three).

(19) "Institution" means a federal, state, county, city or other government correctional or detention facility or government-funded facility where health care historically has been provided and funded through the budget of the operating agency, and includes, but is not limited to: Washington state department of corrections institutions; federal, county and municipal government jail and detention institutions; Washington state department of veterans affairs soldiers' and veterans' homes; department of social and health services state hospitals and facilities and juvenile rehabilitation institutions and group homes. An institution does not include: Educational institutions; government-funded acute health care or mental health facilities except as provided above; chemical dependency facilities; and nursing homes.

(20) "Institutionalized" means to be confined, voluntarily or involuntarily, by court order or health status, in an institution, as defined in subsection (19) of this section. This does not include persons on work release or who are residents of higher education institutions, acute health care facilities, alcohol and chemical dependency facilities, or nursing homes.

(21) "Insurance broker" or "agent" means a person who is currently licensed as a disability insurance broker or agent, according to the laws administered by the office of the insurance commissioner under chapter 48.17 RCW.

(22) "Managed health care system" (or "MHCS") means any health care organization (including health care providers, insurers, health care service contractors, health maintenance organizations, or any combination thereof) which has entered into a contract with the HCA to provide basic health care services.

(23) "Maternity benefits through medical assistance," also known as S-Medical, means the coordinated program between BHP and DSHS for eligible pregnant women. This program includes all Medicaid benefits, including maternity coverage. Eligible members must be at or below one hundred eighty-five percent of the federal poverty level. Eligibility for this program is determined by DSHS, based on Medicaid eligibility criteria.

(24) "Medicaid" means the Title XIX Medicaid program administered by the department of social and health services, and includes the medical care programs provided to the "categorically needy" and the "medically needy" as defined in chapter 388-503 WAC.

(25) "Medicare" means programs established by Title XVIII of Public Law 89-97, as amended, "Health Insurance for the Aged and Disabled."

(26) "Nonsubsidized enrollee" or "full premium enrollee" means an individual who enrolls in BHP, as the subscriber or dependent, and who pays or on whose behalf is paid the full costs for participation in BHP, without subsidy from the HCA.

(27) "Open enrollment" means a time period designated by the administrator during which enrollees may enroll additional dependents or apply to transfer their enrollment from one managed health care system to another.

(28) "Participating employee" means an employee of a participating employer or home care agency who has met all the eligibility requirements and has been enrolled for coverage under BHP.

(29) "Participating employer" means an employer who has been approved for enrollment in BHP as an employer group.

(30) "Preexisting condition" means any illness, injury or condition for which, in the three months immediately preceding an enrollee's effective date of enrollment in BHP:

(a) Treatment, consultation or a diagnostic test was recommended for or received by the enrollee; or

(b) The enrollee was prescribed or recommended medication; or

(c) Symptoms existed which would ordinarily cause a reasonably prudent individual to seek medical diagnosis, care or treatment.

(31) "Premium" means a periodic payment, based upon gross family income and determined under RCW 70.47.060(2), which an individual, their employer or a financial sponsor makes to BHP for subsidized or nonsubsidized enrollment in BHP.

(32) "Program" means subsidized BHP, nonsubsidized BHP, BHP Plus, or maternity benefits through medical assistance.

(33) "Provider" or "health care provider" means a health care professional or institution duly licensed and accredited to provide covered services in the state of Washington.

(34) "Rate" means the per capita amount, including administrative charges and any applicable premium and prepayment tax imposed under RCW 48.14.020, negotiated by the administrator with and paid to a managed health care system, to provide BHP health care benefits to enrollees.

(35) "Schedule of benefits" means the basic health care services adopted and from time to time amended by the administrator, which an enrollee shall be entitled to receive from a managed health care system in exchange for payment of premium and applicable co-payments, as described in the member handbook.

(36) "Service area" means the geographic area served by a managed health care system as defined in its contract with HCA.

(37) "Subscriber" is a person who applies to BHP on his/her own behalf and/or on behalf of his/her dependents, if any, who meets all applicable eligibility requirements, is enrolled in BHP, and for whom the monthly premium has been paid. Notices to a subscriber and, if applicable, a financial sponsor or employer shall be considered notice to the subscriber and his/her enrolled dependents.

(38) "Subsidized enrollee" or "reduced premium enrollee" means an individual who enrolls in BHP, either as the subscriber or an eligible dependent, whose current gross family income does not exceed twice the federal poverty level as adjusted for family size and determined annually by the federal Department of Health and Human Services, and who receives a premium subsidy from the HCA.

