

Title 182 WAC

HEALTH CARE

AUTHORITY

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Chapter 182-04 WAC

PUBLIC RECORDS

WAC

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WAC 182-04-010 Purpose. The purpose of this chapter shall be to insure compliance by the Washington state health care authority (HCA) with the provisions of chapter 42.56 RCW dealing with public records.

[Statutory Authority: RCW 41.05.160, 42.56.040, and 70.02.050. 10-18-051 (Order 10-01), § 182-04-010, filed 8/27/10, effective 9/27/10. Statutory Authority: RCW 41.05.160, 97-21-125, § 182-04-010, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-010, filed 8/26/77.]

WAC 182-04-015 Definitions. The following definitions shall apply:

(1) "HCA" means the Washington state health care authority, created pursuant to chapter 41.05 RCW.

(2) "Public record" is defined in RCW 42.56.010. Except as otherwise provided by law, public records include any written or recorded communication containing information relating to the conduct of the HCA or the performance of any governmental or proprietary function prepared, owned, used, or retained by the HCA.

(3) "Writing" is defined in RCW 42.56.010. It includes handwriting, typewriting, printing, photostating, photographing, and every other means of recording any form of communication or representation including, but not limited to, letters, words, pictures, sounds, or symbols, or combina-

tion thereof, and all papers, maps, magnetic or paper tapes, photographic films and prints, motion picture, film and video recordings, magnetic or punched cards, discs, drums, diskettes, sound recordings, and other documents including existing data compilations from which information may be obtained or translated.

[Statutory Authority: RCW 41.05.160, 42.56.040, and 70.02.050. 10-18-051 (Order 10-01), § 182-04-015, filed 8/27/10, effective 9/27/10. Statutory Authority: RCW 41.05.160, 97-21-125, § 182-04-015, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-015, filed 8/26/77.]

WAC 182-04-020 Whom should I contact about a public records request? The HCA public records officer is in charge of responding to all records requests made to the HCA. The public records officer is responsible for overseeing the release of public records and coordinating HCA public disclosure staff.

[Statutory Authority: RCW 41.05.160, 42.56.040, and 70.02.050. 10-18-051 (Order 10-01), § 182-04-020, filed 8/27/10, effective 9/27/10.]

WAC 182-04-025 How will the HCA respond to my public records request? (1) Except as provided by law, all public records of the HCA as defined in WAC 182-04-015(2) will be made available upon public request for inspection and copying.

(2) Within five business days after receiving a request, the HCA public disclosure officer, or designee will:

(a) Provide the record(s);

(b) Acknowledge your request and give you a reasonable estimate of how long the HCA will need to provide the records. If the request is not clear, the public disclosure officer may ask you for more information (see WAC 182-04-027). If you fail to clarify the request, the public disclosure officer need not respond to it; or

(c) Deny all or part of the public record request in writing with the reason(s) for the denial (see WAC 182-04-050 and 182-04-053).

(3) At his or her discretion, the public records officer may send the requested records to you by e-mail, fax, or regular mail. The records may be delivered on computer or compact disks, or by use of other methods of transmittal or storage.

[Statutory Authority: RCW 41.05.160, 42.56.040, and 70.02.050. 10-18-051 (Order 10-01), § 182-04-025, filed 8/27/10, effective 9/27/10. Statutory Authority: RCW 41.05.160, 97-21-125, § 182-04-025, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-025, filed 8/26/77.]

WAC 182-04-027 Why might the HCA need to extend the time to respond to a public record request? The HCA may need to extend the time to respond to a public record request to:

(1) Locate and gather the information requested;

(2) Notify an individual or organization affected by the request;

(3) Determine whether the information requested is exempt from disclosure and whether all or part of the public record requested can be released; or

(4) Contact you to clarify the intent, scope or specifics of the request. If you fail to clarify the request, the HCA may not have to respond to your request.

[Statutory Authority: RCW 41.05.160, 42.56.040, and 70.02.050. 10-18-051 (Order 10-01), § 182-04-027, filed 8/27/10, effective 9/27/10.]

WAC 182-04-029 What records can I request and/or copy? You may inspect or get copies of all public records unless they are exempted by chapter 42.56, 19.183 or 70.02 RCW, or other applicable law.

[Statutory Authority: RCW 41.05.160, 42.56.040, and 70.02.050. 10-18-051 (Order 10-01), § 182-04-029, filed 8/27/10, effective 9/27/10.]

WAC 182-04-035 When can I inspect or obtain copies of documents? You can inspect public records at the HCA in Thurston County from 9:00 a.m. until noon, and from 1:00 p.m. until 4:00 p.m., Monday through Friday. Records are not available on legal holidays or when the HCA offices are closed for other reasons such as inclement weather or emergencies. The HCA reserves the right to restrict your ability to examine public records when the HCA determines it is necessary to preserve public records or prevent interference with the performance of HCA duties. This does not prevent the HCA from providing you with copies of the public records or limit the duty of the HCA to provide you with copies of the public records.

[Statutory Authority: RCW 41.05.160, 42.56.040, and 70.02.050. 10-18-051 (Order 10-01), § 182-04-035, filed 8/27/10, effective 9/27/10. Statutory Authority: RCW 41.05.160. 97-21-125, § 182-04-035, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-035, filed 8/26/77.]

WAC 182-04-040 How do I make a public record request? In accordance with the requirements of chapter 42.56 RCW that agencies prevent unreasonable invasion of privacy, and to protect public records from damage or disorganization, and to prevent excessive interference with essential functions of the agency, public records may be inspected, or copies of such records may be obtained by the public, by using the following procedures:

(1) Public record requests should be made in writing. The HCA accepts written public record requests made in person or sent by e-mail, fax, or mail. To assist members of the public to make a formal request, forms are available on the HCA web site or by contacting the public records officer. A request need merely identify with reasonable certainty the record sought to be disclosed.

(2) If the HCA form is not used, the public record request should be in writing and include all of the following information:

- (a) The name and contact information of the person requesting the record;
- (b) The calendar date on which the request was made;
- (c) A statement that the requested records are not to be used for commercial purposes; and
- (d) A detailed description of the record requested sufficient to make it identifiable.

(3) In all cases in which a member of the public is making a request, the public disclosure officer or staff member will assist to appropriately identify the public record requested, if necessary.

[Statutory Authority: RCW 41.05.160, 42.56.040, and 70.02.050. 10-18-051 (Order 10-01), § 182-04-040, filed 8/27/10, effective 9/27/10. Statutory Authority: RCW 41.05.160. 97-21-125, § 182-04-040, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-040, filed 8/26/77.]

WAC 182-04-041 Preserving requested records. If a public record request is made at a time when such record exists but is scheduled for destruction in the near future, the public disclosure officer will retain possession of the record, and will not destroy or erase the record until the request is resolved.

[Statutory Authority: RCW 41.05.160, 42.56.040, and 70.02.050. 10-18-051 (Order 10-01), § 182-04-041, filed 8/27/10, effective 9/27/10. Statutory Authority: RCW 41.05.160. 97-21-125, § 182-04-041, filed 10/21/97, effective 11/21/97.]

WAC 182-04-045 Copying costs. (1) No fee is charged for the inspection of public records.

(2) The HCA collects the following fees to reimburse the HCA for its actual costs incident to providing copies of public records:

- (a) Fifteen cents per page for black and white photocopies; and
 - (b) The cost of postage, if any.
- (3) Copies of some records may be provided electronically or on disk to the requestor at no charge.
- (4) The public disclosure officer is authorized to waive the foregoing costs.