(39) "Subsidy" means the difference between the amount of periodic payment the HCA makes to a managed health care system on behalf of a subsidized enrollee, and the amount determined to be the subsidized enrollee's responsibility under RCW 70.47.060(2).

[Statutory Authority: RCW 70.47.050, 70.47.060 and 70.47.100. 99-24-005 (Order 99-06), § 182-25-010, filed 11/18/99, effective 12/19/99. Statutory Authority: RCW 70.47.050, 70.47.060(9) and SHB 2556. 98-15-018, § 182-25-010, filed 7/6/98, effective 8/6/98. Statutory Authority: RCW 70.47.050. 98-07-002, § 182-25-010, filed 3/5/98, effective 4/5/98; 97-15-003, § 182-25-010, filed 7/3/97, effective 8/3/97; 96-15-024, § 182-25-010, filed 7/9/96, effective 8/9/96.]

WAC 182-25-030 Eligibility. (1) To be eligible for enrollment in BHP, an individual must be a Washington state resident who is not:

(a) Eligible for free Medicare coverage or eligible to buy Medicare coverage; or

(b) Institutionalized at the time of enrollment.

(2) Persons not meeting these criteria, as evidenced by information submitted on the application for enrollment or otherwise obtained by BHP, will not be enrolled. An enrollee who is no longer a Washington resident, who becomes eligible for free or purchased Medicare, or who is later determined to have failed to meet BHP's eligibility criteria at the time of enrollment, will be disenrolled from the plan as provided in WAC 182-25-090. An enrollee who was not confined to an institution at the time of enrollment, who is subsequently confined to an institution, will not be disenrolled, provided he or she remains otherwise eligible and continues to make all premium payments when due.

(3) Eligibility for BHP Plus and maternity benefits through medical assistance is determined by DSHS, based on Medicaid eligibility criteria.

(4) For subsidized enrollment in BHP, an individual must meet the eligibility criteria in subsection (1) of this section, have a gross family income that does not exceed two hundred percent of federal poverty level as adjusted for family size and determined annually by the U.S. Department of Health and Human Services, and must pay, or have paid on his or her behalf, the monthly BHP premium.

(5) To be eligible for nonsubsidized enrollment in BHP, an individual may have any income level, must meet the eligibility criteria in subsection (1) of this section, and must pay, or have paid on their behalf, the full costs for participation in BHP, including the cost of administration, without subsidy from the HCA.

(6)(a) An individual otherwise eligible for enrollment in BHP may be denied enrollment if the administrator has determined that acceptance of additional enrollment would exceed limits established by the legislature, would jeopardize the orderly development of BHP, or would result in an overexpenditure of BHP funds. An individual otherwise eligible for enrollment in either the subsidized or nonsubsidized program may also be denied enrollment if no MHCS is accepting new

enrollment in that program or from the geographic area where the applicant lives.

(b) If the administrator closes or limits subsidized enrollment, to the extent funding is available, BHP will continue to accept and process applications for enrollment from:

(i) Applicants who will pay the full premium, provided at least one MHCS is accepting new nonsubsidized enrollment from the geographic area where the applicant lives;

(ii) Children eligible for BHP Plus;

(iii) Children eligible for subsidized BHP, who were referred to DSHS for BHP Plus coverage, but were found ineligible for BHP Plus for reasons other than noncompliance;

(iv) Employees of a home care agency group enrolled or applying for coverage under WAC 182-25-060;

(v) Eligible individual home care providers;

(vi) Licensed foster care workers;

(vii) Limited enrollment of new employer groups; and

(viii) Subject to availability of funding, additional space for enrollment may be reserved for other applicants as determined by the administrator, in order to ensure continuous coverage and service for current individual and group accounts. (For example: Within established guidelines, processing routine income changes that may affect subsidy eligibility for current enrollees; adding new family members to an existing account; transferring enrollees between group and individual accounts; restoring coverage for enrollees who are otherwise eligible for continued enrollment under WAC 182-25-090 after a limited suspension of coverage due to late payment or other health care coverage; adding newly hired employees to an existing employer group; or adding new or returning members of federally recognized native American tribes to that tribe's currently approved financial sponsor group.)

(c) If the administrator has closed or limited subsidized enrollment, applicants for subsidized BHP who are not in any of the categories in (b) of this subsection may reserve space on a reservation list to be processed according to the date the reservation or application is received by BHP. When enrollment is reopened by the administrator, applicants whose names appear on the reservation list will be notified by BHP of the opportunity to enroll. BHP may require new application forms and documentation from applicants on the reservation list, or may contact applicants to verify continued interest in applying, prior to determining their eligibility.