[Statutory Authority: RCW 41.05.160, 42.56.040, and 70.02.050. 10-18-051 (Order 10-01), § 182-04-045, filed 8/27/10, effective 9/27/10. Statutory Authority: RCW 41.05.160. 97-21-125, § 182-04-045, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-045, filed 8/26/77.]

WAC 182-04-050 What happens if the record I requested is exempt from disclosure? Certain records that you wish to review or copy are exempt from disclosure because of federal or state laws. If a record is exempt from disclosure, you will be informed in writing of the reasons why the HCA is withholding the record.

[Statutory Authority: RCW 41.05.160, 42.56.040, and 70.02.050. 10-18-051 (Order 10-01), § 182-04-050, filed 8/27/10, effective 9/27/10. Statutory Authority: RCW 41.05.160. 97-21-125, § 182-04-050, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-050, filed 8/26/77.]

WAC 182-04-055 Will the HCA review the denial of my request? If the HCA denies your public record request, you may ask the HCA to review the denial. To request a review, you must make your request in writing.

Following receipt of a written request for review of a decision denying a public record request, the disclosure officer will consider the matter and either affirm or reverse the denial. This shall constitute final HCA action for the purposes of judicial review, pursuant to RCW 42.56.520.

[Statutory Authority: RCW 41.05.160, 42.56.040, and 70.02.050. 10-18-051 (Order 10-01), § 182-04-055, filed 8/27/10, effective 9/27/10. Statutory Authority: RCW 41.05.160. 97-21-125, § 182-04-055, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-055, filed 8/26/77.]

WAC 182-04-060 Protection of public records. Following are guidelines which shall be adhered to by any person inspecting such public records:

(1) Inspection of any public records shall be conducted only during working hours as specified in WAC 182-04-035 in the presence of an HCA employee;

(2) Original records cannot be removed from the HCA building. The HCA has a duty to protect public records (see RCW 42.56.100);

(3) Public records shall not be marked, torn, or otherwise damaged;

(4) Public records must be maintained as they are in file or in a chronological order, and shall not be dismantled except for purposes of copying and then only by an HCA employee;

(5) Access to file cabinets and other places where public records are kept is restricted.

[Statutory Authority: RCW 41.05.160, 42.56.040, and 70.02.050. 10-18-051 (Order 10-01), § 182-04-060, filed 8/27/10, effective 9/27/10. Statutory Authority: RCW 41.05.160, 97-21-125, § 182-04-060, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-060, filed 8/26/77.]

WAC 182-04-070 Request for inspection of records.

The HCA hereby adopts for use by all persons requesting inspection and/or copying of its records, the form set out below, entitled "Request for Inspection of Records."

The information requested in Blocks 4 through 6 is not mandatory, however, the completion of these blocks will enable this office to expedite your request and contact you should the record you seek not be immediately available.

1. Name	4. Phone Number
.....
2. Address	5. Representing (if applicable)
.....
3. Zip Code	6. If urgent - date needed
.....

Below please state what record(s) you wish to inspect and be as specific as possible. If you are uncertain as to the type or identification of specific record or records we will assist you.

I certify that the information requested from the above record(s) will not be part of a list of individuals to be used for commercial purposes.

(Signed)

Date

Return the request for inspection of records to:

Public Disclosure Office
Health Care Authority
676 Woodland Square Loop S.E.
Post Office Box 42700
Olympia, Washington 98504-2700

[Statutory Authority: RCW 41.05.160, 42.56.040, and 70.02.050. 10-18-051 (Order 10-01), § 182-04-070, filed 8/27/10, effective 9/27/10. Statutory Authority: RCW 41.05.160 and chapter 41.05 RCW. 98-17-063, § 182-04-070, filed 8/17/98, effective 9/17/98. Statutory Authority: RCW 41.05.160, 97-21-125, § 182-04-070, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-070, filed 8/26/77.]

**Chapter 182-08 WAC
PROCEDURES**

WAC	
182-08-015	Definitions.
182-08-180	Premium payments and refunds.
182-08-196	What happens if my health plan becomes unavailable?
182-08-197	When must newly eligible employees select PEBB benefits and complete enrollment forms?
182-08-198	When may a subscriber change health plans?
182-08-199	When may an employee enroll in or change his or her election under the premium payment plan, medical

flexible spending arrangement (FSA) or dependent care assistance program (DCAP)?

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

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

"Agency" means the health care authority.

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

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

"Comprehensive employer sponsored medical" includes insurance coverage continued by the employee or their dependent under COBRA. It does not include an employer's retiree coverage, with the exception of a federal retiree plan.

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

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

"Dependent" means a person who meets eligibility requirements in WAC 182-12-260.

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

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

"Employer group" means those employee organizations representing state civil service employees, counties, municipalities, political subdivisions, tribal governments, school districts, and educational service districts participating in PEBB insurance coverage under contractual agreement as described in WAC 182-08-230.

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

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

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

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

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

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

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

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

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

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

"Open enrollment" means a time period when: Subscribers may apply to transfer their enrollment from one health plan to another; a dependent may be enrolled; a dependent may be removed from coverage; or an employee who previously waived medical may enroll in medical. Open enrollment is also the time when employees may enroll in or change their election under the DCAP, the medical FSA, or the premium payment plan. An "annual" open enrollment, designated by the administrator, is an open enrollment when all PEBB subscribers may make enrollment changes for the upcoming year. A "special" open enrollment is triggered by a specific life event. For special open enrollment events as they relate to specific PEBB benefits, see WAC 182-08-198, 182-08-199, 182-12-128, 182-12-262.

"PEBB" means the public employees benefits board.

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

"PEBB benefits" means one or more insurance coverage or other employee benefit administered by the PEBB program within the HCA.

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

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

"Salary reduction plan" means a benefit plan whereby state and public employees may agree to a reduction of salary

on a pretax basis to participate in the DCAP, medical FSA, or premium payment plan as authorized in chapter 41.05 RCW.

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

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

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

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

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

"Waive" means to interrupt an eligible employee's enrollment in a PEBB health plan because the employee is enrolled in other comprehensive group coverage or is on approved educational leave (see WAC 182-12-128 and 182-12-136).

[Statutory Authority: RCW 41.05.160, 10-20-147 (Order 10-02), § 182-08-015, filed 10/6/10, effective 1/1/11; 09-23-102 (Order 09-02), § 182-08-015, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-08-015, filed 10/1/08, effective 1/1/09; 07-20-129 (Order 07-01), § 182-08-015, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05-068, 06-23-165 (Order 06-09), § 182-08-015, filed 11/22/06, effective 12/23/06. Statutory Authority: RCW 41.05.160 and 41.05.165, 04-18-039, § 182-08-015, filed 8/26/04, effective 1/1/05; 03-17-031 (Order 02-07), § 182-08-015, filed 8/14/03, effective 9/14/03. Statutory Authority: Chapter 41.05 RCW, 96-08-042, § 182-08-015, filed 3/29/96, effective 4/29/96.]

WAC 182-08-180 Premium payments and refunds.

PEBB premiums for retiree, COBRA or PEBB continuation coverage begin to accrue the first of the month in which PEBB insurance coverage is effective.

Premium is due for the entire month of insurance coverage and will not be prorated during the month of death or loss of eligibility of the enrollee except for life insurance premiums when the individual is eligible for life conversion.