[Statutory Authority: RCW 70.47.050, 70.47.060 and 70.47.100. 99-24-005 (Order 99-06), § 182-25-030, filed 11/18/99, effective 12/19/99. Statutory Authority: RCW 70.47.050 and 70.47.060. 99-16-022 (Order 99-02), § 182-25-030, filed 7/26/99, effective 8/26/99. Statutory Authority: RCW 70.47.050. 98-07-002, § 182-25-030, filed 3/5/98, effective 4/5/98; 97-15-003, § 182-25-030, filed 7/3/97, effective 8/3/97; 96-15-024, § 182-25-030, filed 7/9/96, effective 8/9/96.]

WAC 182-25-031 Transition coverage. (1) During plan year 2000, because most MHCS are not accepting new enrollment in the nonsubsidized program, all MHCS serving subsidized enrollees will offer limited transition coverage for enrollees who lose eligibility for premium subsidy. For coverage after December 31, 1999, a subsidized enrollee who loses eligibility for premium subsidy may remain enrolled with no change in MHCS, benefits, or copayments through December 31, 2000, provided:

(a) The enrollee's subsidy change was processed after September 10, 1999;

(b) The enrollee is otherwise eligible for BHP;

(c) The enrollee continues to reside within the MHCS service area; and

(d) The enrollee pays the full cost of his or her coverage, plus a fee for HCA administrative costs.

(2) To retain coverage for plan year 2001, the enrollee will be required to select a MHCS contracting to serve nonsubsidized enrollees and will be covered according to the schedule of benefits for nonsubsidized enrollees.

[Statutory Authority: RCW 70.47.050, 70.47.060 and 70.47.100. 99-24-005 (Order 99-06), § 182-25-031, filed 11/18/99, effective 12/19/99.]

WAC 182-25-040 Enrollment in the plan. (1) Any individual applying for enrollment in BHP must submit a signed, completed BHP application for enrollment. Applications for enrollment of children under the age of eighteen must be signed by the child's parent or legal guardian, who shall also be held responsible for payment of premiums due on behalf of the child. If an applicant is accepted for enrollment, the applicant's signature acknowledges the applicant's obligation to pay the monthly premium in accordance with the terms and conditions identified in the member handbook. Applications for subsidized enrollment on behalf of children under the age of nineteen shall be referred to the department of social and health services for Medicaid eligibility determination, unless the family chooses not to access this option.

(2) Each applicant shall list all eligible dependents to be enrolled and supply other information and documentation as required by BHP and, where applicable, DSHS medical assistance.

(a) Documentation will be required, showing the amount and sources of the applicant's gross family income. Documentation will include a copy of the applicant's most recently filed federal income tax form, and/or other documentation that shows year-to-date income, or income for the most recent thirty days or complete calendar month as of the date of application. An average of documented income received over a period of several months may be required for purposes of eligibility determination.

(b) Documentation of Washington state residency shall also be required, displaying the applicant's name and address. Other documentation may be accepted if the applicant does not have a physical residence.

(c) BHP may request additional information from applicants for purposes of establishing or verifying eligibility, premium responsibility or managed health care system selection.

(d) Submission of incomplete or inaccurate information may delay or prevent an applicant's enrollment in BHP. Intentional submission of false information may result in disenrollment of the subscriber and all enrolled dependents.

(3) Each member may be enrolled in only one BHP account. Each family applying for enrollment must designate a managed health care system from which the applicant and all enrolled dependents will receive covered services. All applicants from the same family who are covered under the same account must receive covered services from the same

managed health care system (with the exception of cases in which a subscriber who is paying for BHP coverage for his/her dependent who lives in a different service area). No applicant will be enrolled for whom designation of a managed health care system has not been made as part of the application for enrollment. The administrator will establish procedures for the selection of managed health care systems, which will include conditions under which an enrollee may change from one managed health care system to another. Such procedures will allow enrollees to change from one managed health care system to another during open enrollment, or otherwise upon showing of good cause for the transfer.

(4) When a managed health care system assists BHP applicants in the enrollment process, it must provide them with the toll-free number for BHP and information on all MHCS available within the applicant's county of residence and the estimated premiums for each available MHCS.

(5) If specific funding has been appropriated for that purpose, insurance brokers or agents who have met all statutory and regulatory requirements of the office of the insurance commissioner, are currently licensed through the office of the insurance commissioner, and who have completed BHP's training program, will be paid a commission for assisting eligible applicants to enroll in BHP.

(a) Individual policy commission: Subject to availability of funds, and as a pilot program, BHP will pay a one-time fee to any currently licensed insurance broker or agent who sells BHP to an eligible individual applicant if that applicant has not been a BHP member within the previous five years.

(b) Group policy commission: Subject to availability of funds, and as a pilot program, fees paid for the sale of BHP group coverage to an eligible employer will be based on the number of employees in the group for the first and second months of the group's enrollment.

(c) Insurance brokers or agents must provide the prospective applicant with the BHP toll-free information number and inform them of BHP benefits, limitations, exclusions, waiting periods, co-payments, all managed health care systems available to the applicant within his/her county of residence and the estimated premium for each of them.

(d) All statutes and regulations of the office of the insurance commissioner will apply to brokers or agents who sell BHP, except they will not be required to be appointed by the MHCS.

(e) BHP will not pay renewal commissions.

(6) Except as provided in WAC 182-25-030(6), applications for enrollment will be reviewed by BHP within thirty days of receipt and those applicants satisfying the eligibility criteria and who have provided all required information, documentation and premium payments will be notified of their effective date of enrollment.

(7) Eligible applicants will be enrolled in BHP in the order in which their completed applications, including all required documentation, have been received by BHP, provided that:

(a) At least one MHCS is accepting new enrollment in the program for which the applicant is applying and from the geographic area where the applicant lives; and

(b) The applicant also remits full payment of the first premium bill to BHP by the due date specified by BHP.

In the event a reservation list is implemented, eligible applicants will be enrolled in accordance with WAC 182-25-030(6).

(8) An open enrollment period of at least twenty consecutive days will be held annually. During this open enrollment period, enrollees may apply to enroll additional family members or to transfer their enrollment to a different MHCS, provided the MHCS selected is accepting new enrollment for the enrollee's program in the geographic area where the enrollee lives.

(9) Not all family members are required to apply for enrollment in BHP; however, any family member for whom application for enrollment is not made at the same time that other family members apply, may not subsequently enroll as a family member until the next open enrollment period, unless the subscriber has experienced a "qualifying change in family status." "Qualifying changes in family status" include:

(a) The loss of other health care coverage, for a family member who has previously waived coverage, provided BHP receives the family member's application within thirty days of the loss of other coverage, along with proof of the family member's continuous medical coverage from the date the subscriber enrolled in BHP;

(b) Marriage or assuming custody or dependency of a child or adult dependent (other than newborn or newly adopted children), provided BHP receives the new family member's application within thirty days of the change in family status; or

(c) Addition of an eligible newborn child or a child newly placed for adoption provided BHP receives the child's application for enrollment within sixty days of the date of birth or placement for adoption. These children may be enrolled effective from the date of birth or placement for adoption.

(10) On a schedule approved by the administrator, BHP will request verification of information from all or a subset of enrollees ("recertification"), requiring new documentation of income to determine if the enrollee has had a change in income that would result in a different subsidy level. For good cause, BHP may require recertification on a more widespread or more frequent basis. Enrollees who fail to comply with a recertification request will be converted to nonsubsidized enrollment for at least one month, until new income documentation has been submitted and processed. Each enrollee is responsible for notifying BHP within thirty days of any changes which could affect the enrollee's eligibility or premium responsibility. If, as a result of recertification, BHP determines that an enrollee has not reported income or income changes accurately, the enrollee will be subject to the provisions of WAC 182-25-085.

[Statutory Authority: RCW 70.47.050, 70.47.060 and 70.47.100. 99-24-005 (Order 99-06), § 182-25-040, filed 11/18/99, effective 12/19/99. Statutory Authority: RCW 70.47.050 and 70.47.060. 99-16-022 (Order 99-02), § 182-25-040, filed 7/26/99, effective 8/26/99. Statutory Authority: RCW 70.47.050. 98-07-002, § 182-25-040, filed 3/5/98, effective 4/5/98; 97-15-003, § 182-25-040, filed 7/3/97, effective 8/3/97; 96-15-024, § 182-25-040, filed 7/9/96, effective 8/9/96.]

WAC 182-25-085 Enrollees' failure to report correct income. (1) If the HCA determines that the enrollee has received a subsidy overpayment due to failure to report income correctly, the HCA may:

(a) Bill the enrollee for the amount of subsidy overpaid by the state; or

(b) Impose civil penalties of up to two hundred percent of the subsidy overpayment.

(2) Any HCA determination under subsection (1) of this section is subject to the enrollee appeal provisions in WAC 182-25-105.

(3) When a decision under subsection (1)(a) of this section is final, the HCA may establish a payment schedule and collect the amount owed through future premium statements. The payment schedule will be for a period of no more than six months, unless the HCA approves an alternative payment schedule requested by the enrollee. When a payment schedule is established, the HCA will send the enrollee advance written notice of the schedule and the total amount due. The total amount due each month will include the regular monthly premium plus charges for subsidy overpayment. If an enrollee does not pay the amount due, including charges for subsidy overpayment, the enrollee and all family members enrolled on the account will be disenrolled for nonpayment under WAC 182-25-090 (2)(b).