PEBB premiums for employees, retirees, COBRA, or PEBB continuation coverage will be refunded using the following method:

(1) When any PEBB subscriber submits an enrollment change affecting eligibility, such as for example: Death, divorce, or when no longer an eligible dependent as defined at WAC 182-12-260 no more than three months of accounting adjustments and any excess premium paid will be refunded to any individual or employing agency except as indicated in WAC 182-12-148(4).

(2) Notwithstanding subsection (1) of this section, the PEBB assistant administrator or the PEBB appeals committee may approve a refund which does not exceed twelve months of premium if both of the following occur:

(a) The PEBB subscriber or a dependent or beneficiary of a subscriber submits a written appeal to the PEBB appeals committee; and

(b) Proof is provided that extraordinary circumstances beyond the control of the subscriber, dependent or beneficiary made it virtually impossible to submit the necessary information to accomplish an enrollment change within sixty days after the event that created a change of premium.

(3) Errors resulting in an underpayment to HCA must be reimbursed by the employing agency or subscriber to the HCA. Upon request of an employing agency, subscriber, or beneficiary, as appropriate, the HCA will develop a repayment plan designed not to create undue hardship on the employing agency or subscriber.

(4) HCA errors will be adjusted by returning the excess premium paid, if any, to the employing agency, subscriber, or beneficiary, as appropriate.

[Statutory Authority: RCW 41.05.160. 10-20-147 (Order 10-02), § 182-08-180, filed 10/6/10, effective 1/1/11; 09-23-102 (Order 09-02), § 182-08-180, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-08-180, filed 10/1/08, effective 1/1/09; 07-20-129 (Order 07-01), § 182-08-180, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-08-180, filed 8/26/04, effective 1/1/05; 03-17-031 (Order 02-07), § 182-08-180, filed 8/14/03, effective 9/14/03. Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-180, filed 3/29/96, effective 4/29/96; Order 01-77, § 182-08-180, filed 8/26/77.]

WAC 182-08-196 What happens if my health plan becomes unavailable? Employees, retirees and survivors, and enrollees in PEBB continuation coverage for whom the chosen health plan becomes unavailable due to a change in contracting service area or the retiree's entitlement to medicare must select a new health plan within sixty days after notification by the PEBB program.

(1) Employees who fail to select a new medical or dental plan within the prescribed time period will be enrolled in a successor plan if one is available or will be enrolled in the Uniform Medical Plan, the Uniform Dental Plan, or a plan selected by the administrator, along with the employee's existing dependent enrollment.

(2) Retirees and survivors eligible under WAC 182-12-250 or 182-12-265 who fail to select a new health plan within the prescribed time period will be enrolled in a successor plan if one is available or will be enrolled in the Uniform Medical Plan, and the Uniform Dental Plan, or a plan selected by the administrator.

Any subscriber assigned to a health plan as described in this rule may not change health plans until the next open enrollment except as allowed in WAC 182-08-198.

(3) Enrollees in PEBB continuation coverage under WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, or 182-12-270(2) must select a new health plan no later than sixty days after notification by the PEBB program. If enrollees fail to select a new health plan within sixty days of the notification, health plan coverage will end as of the last day of the month in which the plan is available.

[Statutory Authority: RCW 41.05.160. 10-20-147 (Order 10-02), § 182-08-196, filed 10/6/10, effective 1/1/11; 09-23-102 (Order 09-02), § 182-08-196,

filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-08-196, filed 10/1/08, effective 1/1/09; 07-20-129 (Order 07-01), § 182-08-196, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160, 41.05.350, and 41.05.165. 05-16-046 (Order 05-01), § 182-08-196, filed 7/27/05, effective 8/27/05. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-08-196, filed 8/26/04, effective 1/1/05; 03-17-031 (Order 02-07), § 182-08-196, filed 8/14/03, effective 9/14/03.]

WAC 182-08-197 When must newly eligible employees select PEBB benefits and complete enrollment forms?

(1) Employees who are newly eligible for PEBB benefits must complete the appropriate forms indicating enrollment and their health plan choice, or their decision to waive medical under WAC 182-12-128. Employees must return the forms to their employing agency no later than thirty-one days after they become eligible for PEBB benefits under WAC 182-12-114. Newly eligible employees who do not return an enrollment form to their employing agency indicating their medical and dental choice within thirty-one days will be enrolled in a health plan as follows:

(a) Medical enrollment will be Uniform Medical Plan;

(b) Dental enrollment (if the employer group participates in PEBB dental) will be Uniform Dental Plan; and

(c) Dependents will not be enrolled.

(2) Employees who are newly eligible may enroll in optional insurance coverage (except for employees of employer groups that do not participate in life insurance or long-term disability insurance).

(a) To enroll in the amounts of optional life insurance available without health underwriting, employees must return a completed life insurance enrollment form to their employing agency no later than sixty days after becoming eligible for PEBB benefits.

(b) To enroll in optional long-term disability insurance without health underwriting, employees must return a completed long-term disability enrollment form to their employing agency no later than thirty-one days after becoming eligible for PEBB benefits.

(c) To enroll in long-term care insurance with limited health underwriting, employees must return a completed long-term care enrollment form to the contracted vendor no later than thirty-one days after becoming eligible for PEBB benefits.

(d) Employees may apply for optional life, long-term disability, and long-term care insurance at any time by providing evidence of insurability and receiving approval from the contracted vendor.

(3) Employees who are eligible to participate in the state's salary reduction plan (see WAC 182-12-116) will be automatically enrolled in the premium payment plan upon enrollment in medical so employee medical premiums are taken on a pretax basis. To opt out of the premium payment plan, new employees must complete the appropriate form and return it to their employing agency no later than thirty-one days after they become eligible for PEBB benefits.

(4) Employees who are eligible to participate in the state's salary reduction plan may enroll in the state's medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP) or both. To enroll in these optional PEBB benefits, employees must return the appropriate enrollment forms to their employing agency or PEBB

designee no later than thirty-one days after becoming eligible for PEBB benefits.

(5) The employer contribution toward insurance coverage ends according to WAC 182-12-131. Employees who become newly eligible for the employer contribution enroll as described in subsections (1) and (2) of this section, with the following exceptions in which insurance coverage elections stay the same:

(a) When an employee transfers from one employing agency to another employing agency without a break in state service. This includes movement of employees between any entities described in WAC 182-12-111 and participating in PEBB benefits.

(b) When employees have a break in state service that does not interrupt their employer contribution toward PEBB insurance coverage.

(c) When employees continue insurance coverage by self-paying the full premium under WAC 182-12-133(1) or 182-12-142 and become newly eligible for the employer contribution before the end of the maximum number of months allowed for continuing PEBB health plan enrollment under those rules. Employees who are eligible to continue optional life or optional long-term disability under continuation coverage but discontinue that insurance coverage are subject to the insurance underwriting requirements if they apply for the insurance when they return to work or become eligible again for the employer contribution.

(6) When an employee's employment ends, participation in the state's salary reduction plan ends. If the employee is hired into a new position that is eligible for PEBB benefits in the same year, the employee may not resume participation in DCAP or medical FSA until the beginning of the next plan year, unless the time between employments is less than thirty days.

[Statutory Authority: RCW 41.05.160, 10-20-147 (Order 10-02), § 182-08-197, filed 10/6/10, effective 1/1/11; 09-23-102 (Order 09-02), § 182-08-197, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-08-197, filed 10/1/08, effective 1/1/09; 07-20-129 (Order 07-01), § 182-08-197, filed 10/3/07, effective 11/3/07; 06-11-156 (Order 06-02), § 182-08-197, filed 5/24/06, effective 6/24/06. Statutory Authority: RCW 41.05.160, 41.05.350, and 41.05.165, 05-16-046 (Order 05-01), § 182-08-197, filed 7/27/05, effective 8/27/05.]

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

(1) **During annual open enrollment:** Subscribers may change health plans during the annual open enrollment. The subscriber must submit the appropriate enrollment forms to change health plan no later than the end of the annual open enrollment. Enrollment in the new health plan will begin January 1st of the following year.

(2) **During a special open enrollment:** Subscribers may change health plans outside of the annual open enrollment if a special open enrollment event occurs. The change in enrollment must be allowable under Internal Revenue Code (IRC) and correspond to the event that creates the special open enrollment for either the subscriber or the subscriber's dependents or both. To make a health plan change, the subscriber must submit the appropriate enrollment forms (and a completed disenrollment form, if required) no later than sixty days after the event occurs. Employees submit the enrollment

forms to their employing agency. All other subscribers, including retirees, COBRA, and other self-pay subscribers, submit the enrollment forms to the PEBB program. Insurance coverage in the new health plan will begin the first day of the month following the event that created the special open enrollment; or in cases where the event occurs on the first day of the month, insurance coverage will begin on that date. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, insurance coverage will begin the month in which the event occurs. The following events create a special open enrollment:

(a) Subscriber's dependent becomes eligible under PEBB rules:

(i) Through marriage or registering a domestic partnership with Washington's secretary of state;

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

(iii) Through legal custody or legal guardianship; or

(iv) When a child becomes eligible as an extended dependent;

(b) Subscriber's dependent no longer meets PEBB eligibility criteria because:

(i) Subscriber has a change in marital status or Washington state registered domestic partnership status, including legal separation documented by a court order;

(ii) A child dependent turns age twenty-six;

(iii) A child dependent ceases to be eligible as an extended dependent or as a dependent with disabilities; or

(iv) A dependent dies;

(c) Subscriber or a dependent loses coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);

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

(e) Subscriber or a dependent has a change in residence that affects health plan availability. If the subscriber moves and the subscriber's current health plan is not available in the new location but the subscriber does not select a new health plan, the PEBB program may enroll the subscriber in the Uniform Medical Plan or Uniform Dental Plan;

(f) Subscriber receives a court order or medical support order requiring the subscriber, the subscriber's spouse, or the subscriber's Washington state registered domestic partner to provide insurance coverage for an eligible dependent (a former spouse or former registered domestic partner is not an eligible dependent);

(g) Subscriber or a dependent becomes eligible for a medical assistance program under the department of social and health services, including medicaid or the children's health insurance program (CHIP), or the subscriber or a dependent loses eligibility a medical assistance program;

(h) Seasonal employees whose off-season occurs during the annual open enrollment. They may select a new health plan upon their return to work;

(i) Subscriber or an eligible dependent becomes entitled to medicare, enrolls in or disenrolls from a medicare Part D plan;

(j) Subscriber experiences a disruption that could function as a reduction in benefits for the subscriber or the subscriber's dependent(s) due to a specific condition or ongoing course of treatment. A subscriber may not change their health plan if the subscriber's or an enrolled dependent's physician stops participation with the subscriber's health plan unless the PEBB program determines that a continuity of care issue exists. The PEBB program criteria used will include, but is not limited to, the following in determining if a continuity of care issue exists:

- (i) Active cancer treatment; or
- (ii) Recent transplant (within the last twelve months); or
- (iii) Scheduled surgery within the next sixty days; or
- (iv) Major surgery within the previous sixty days; or
- (v) Third trimester of pregnancy; or
- (vi) Language barrier.

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

[Statutory Authority: RCW 41.05.160, 10-20-147 (Order 10-02), § 182-08-198, filed 10/6/10, effective 1/1/11; 09-23-102 (Order 09-02), § 182-08-198, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-08-198, filed 10/1/08, effective 1/1/09; 08-09-027 (Order 08-01), § 182-08-198, filed 4/8/08, effective 4/9/08; 07-20-129 (Order 07-01), § 182-08-198, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.-068, 06-23-165 (Order 06-09), § 182-08-198, filed 11/22/06, effective 12/23/06. Statutory Authority: RCW 41.05.160, 41.05.350, and 41.05.165, 05-16-046 (Order 05-01), § 182-08-198, filed 7/27/05, effective 8/27/05.]

WAC 182-08-199 When may an employee enroll in or change his or her election under the premium payment plan, medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP)? An eligible employee may enroll in or change his or her election under the premium payment plan, medical flexible spending arrangement (FSA), or dependent care assistance program (DCAP) at the following times:

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

(2) **During annual open enrollment:** An eligible employee may enroll in or change their election under the state's premium payment plan, medical FSA or DCAP during the annual open enrollment. Employees must submit, in paper or on-line, the appropriate enrollment form to reenroll no later than the last day of the annual open enrollment. The enrollment or new election will be effective January 1st of the following year.

(3) **During a special open enrollment:** Employees may enroll or change their election under the state's premium payment plan, medical FSA or DCAP outside of the annual open enrollment if a special open enrollment event occurs. The enrollment or change in enrollment must be allowable under Internal Revenue Code (IRC) and correspond to the event that creates the special open enrollment. To make a change or enroll, the employee must submit the appropriate forms as instructed on the forms no later than sixty days after the event occurs. Enrollment will be effective the first day of the month following approval by the administrator.

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

The following events create a special open enrollment for purposes of an eligible employee making a change:

(a) Employee's dependent becomes eligible under PEBB rules:

- (i) Through marriage;
 - (ii) Through birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption;
 - (iii) Through legal custody or legal guardianship; or
 - (iv) When a child becomes eligible as an extended eligible dependent;
- (b) Employee's dependent no longer meets PEBB eligibility criteria because:

- (i) Employee has a change in marital status, including legal separation documented by a court order;
- (ii) An eligible dependent child turns age twenty-six;
- (iii) An eligible dependent ceases to be eligible as an extended dependent or as a dependent with disabilities; or
- (iv) An eligible dependent dies;

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

(d) Employee or an eligible dependent has a change in employment status that affects the employee's or a dependent's eligibility for group health coverage or the employer contribution toward insurance coverage;

(e) Employee receives a court order or medical support order requiring the employee or the employee's spouse to provide insurance coverage for an eligible dependent;

(f) Employee or an eligible dependent becomes eligible for a medical assistance program under the department of social and health services, including medicaid or the children's health insurance program (CHIP), or the subscriber or dependent loses eligibility in such a medical assistance program;

(g) Seasonal employees whose off-season occurs during the annual open enrollment may enroll in the plan upon their return to work;

(h) Employee or an eligible dependent gains or loses eligibility for medicare;

(i) In addition to (a) through (h) of this section, the following are events that create a special open enrollment for purposes of an eligible employee making a change in his or her DCAP:

(i) Employees who change dependent care providers may make a change in their DCAP to reflect the cost of the new provider;

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

(iii) If an employee's dependent care provider imposes a change in the cost of dependent care, the employee may make a change in the DCAP to reflect the new cost if the dependent

care provider is not a relative as defined in Section 152 (a)(1) through (8), incorporating the rules of Section 152 (b)(1) and (2) of the IRC.