(4) When a decision under subsection (1)(b) of this section becomes final, the HCA will send the enrollee notice that payment of the civil penalty is due within thirty days after the decision becomes final, unless the HCA approves a different due date at the enrollee's request. If the enrollee does not pay the civil penalty by the due date, the enrollee and all family members on the account will be disenrolled for nonpayment under WAC 182-25-090 (2)(c).

(5) Individuals who are disenrolled from BHP may not reenroll until charges for subsidy overpayments or civil penalties imposed under subsection (1) of this section have been paid or the HCA has approved a payment schedule.

(6) The HCA will take all necessary and appropriate administrative and legal actions to collect the unpaid amount of any subsidy overpayment or civil penalty.

(7) Enrollees under employer group or financial sponsor group coverage who do not follow the income reporting procedures established by BHP and their employer or financial sponsor may be billed directly by the HCA for subsidy overpayments or civil penalties assessed under subsection (1) of this section. Enrollees who do not pay the amount due will be disenrolled under WAC 182-25-090 (2)(b) or (c). Enrollees who are disenrolled for nonpayment of a subsidy overpayment or civil penalties will be excluded from the minimum participation calculation for employer groups under WAC 182-25-050(2).

[Statutory Authority: RCW 70.47.050, 70.47.060 and 70.47.090. 99-12-033 (Order 99-01), § 182-25-085, filed 5/26/99, effective 6/26/99.]

WAC 182-25-090 Disenrollment from BHP. (1) An enrollee or employer group may disenroll effective the first day of any month by giving BHP at least ten days prior written notice of the intention to disenroll.

(2) BHP may disenroll any enrollee or group from BHP for good cause, which includes:

(a) Failure to meet the eligibility requirements set forth in WAC 182-25-030, 182-25-050, 182-25-060, and 182-25-070;

(b) Nonpayment of premium under the provisions of subsection (5) of this section;

(c) Nonpayment of civil penalties assessed under WAC 182-25-085;

(d) When the enrollee's MHCS will no longer be available to him or her and no other MHCS in the area where the enrollee lives is accepting new enrollment in the enrollee's program;

(e) Repeated failure to pay co-payments in full on a timely basis;

(f) Fraud, failure to provide requested verification of eligibility, or knowingly providing false information;

(g) Abuse or intentional misconduct;

(h) Danger or threat to the safety or property of the MHCS or the health care authority or their staff, providers, patients or visitors; and

(i) Refusal to accept or follow procedures or treatment determined by a MHCS to be essential to the health of the enrollee, when the MHCS has advised the enrollee and demonstrated to the satisfaction of BHP that no professionally acceptable alternative form of treatment is available from the MHCS.

In addition to being disenrolled, any enrollee who knowingly provides false information to BHP or to a participating managed health care system may be held financially responsible for any covered services fraudulently obtained through BHP.

(3) At least ten days prior to the effective date of disenrollment under subsection (2) of this section, BHP will send enrollees written notice of disenrollment.

(a) The notice of disenrollment will:

(i) State the reason for the disenrollment;

(ii) State the effective date of the disenrollment;

(iii) Describe the procedures for disenrollment; and

(iv) Inform the enrollee of his or her right to appeal the disenrollment decision as set forth in WAC 182-25-100 and 182-25-105.

(b) The notice of disenrollment will be sent to both the employer or sponsor and to all members of an employer group, home care agency group or financial sponsor group that is disenrolled under these provisions. Enrollees affected by the disenrollment of a group account will be offered coverage under individual accounts. Coverage under individual accounts will not begin unless the premium for individual coverage is paid by the due date for the coverage month. A one-month break in coverage may occur for enrollees who choose to transfer to individual accounts.

(4) Enrollees covered under BHP Plus or receiving maternity benefits through medical assistance will not be disenrolled from those programs when other family members lose BHP coverage, as long as they are still eligible for those programs.

(5) Under the provisions of this subsection, BHP will suspend or disenroll enrollees and groups who do not pay their premiums when due, including amounts owed for subsidy overpayment. Partial payment or payment by check

which cannot be processed or is returned due to nonsufficient funds will be regarded as nonpayment.

(a) At least ten days before coverage will lapse, BHP will send a delinquency notice to each subscriber whose premium payment has not been received by the due date. The delinquency notice will include a delinquency due date and a notice that BHP coverage will lapse unless payment is received by the delinquency due date.

(b) Except as provided in (c) of this subsection, coverage will be suspended for one month if an enrollee's premium payment is not received by the delinquency due date. BHP will send written notice of suspension to the subscriber, stating:

(i) The effective date of the suspension;

(ii) The due date by which payment must be received to restore coverage after the one-month suspension;

(iii) The subscriber and any enrolled dependents will be disenrolled if payment is not received by the final due date; and

(iv) The enrollee's right to appeal under WAC 182-25-105.

(c) Enrollees whose premium payment has not been received by the delinquency due date, and who have been suspended twice within the previous twelve months will be disenrolled for nonpayment as of the effective date of the third suspension.

(d) Enrollees who are suspended and do not pay the premium for the next coverage month by the due date on the notice of suspension will be immediately disenrolled and issued a notice of disenrollment as provided in subsection (3)(a) of this section.

(6)(a) Enrollees who voluntarily disenroll or are disenrolled from BHP may not reenroll for a period of twelve months from the date their coverage ended. An exception to this provision will be made for:

(i) Enrollees who left BHP for other health insurance, who are able to provide proof of continuous coverage from the date of disenrollment, and who apply to reenroll in BHP within thirty days of losing the other coverage;

(ii) Enrollees who left BHP because they lost eligibility and who subsequently become eligible to reenroll; and

(iii) Persons enrolling in subsidized BHP, who had enrolled and subsequently disenrolled from nonsubsidized BHP under subsection (1) or (2)(b) of this section while waiting on a reservation list for subsidized coverage.

(iv) Enrollees who were disenrolled by BHP because no MHCS was contracted to serve the program in which they were enrolled in the geographic area where they live; these enrollees may reenroll if a MHCS begins accepting enrollment for their program in their area or if they become eligible and apply for another BHP program.

(b) An enrollee who is required to wait twelve months for reenrollment under (a) of this subsection and who has been waiting on a reservation list for subsidized BHP may not reenroll prior to the end of the required twelve-month wait. If the enrollee satisfies the required twelve-month wait for reenrollment while on the reservation list, enrollment will not be completed until funding is available to enroll him or her from the reservation list.

[Statutory Authority: RCW 70.47.050, 70.47.060 and 70.47.100. 99-24-005 (Order 99-06), § 182-25-090, filed 11/18/99, effective 12/19/99. Statutory Authority: RCW 70.47.050, 70.47.060 and 70.47.090. 99-12-033 (Order 99-01), § 182-25-090, filed 5/26/99, effective 6/26/99. Statutory Authority: RCW 70.47.050. 98-07-002, § 182-25-090, filed 3/5/98, effective 4/5/98; 97-15-003, § 182-25-090, filed 7/3/97, effective 8/3/97; 96-15-024, § 182-25-090, filed 7/9/96, effective 8/9/96.]

WAC 182-25-100 Where to find instructions for filing an appeal. (1) WAC 182-25-105 and 182-25-110 cover appeals submitted by or on behalf of **basic health plan** enrollees or applicants. To appeal a decision regarding a child enrolled in **BHP plus** or a woman receiving **maternity benefits through medical assistance**, subscribers must contact the Washington state department of social and health services (DSHS) to request a fair hearing under chapters 388-08 and 388-526 WAC.

(2) WAC 182-25-105 covers appeals of decisions made by the health care authority, such as decisions regarding basic health plan eligibility, premium, premium adjustments or penalties, enrollment, suspension, disenrollment, or a member's selection of managed health care system (MHCS). Decisions which affect an entire group (for example, the disenrollment of an employer group) should be appealed for the entire group by the employer, home care agency, or financial sponsor, using these same rules.

(3) WAC 182-25-110 covers appeals of decisions made by the enrollee's managed health care system (MHCS), such as decisions regarding coverage disputes or benefits interpretation. The term MHCS, which is defined in WAC 182-25-010(22), refers to the health plan or carrier that provides BHP coverage.

[Statutory Authority: RCW 70.47.050. 99-07-078, § 182-25-100, filed 3/18/99, effective 4/18/99; 98-07-002, § 182-25-100, filed 3/5/98, effective 4/5/98; 96-15-024, § 182-25-100, filed 7/9/96, effective 8/9/96.]

WAC 182-25-105 How to appeal health care authority decisions. (1) Under this section, enrollees or applicants may file appeals of health care authority decisions regarding eligibility, premiums, premium adjustments or penalties, enrollment, suspension, disenrollment, or a member's selection of managed health care system (MHCS).