[Statutory Authority: RCW 41.05.160, 10-20-147 (Order 10-02), § 182-08-199, filed 10/6/10, effective 1/1/11; 09-23-102 (Order 09-02), § 182-08-199, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-08-199, filed 10/1/08, effective 1/1/09.]

Chapter 182-12 WAC

ELIGIBLE AND NONELIGIBLE EMPLOYEES

WAC

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

"Administrator" means the administrator of the HCA or designee.

"Agency" means the health care authority.

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

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

"Comprehensive employer sponsored medical" includes insurance coverage continued by the employee or their dependent under COBRA. It does not include an employer's retiree coverage, with the exception of a federal retiree plan.

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

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

"Dependent" means a person who meets eligibility requirements in WAC 182-12-260.

"Dependent care assistance program" or "DCAP" means a benefit plan whereby state and public employees may pay for certain employment related dependent care with pretax

dollars as provided in the salary reduction plan authorized in chapter 41.05 RCW.

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

"Employer group" means those employee organizations representing state civil service employees, counties, municipalities, political subdivisions, tribal governments, school districts, and educational service districts participating in PEBB insurance coverage under contract as described in WAC 182-08-230.

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

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

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

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

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

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

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

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

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

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

"Open enrollment" means a time period when: Subscribers may apply to transfer their enrollment from one health plan to another; a dependent may be enrolled; a dependent may be removed from coverage; or an employee who previously waived medical may enroll in medical. Open enrollment is also the time when employees may enroll in or change their election under the DCAP, the medical FSA, or the premium payment plan. An "annual" open enrollment,

designated by the administrator, is an open enrollment when all PEBB subscribers may make enrollment changes for the upcoming year. A "special" open enrollment is triggered by a specific life event. For special open enrollment events as they relate to specific PEBB benefits, see WAC 182-08-198, 182-08-199, 182-12-128, 182-12-262.

"PEBB" means the public employees benefits board.

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

"PEBB benefits" means one or more insurance coverage or other employee benefit administered by the PEBB program within HCA.

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

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

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

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

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

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

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

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

"Waive" means to interrupt an eligible employee's enrollment in a PEBB health plan because the employee is enrolled in other comprehensive group coverage or is on approved educational leave (see WAC 182-12-128 and 182-12-136).

[Statutory Authority: RCW 41.05.160, 10-20-147 (Order 10-02), § 182-12-109, filed 10/6/10, effective 1/1/11; 09-23-102 (Order 09-02), § 182-12-109, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-12-109, filed 10/1/08, effective 1/1/09; 07-20-129 (Order 07-01), § 182-12-109, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.068, 06-23-165 (Order 06-09), § 182-12-109, filed 11/22/06, effective 12/23/06. Statutory Authority: RCW 41.05.160 and 41.05.165, 04-18-039, § 182-12-109, filed 8/26/04, effective 1/1/05.]

WAC 182-12-111 Eligible entities and individuals.

The following entities and individuals shall be eligible for PEBB insurance coverage subject to the terms and conditions set forth below:

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

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

(b) Community and 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) Employer groups: Employer groups may participate in PEBB insurance coverages at the option of each employer group provided all of the following requirements are met:

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

- Bargaining units may elect to participate separately from the whole group; and
- Nonrepresented employees may elect to participate separately from the whole group provided all nonrepresented employees join as a group.

(b) PEBB health plans must be the only employer sponsored health plans available to eligible employees.

(c) The employer group must submit to the HCA an application when it first applies, the contents of which will be specified by HCA. The application for employer groups, with the exception of school districts and educational service districts, is subject to review and approval by the HCA, and the decision to approve or deny the application shall be provided to the applying employer group by the HCA.

(d) Each employer group purchasing PEBB insurance coverage must sign a contract with the HCA. The employer group must abide by the eligibility, enrollment, and payment terms specified in the contract. Any subsequent changes to the contract must be submitted for approval in advance of the change.

(e) The employer group must maintain its PEBB insurance coverage participation at least one full year, and may end participation only at the end of a plan year.

(f) The employer group must give the HCA written notice of its intent to end PEBB insurance coverage participation at least sixty days before the effective date of termination. With the exception of retired and disabled employees of school districts or educational service districts, if the employer group ends PEBB insurance coverage, retired and disabled employees who began participating after September 15, 1991, are not eligible for PEBB insurance coverage beyond the mandatory extension requirements specified in WAC 182-12-146.

(g) Employees eligible for PEBB participation include only those employees whose services are substantially all in the performance of essential governmental functions but not in the performance of commercial activities, whether or not those activities qualify as essential governmental functions. Employer groups shall determine eligibility in order to ensure PEBB's continued status as a governmental plan under Section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA) as amended.

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

(a) The HCA will collect an amount equal to the composite rate charged to state agencies plus an amount equal to the employee premium by health plan and family size as would be charged to state employees for each participating school district or educational service district.

(b) The HCA may collect these amounts in accordance with the district fiscal year, as described in RCW 28A.505-.030.

(4) Blind vendors means a "licensee" as defined in RCW 74.18.200: Vendors actively operating a business enterprise program facility in the state of Washington and deemed eligible by the department of services for the blind may voluntarily participate in PEBB insurance coverage.

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

(b) Department of services for the blind will notify eligible vendors of their eligibility in advance of the date that they are eligible to apply for enrollment in PEBB insurance coverage.

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

(5) 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 health plans while enrolled in that program.

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

(6) Individuals that are not eligible include:

(a) Adult family home providers as defined in RCW 70.128.010;

(b) Unpaid volunteers;

(c) Patients of state hospitals;

(d) Inmates;

(e) Employees of the Washington state convention and trade center as provided in RCW 41.05.110;

(f) Students of institutions of higher education as determined by their institutions; and

(g) Any others not expressly defined as employees under RCW 41.05.011.

[Statutory Authority: RCW 41.05.160, 10-20-147 (Order 10-02), § 182-12-111, filed 10/6/10, effective 1/1/11; 09-23-102 (Order 09-02), § 182-12-111, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-12-111, filed 10/1/08, effective 1/1/09; 07-20-129 (Order 07-01), § 182-12-111, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.-165, 04-18-039, § 182-12-111, filed 8/26/04, effective 1/1/05; 03-17-031 (Order 02-07), § 182-12-111, filed 8/14/03, effective 9/14/03. Statutory Authority: RCW 41.05.160, 02-18-087 (Order 02-02), § 182-12-111, filed 9/3/02, effective 10/4/02; 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 182-12-114 How do employees establish eligibility for PEBB benefits? Eligibility for an employee whose work circumstances are described by more than one of the eligibility categories in subsections (1) through (5) of this section shall be 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. Employing agencies must request the PEBB program's approval to include temporary training or emergency hours in determining eligibility.

For how the employer contribution toward insurance coverage is maintained after eligibility is established under this section, see WAC 182-12-131.

(1) Employees are eligible for PEBB benefits as follows, except as provided in subsections (2) through (5) of this section:

(a) **Eligibility.** An employee is eligible if he or she works an average of at least eighty hours per month and works for at least eight hours in each month for more than six consecutive months.

(b) **Determining eligibility.**

(i) **Upon employment:** An employee is eligible from the date of employment if the employing agency anticipates the employee will work according to the criteria in (a) of this subsection.