(2) To appeal a health care authority (HCA) decision, enrollees or applicants must send a letter of appeal to the HCA appeals committee. The letter of appeal must be signed by the appealing party and received by the HCA within thirty calendar days of the date of the decision. The letter of appeal must include:

(a) The name, mailing address, and BHP account number of the subscriber or applicant;

(b) The name and address of the enrollee or applicant affected by the decision, if that person is not the subscriber on the account;

(c) A copy of the HCA notice of the decision that is being appealed or, if the notice is not available, a statement of the decision being appealed; and

(d) A statement explaining why the appealing party believes the decision was incorrect, outlining the facts surrounding the decision and including supporting documentation.

(3) Upon receiving the letter of appeal, the HCA will send notification to the appealing party, confirming that the appeal has been received and indicating when a decision can be expected.

(4) The HCA will conduct appeals according to RCW 34.05.485. The HCA appeals committee or a hearings officer designated by the HCA will review and decide the appeal based on submitted documents unless the HCA and the appealing party agree to hold a hearing in person or by telephone.

(5) The HCA will send the appealing party written notification of the appeals committee's or hearings officer's initial decision within sixty days of receiving the letter of appeal. The notification will include the reasons for their initial decision, and instructions on further appeal rights.

(6) The initial decision of the appeals committee or hearings officer becomes the final decision unless the HCA receives a request for a review hearing from the appealing party within thirty days of the date of the decision. The appealing party may request review of the initial decision either verbally or in writing. The person requesting review must reference the initial decision and provide any additional written information that the appealing party would like considered in the review.

(a) If the appealing party requests a review of the appeals committee's or hearings officer's initial decision regarding a disenrollment, the office of administrative hearings will review the decision through a hearing conducted under chapter 34.12 RCW and RCW 34.05.488 through 34.05.494.

(b) If the appealing party requests a review of any decision of the appeals committee or hearings officer other than a disenrollment decision, a hearings officer designated by the HCA will review the decision through a hearing conducted under RCW 34.05.488 through 34.05.494.

(7) In a review under subsection (6)(a) or (b) of this section:

(a) The hearings officer will review and decide the appeal based on submitted documents unless the HCA and the appealing party agree to hold a hearing in person or by telephone.

(b) The review officer will make any inquiries necessary to determine whether the proceeding must become a formal adjudicative proceeding under the provisions of chapter 34.05 RCW.

(8) If an enrollee submits a timely appeal of a disenrollment decision that was based on eligibility issues and not related to premium payments, the enrollee will remain enrolled during the appeal process, provided the enrollee:

(a) Otherwise remains eligible;

(b) Continues to make all premium payments when due; and

(c) Has not demonstrated a danger or threat to the safety or property of the MHCS or health care authority or their staff, providers, patients or visitors.

(9) An enrollee who has appealed a disenrollment decision related to nonpayment of premium or any issue other than eligibility will remain disenrolled during the appeal process.

(10) If the appealing party disagrees with a review decision under subsection (6) of this section, the appealing party may request judicial review of the decision, as provided for in RCW 34.05.542. Request for judicial review must be filed with the court within thirty days of service of the final agency decision.

[Statutory Authority: RCW 70.47.050. 99-07-078, § 182-25-105, filed 3/18/99, effective 4/18/99; 98-07-002, § 182-25-105, filed 3/5/98, effective 4/5/98; 96-15-024, § 182-25-105, filed 7/9/96, effective 8/9/96.]

WAC 182-25-110 How to appeal a managed health care system (MHCS) decision. (1) Enrollees who are appealing a MHCS decision, including decisions related to coverage disputes, denial of claims, or benefits interpretation, must first appeal the decision through their MHCS's grievance/appeals process. Under this section, the HCA may review MHCS decisions that have been the subject of a MHCS grievance/appeal process.

(2) Each MHCS must maintain a grievance/appeals process for enrollees and must provide enrollees with instructions for filing a grievance or appeal. This grievance/appeals process must comply with HCA contract requirements for timeliness in responding to complaints, including procedures for an expedited review if the enrollee is urgently in need of medical care. In addition, the MHCS grievance/appeal process must include review of MHCS decisions by:

(a) MHCS personnel who have the authority to require corrective action; and

(b) Appropriate medical personnel, if the appeal includes complaints regarding quality of care or access to urgently needed services.

(3) An enrollee who has appealed a MHCS decision may ask the HCA to initiate informal dispute resolution in either of the following circumstances:

(a) The appeal has not been resolved within the timelines established by the MHCS grievance/appeal process or agreed to by the MHCS and the appealing party; or

(b) The enrollee has not received a response from the MHCS within thirty days of initiating the appeal. The response from the MHCS may be a decision or, if a delay of the appeal decision is necessary, it may be notification of a delay. If the decision has been delayed, the notice must include the reason for the delay and the date the enrollee can expect a decision from the MHCS. The HCA has the authority to determine if the delay is reasonable.