(ii) **Upon revision of anticipated work pattern:** If an employing agency revises an employee's anticipated work hours such that the employee meets the eligibility criteria in (a) of this subsection, the employee becomes eligible when the revision is made.

(iii) **Based on work pattern:** An employee who is determined to be ineligible, but later meets the eligibility criteria in (a) of this subsection, becomes eligible the first of the month following the six-month averaging period.

(c) **Stacking of hours.** As long as the work is within one state agency, employees may "stack" or combine hours

worked in more than one position or job to establish eligibility and maintain the employer contribution toward insurance coverage. Employees must notify their employing agency if they believe they are eligible through stacking. Stacking includes work situation in which:

(i) The employee works two or more positions or jobs at the same time (concurrent stacking);

(ii) The employee moves from one position or job to another (consecutive stacking); or

(iii) The employee combines hours from a seasonal position to hours from a nonseasonal position or job. An employee who establishes eligibility by stacking hours from a seasonal position or job with hours from a nonseasonal position or job shall maintain the employer contribution toward insurance coverage under WAC 182-12-131(1).

(d) When PEBB benefits begin. Medical and dental insurance coverage and basic life and basic long-term disability insurance coverage 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, these PEBB benefits begin on that date.

(2) Seasonal employees, as defined in WAC 182-12-109, are eligible as follows:

(a) Eligibility. A seasonal employee is eligible if he or she works an average of at least eighty hours per month and works for at least eight hours in each month of the season. A season is any recurring, cyclical period of work at a specific time of year that lasts three to eleven months.

(b) Determining eligibility.

(i) Upon employment: A seasonal employee is eligible from the date of employment if the employing agency anticipates that he or she will work according to the criteria in (a) of this subsection.

(ii) Upon revision of anticipated work pattern. If an employing agency revises an employee's anticipated work hours such that the employee meets the eligibility criteria in (a) of this subsection, the employee becomes eligible when the revision is made.

(iii) Based on work pattern. An employee who is determined to be ineligible for benefits, but later works an average of at least eighty hours per month and works for at least eight hours in each month and works for more than six consecutive months, becomes eligible the first of the month following a six-month averaging period.

(c) Stacking of hours. As long as the work is within one state agency, employees may "stack" or combine hours worked in more than one position or job to establish eligibility and maintain the employer contribution toward insurance coverage. Employees must notify their employing agency if they believe they are eligible through stacking. Stacking includes work situations in which:

(i) The employee works two or more positions or jobs at the same time (concurrent stacking);

(ii) The employee moves from one position or job to another (consecutive stacking); or

(iii) The employee combines hours from a seasonal position or job to hours from a nonseasonal position or job. An employee who establishes eligibility by stacking hours from a seasonal position or job with hours from a nonseasonal position or job shall maintain the employer contribution toward insurance coverage under WAC 182-12-131(1).

(d) When PEBB benefits begin. Medical and dental insurance coverage and basic life and basic long-term disability insurance coverage 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, these PEBB benefits begin on that date.

(3) Faculty are eligible as follows:

(a) Determining eligibility. "Half-time" means one-half of the full-time academic workload as determined by each institution, except that half-time for community and technical college faculty employees is governed by RCW 28B.50.489.

(i) Upon employment: 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.

(ii) 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.

(iii) Upon revision of anticipated work pattern: Faculty who receive additional workload after the beginning of the anticipated work period (quarter, semester, or instructional year), such that their workload meets the eligibility criteria of (a)(i) or (ii) of this subsection become eligible when the revision is made.

(b) Stacking. Faculty may establish eligibility and maintain the employer contribution toward insurance coverage by working as faculty for more than one institution of higher education. Faculty workloads may only be stacked with other faculty workloads to establish eligibility under this section or maintain eligibility under WAC 182-12-131(3). When a faculty works for more than one institution of higher education, the faculty must notify his or her employing agencies that he or she works at more than one institution and may be eligible through stacking.

(c) When PEBB benefits begin.

(i) Medical and dental insurance coverage and basic life and basic long-term disability insurance coverage begin on the first day of the month following the day the faculty becomes eligible. If the faculty becomes eligible on the first working day of a month, these PEBB benefits begin on that date.

(ii) For faculty hired on a quarter/semester to quarter/semester basis under (a)(ii) of this subsection, medical and dental insurance coverage and basic life and basic long-term disability insurance coverage begin the first day of the month following the beginning of the second consecutive quarter/semester of half-time or more employment. If the first day of the second consecutive quarter/semester is the first working day of the month, these PEBB benefits begin at the beginning of the second consecutive quarter/semester.

(4) Elected and full-time appointed officials of the legislative and executive branches of state government are eligible as follows:

(a) **Eligibility.** A legislator is eligible for PEBB benefits on the date his or her term begins. All other elected and full-time appointed officials of the legislative and executive branches of state government are eligible on the date their terms begin or the date they take the oath of office, whichever occurs first.

(b) **When PEBB benefits begin.** Medical and dental insurance coverage and basic life and basic long-term disability insurance coverage 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, these PEBB benefits begin on that date.

(5) **Justices and judges** are eligible as follows:

(a) **Eligibility.** A justice of the supreme court and judges of the court of appeals and the superior courts become eligible for PEBB benefits on the date they take the oath of office.

(b) **When PEBB benefits begin.** Medical and dental insurance coverage and basic life and basic long-term disability insurance coverage 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, these PEBB benefits begin on that date.

[Statutory Authority: RCW 41.05.160, 10-20-147 (Order 10-02), § 182-12-114, filed 10/6/10, effective 1/1/11; 09-23-102 (Order 09-02), § 182-12-114, filed 11/17/09, effective 1/1/10.]

WAC 182-12-123 Dual enrollment is prohibited. PEBB health plan coverage is limited to a single enrollment per individual.

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

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

(3) Children eligible for medical and dental under two subscribers may be enrolled as a dependent under the health plan of only one subscriber.

(4) An employee who is eligible for the employer contribution to PEBB benefits due to employment in more than one PEBB-participating employing agency may enroll only under one employing agency. The employee must choose to enroll in PEBB benefits under only one employing agency.

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

[Statutory Authority: RCW 41.05.160, 10-20-147 (Order 10-02), § 182-12-123, filed 10/6/10, effective 1/1/11; 09-23-102 (Order 09-02), § 182-12-123, filed 11/17/09, effective 1/1/10; 07-20-129 (Order 07-01), § 182-12-123, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.165, 04-18-039, § 182-12-123, filed 8/26/04, effective 1/1/05.]

WAC 182-12-128 May an employee waive health plan enrollment? Employees must enroll in dental, life and long-term disability insurance (unless the employing agency does not participate in these PEBB insurance coverages). However, employees may waive PEBB medical if they have other comprehensive group medical coverage.

(1) Employees may waive enrollment in PEBB medical by submitting the appropriate enrollment form to their employing agency during the following times:

(a) **When the employee becomes eligible:** Employees may waive medical when they become eligible for PEBB benefits. Employees must indicate they are waiving medical on the appropriate enrollment form they submit to their employing agency no later than thirty-one days after the date they become eligible (see WAC 182-08-197). Medical will be waived as of the date the employee becomes eligible for PEBB benefits.

(b) **During the annual open enrollment:** Employees may waive medical during the annual open enrollment if they submit the appropriate enrollment form to their employing agency before the end of the annual open enrollment. Medical will be waived beginning January 1st of the following year.