(i) If the HCA determines the delay to be unreasonable, the HCA will initiate informal dispute resolution.

(ii) If the HCA determines the delay to be reasonable, the HCA will not initiate informal dispute resolution unless the MHCS fails to issue a decision by the date indicated in the delay notice.

(4) Enrollees requesting informal dispute resolution must submit a written request to the HCA, which includes:

(a) The name, mailing address, and BHP account number of the subscriber;

(b) The name and address of the enrollee affected by the decision, if that person is not the subscriber on the account;

(c) A statement of the dispute and efforts to resolve it; and

(d) A statement, with facts and documentation, in support of the appealing party's opinion.

(5) When the HCA receives the request for informal dispute resolution, the HCA will notify the MHCS and will attempt to resolve the dispute. The HCA will notify the enrollee of the outcome of the informal dispute resolution or of the reason for a delay, within thirty days of receiving the request. If the issue has not been resolved to the satisfaction of the enrollee, the appealing party may ask the HCA appeals committee to review the MHCS decision. The request may be written or oral and must be received within thirty days of the date the HCA notifies the appealing party of the outcome of the informal dispute resolution. The appealing party may submit additional documentation with the request.

(6) Enrollees may appeal a final MHCS decision by sending a letter of appeal to the HCA appeals committee, asking for review of the final MHCS decision. The letter of appeal must be signed by the appealing party and received by the HCA within thirty days of the date of the final MHCS decision, and must include the information listed in subsection (4) of this section.

(7) The HCA will follow the procedures in WAC 182-25-105 (3) through (7) when conducting reviews of MHCS decisions. The MHCS must be given the opportunity to submit written comments or participate in any proceeding before the appeals committee or in any subsequent administrative review.

[Statutory Authority: RCW 70.47.050. 99-07-078, § 182-25-110, filed 3/18/99, effective 4/18/99; 96-15-024, § 182-25-110, filed 7/9/96, effective 8/9/96.]

Title 192 WAC

EMPLOYMENT SECURITY DEPARTMENT

Chapters

Chapter 192-04 WAC
PRACTICE AND PROCEDURE

WAC

WAC 192-04-060 Appeals—Petitions for hearing—Petitions for review—Time limitation—Forms. (1) **Appeals and petitions for hearing.** Any interested party who is aggrieved by any decision of the department set forth in WAC 192-04-050 may file a written appeal or petition for hearing by mailing it or sending it via electronic telefacsimile to the unemployment claims telecenter indicated on the determination notice or order and notice of assessment.

The appeal or petition for hearing shall be filed within thirty days of the date the decision is delivered or mailed, whichever is the earlier. The appeal and/or petition for hearing shall be filed in accordance with the provisions of RCW 50.32.025.

(2) **Petitions for review.** Any interested party who is aggrieved by a decision of the office of administrative hearings, other than an order approving a withdrawal of appeal, an order approving a withdrawal of a petition for hearing, a consent order, or an interim order, may file a written petition for review in accordance with the provisions of WAC 192-04-170. The petition for review shall be filed within thirty days of the date of delivery or mailing of the decision of the office of administrative hearings, whichever is the earlier. The petition for review shall be filed in accordance with the provisions of RCW 50.32.025.

(3) **Forms.** At the request of an interested, aggrieved party, the employment security department shall furnish forms for the filing of a notice of appeal, petition for hearing, or petition for review, but the use of such forms is not a jurisdictional requirement.

[Statutory Authority: RCW 50.20.010 and 50.12.040. 99-15-069, § 192-04-060, filed 7/19/99, effective 8/19/99. Statutory Authority: RCW 50.12.010, [50.12.]040 and RCW 34.05.310 et seq. 95-18-055, § 192-04-060, filed 8/31/95, effective 10/1/95. Statutory Authority: RCW 50.12.010 and 50.12.040. 89-24-030, § 192-04-060, filed 11/30/89, effective 1/1/90.]

WAC 192-04-170 Decision of commissioner—Petition for review—Filing—Reply. (1) The written petition for review shall be filed by mailing it to the Agency Records Center, Employment Security Department, Post Office Box 9046, Olympia, WA 98507-9046, within thirty days of the date of mailing or delivery of the decision of the office of administrative hearings, whichever is the earlier.

(2) Any written argument in support of the petition for review must be attached to the petition for review and be filed contemporaneously therewith.The commissioner's review office will acknowledge receipt of the petition for review by assigning a review number to the case, entering the review number on the face of the petition for review, and setting forth the acknowledgement date on the petition for review.The commissioner's review office will also mail copies of the acknowledged petition for review and attached