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

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

(3) Once medical is waived, enrollment is only allowed during the following times:

(a) During the annual open enrollment;

(b) During a special open enrollment created by an event that allows for enrollment outside of the annual open enrollment as described in subsection (4) of this section. In addition to the appropriate forms, the PEBB program may require the employee to provide evidence of eligibility and evidence of the event that creates a special open enrollment.

(4) **Special open enrollment:** Employees may waive enrollment in medical or enroll in medical if one of these special open enrollment events occur. The change in enrollment must correspond to the event that creates the special open enrollment. The following events create a special open enrollment:

(a) Employee's dependent becomes eligible under PEBB rules:

(i) Through marriage or registering a domestic partnership with Washington state;

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

(iii) Through legal custody or legal guardianship; or

(iv) When a child becomes eligible as an extended dependent;

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

(i) Employee has a change in marital status or Washington state registered domestic partnership status, including legal separation documented by a court order;

(ii) A child dependent turns age twenty-six;

(iii) A child dependent ceases to be eligible as an extended dependent or as a dependent with disabilities; or

(iv) A dependent dies;

(c) Employee or a dependent loses coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);

(d) Employee or a dependent has a change in employment status that affects the employee's or a dependent's eligibility for group health coverage or the employer contribution toward insurance coverage;

(e) Employee or a dependent has a change in residence that affects health plan availability;

(f) Employee receives a court order or medical support order requiring the employee, spouse, or Washington state registered domestic partner to provide insurance coverage for an eligible dependent (a former spouse or former registered domestic partner is not an eligible dependent);

(g) Employee or dependent becomes eligible for a medical assistance program under the department of social and health services, including medicaid or the children's health insurance program (CHIP), or the employee or dependent loses eligibility in a medical assistance program.

To waive or enroll during a special open enrollment, the employee must submit the appropriate forms to their employing agency no later than sixty days after the event that creates the special open enrollment.

Enrollment in insurance coverage will begin the first of the month following the event that created the special open enrollment; or in cases where the event occurs on the first day of a month, enrollment will begin on that date. If the special open enrollment is due to the birth or adoption of a child, insurance coverage will begin the first of the month in which the event occurs.

[Statutory Authority: RCW 41.05.160, 10-20-147 (Order 10-02), § 182-12-128, filed 10/6/10, effective 1/1/11; 09-23-102 (Order 09-02), § 182-12-128, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-12-128, filed 10/1/08, effective 1/1/09; 08-09-027 (Order 08-01), § 182-12-128, filed 4/8/08, effective 4/9/08; 07-20-129 (Order 07-01), § 182-12-128, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.165, 04-18-039, § 182-12-128, filed 8/26/04, effective 1/1/05.]

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

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

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

(a) A benefits-eligible seasonal employee (eligible under WAC 182-12-114(2)) who works a season of less than nine months is eligible for the employer contribution in any month of his or her season in which he or she is in pay status eight or more hours during that month. The employer contribution toward PEBB benefits for seasonal employees returning after their off season begins on the first day of the first month of the season in which they are in pay status eight hours or more.

(b) A benefits-eligible seasonal employee (eligible under WAC 182-12-114(2)) who works a season of nine months or more is eligible for the employer contribution:

(i) In any month of his or her season in which he or she is in pay status eight or more hours during that month; and

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

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

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

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

(c) Summer or off-quarter/semester coverage: All benefits-eligible faculty (eligible under WAC 182-12-114(3)) who work an average of half-time or more throughout the entire instructional year or equivalent nine-month period and work each quarter/semester of the instructional year or equivalent nine-month period are eligible for the employer contribution toward summer or off-quarter/semester insurance coverage.

Exception:

Eligibility for the employer contribution toward summer or off-quarter/semester insurance coverage ends on the end date specified in an employing agency's termination notice or an employee's resignation letter, whichever is earlier, if the employing agency has no anticipation that the employee will be returning as faculty at any institution of higher education where the employee has employment.

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

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

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

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

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

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

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

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

- (i) Employees on authorized leave without pay;
- (ii) Employees on approved educational leave;
- (iii) Employees receiving time-loss benefits under workers' compensation;
- (iv) Employees called to active duty in the uniformed services as defined under the Uniformed Services Employment and Reemployment Rights Act (USERRA); or
- (v) Employees applying for disability retirement.

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

(6) Employees who are in pay status less than eight hours in a month. Unless otherwise indicated in this rule, when there is a month in which an employee is not in pay status for at least eight hours, the employee:

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

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

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

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

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

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

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

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

The employer contribution toward PEBB medical, dental and life insurance for an employee, spouse, Washington state registered domestic partner, or child ceases at 12:00 midnight, the last day of the month in which the employee is eligible for the employer contribution under this rule.

(8) Options for continuation coverage by self-paying. During temporary or permanent loss of the employer contribution toward insurance coverage, employees have options for providing continuation coverage for themselves and their dependents by self-paying the full premium set by the HCA.

These options are available according to WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, and 182-12-270.

[Statutory Authority: RCW 41.05.160. 10-20-147 (Order 10-02), § 182-12-131, filed 10/6/10, effective 1/1/11; 09-23-102 (Order 09-02), § 182-12-131, filed 11/17/09, effective 1/1/10; 07-20-129 (Order 07-01), § 182-12-131, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-131, filed 8/26/04, effective 1/1/05.]

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

(1) When an employee is no longer eligible for the employer contribution toward PEBB benefits due to an event described in (a) through (f) of this subsection, insurance coverage may be continued by self-paying the full premium set by the HCA, with no contribution from the employer. Employees may self-pay for a maximum of twenty-nine months. The employee must pay the premium amounts for insurance coverage as premiums become due. If premiums are more than sixty days delinquent, insurance coverage will end as of the last day of the month for which a full premium was paid. Employees may continue any combination of medical, dental and life insurance; however, only employees on approved educational leave or called in to active duty in the uniformed services as defined under the Uniformed Services Employment and Reemployment Rights Act (USERRA) may continue long-term disability insurance. Employees in the following circumstances qualify to continue coverage under this subsection:

- (a) The employee is on authorized leave without pay;
- (b) The employee is on approved educational leave;
- (c) The employee is receiving time-loss benefits under workers' compensation;
- (d) The employee is called to active duty in the uniformed services as defined under the Uniformed Services Employment and Reemployment Rights Act (USERRA);
- (e) The employee's employment ends due to a layoff as defined in WAC 182-12-109; or
- (f) The employee is applying for disability retirement.

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

[Statutory Authority: RCW 41.05.160. 10-20-147 (Order 10-02), § 182-12-133, filed 10/6/10, effective 1/1/11; 09-23-102 (Order 09-02), § 182-12-133, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-12-133, filed 10/1/08, effective 1/1/09; 07-20-129 (Order 07-01), § 182-12-133, filed 10/3/07, effective 11/3/07; 06-11-156 (Order 06-02), § 182-12-133, filed

5/24/06, effective 6/24/06. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-133, filed 8/26/04, effective 1/1/05.]

WAC 182-12-141 If an employee reverts from an eligible position to another position, what happens to his or her insurance coverage? (1) If an employee reverts for reasons other than a layoff and is not eligible for the employer contribution toward insurance coverage under this chapter, he or she may continue PEBB insurance coverage by self-paying the full premium set by the HCA for up to eighteen months under the same terms as an employee who is granted leave without pay under WAC 182-12-133(1).

(2) If an employee is reverted due to a layoff, the employee may be eligible for the employer contribution toward insurance coverage under the criteria of WAC 182-12-129. If determined not to be eligible under WAC 182-12-129, the employee may continue PEBB insurance coverage by self-paying the full premium set by the HCA under WAC 182-12-133.

[Statutory Authority: RCW 41.05.160. 10-20-147 (Order 10-02), § 182-12-141, filed 10/6/10, effective 1/1/11; 09-23-102 (Order 09-02), § 182-12-141, filed 11/17/09, effective 1/1/10; 07-20-129 (Order 07-01), § 182-12-141, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-141, filed 8/26/04, effective 1/1/05.]

WAC 182-12-142 What options for continuation coverage are available to faculty and seasonal employees who are between periods of eligibility? (1) **Faculty** may continue any combination of medical, dental and life insurance coverage by self-paying the full premium set by the HCA, with no contribution from the employer, for a maximum of twelve months between periods of eligibility. The employee must pay the premium amounts associated with insurance coverage as premiums become due. If premiums are more than sixty days delinquent, insurance coverage will end as of the last day of the month for which a full premium was paid.

(2) **Benefits-eligible seasonal employees** may continue any combination of medical, dental, and life insurance coverage by self-paying the full premium set by the HCA, with no contribution from the employer, for a maximum of twelve months between periods of eligibility. The employee must pay the premium amounts associated with insurance coverage as premiums become due. If premiums are more than sixty days delinquent, insurance coverage will end as of the last day of the month for which a full premium was paid.

(3) **COBRA.** An employee who is no longer eligible for continuation coverage as described in subsections (1) and (2) of this section, but who has not used the maximum number of months allowed under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), may continue medical and dental for the remaining difference in months by self-paying the full premium set by the HCA under COBRA as described in WAC 182-12-146. The number of months that a faculty or seasonal employee self-pays premiums under the criteria in subsection (1) or (2) of this section will count toward the total months of continuation coverage allowed under COBRA.

[Statutory Authority: RCW 41.05.160. 10-20-147 (Order 10-02), § 182-12-142, filed 10/6/10, effective 1/1/11; 09-23-102 (Order 09-02), § 182-12-142, filed 11/17/09, effective 1/1/10.]

WAC 182-12-171 When are retiring employees eligible to enroll in retiree insurance? (1) Procedural requirements. Retiring employees must meet these procedural requirements, as well as have substantive eligibility under subsection (2) or (3) of this section.

(a) The employee must submit the appropriate forms to enroll or defer insurance coverage within sixty days after the employee's employer paid or COBRA coverage ends. The effective date of health plan enrollment will be the first day of the month following the loss of other coverage.

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

Employees who do not enroll in a PEBB health plan at retirement are only eligible to enroll at a later date if they have deferred enrollment as identified in WAC 182-12-200 or 182-12-205 and maintained comprehensive employer sponsored medical as defined in WAC 182-12-109.

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

(2) **Eligibility requirements.** Eligible employees (as defined in WAC 182-12-114 and 182-12-131) who end public employment after becoming vested in a Washington state-sponsored retirement plan (as defined in subsection (4) of this section) are eligible to continue PEBB insurance coverage as a retiree if they meet procedural and eligibility requirements. To be eligible to continue PEBB insurance coverage as a retiree, the employee must be eligible to retire under a Washington state-sponsored retirement plan when the employee's employer paid or COBRA coverage ends.

Employees who do not meet their Washington state-sponsored retirement plan's age requirements when their employer paid or COBRA coverage ends, but who meet the age requirement within sixty days of coverage ending, may request that their eligibility be reviewed by the PEBB appeals committee to determine eligibility (see WAC 182-16-032). Employees must meet other retiree insurance election procedural requirements.

- Employees must immediately begin to receive a monthly retirement plan payment, with exceptions described below.

- Employees who receive a lump-sum payment instead of a monthly retirement plan payment are only eligible if this is required by department of retirement systems because their monthly retirement plan payment is below the minimum payment that can be paid.

- Employees who are members of a Plan 3 retirement, also called separated employees (defined in RCW 41.05.011 (13)), are eligible if they meet their retirement plan's age requirement and length of service when PEBB employee insurance coverage ends. They do not have to receive a retirement plan payment.

- Employees who are members of a Washington higher education retirement plan are eligible if they immediately begin to receive a monthly retirement plan payment, or meet

their plan's age requirement, or are at least age fifty-five with ten years of state service.

- Employees who are permanently and totally disabled are eligible if they start receiving or defer a monthly disability retirement plan payment.

- Employees not retiring under a Washington state-sponsored retirement plan must meet the same age and years of service had the person been employed as a member of either public employees retirement system Plan 1 or Plan 2 for the same period of employment.

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

(a) **Local government employees.** If the local government ends participation in PEBB insurance coverage, employees who enrolled after September 15, 1991, are no longer eligible for PEBB retiree insurance. These employees may continue PEBB health plan enrollment under COBRA (see WAC 182-12-146).

(b) **Tribal government employees.** If a tribal government ends participation in PEBB insurance coverage, its employees are no longer eligible for PEBB retiree insurance. These employees may continue PEBB health plan enrollment under COBRA (see WAC 182-12-146).

(c) **Washington state K-12 school district and educational service district employees for districts that do not participate in PEBB benefits.** Employees of Washington state K-12 school districts and educational service districts who separate from employment after becoming vested in a Washington state-sponsored retirement system are eligible to enroll in PEBB health plans when retired or permanently and totally disabled.

Except for employees who are members of a retirement Plan 3, employees who separate on or after October 1, 1993, must immediately begin to receive a monthly retirement plan payment from a Washington state-sponsored retirement system. Employees who receive a lump-sum payment instead of a monthly retirement plan payment are only eligible if department of retirement systems requires this because their monthly retirement plan payment is below the minimum payment that can be paid or they enrolled before 1995.

Employees who are members of a Plan 3 retirement, also called separated employees (defined in RCW 41.05.011(13)), are eligible if they meet their retirement plan's age requirement and length of service when employer paid or COBRA coverage ends.

Employees who separate from employment due to total and permanent disability who are eligible for a deferred retirement allowance under a Washington state-sponsored retirement system (as defined in chapter 41.32, 41.35 or 41.40 RCW) are eligible if they enrolled before 1995 or within sixty days following retirement.

Employees who retired as of September 30, 1993, and began receiving a retirement allowance from a state-sponsored retirement system (as defined in chapter 41.32, 41.35 or 41.40 RCW) are eligible if they enrolled in a PEBB health plan not later than the HCA's annual open enrollment period for the year beginning January 1, 1995.

(3) **Elected and full-time appointed officials of the legislative and executive branches.** Employees who are elected and full-time appointed state officials (as defined under WAC 182-12-114(4)) who voluntarily or involuntarily leave public office are eligible to continue PEBB insurance coverage as a retiree if they meet procedural and eligibility requirements. They do not have to receive a retirement plan payment from a state-sponsored retirement system.

(4) **Washington state-sponsored retirement systems include:**

- Higher education retirement plans;
- Law enforcement officers' and firefighters' retirement system;
- Public employees' retirement system;
- Public safety employees' retirement system;
- School employees' retirement system;
- State judges/judicial retirement system;
- Teacher's retirement system; and
- State patrol retirement system.

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

[Statutory Authority: RCW 41.05.160, 10-20-147 (Order 10-02), § 182-12-171, filed 10/6/10, effective 1/1/11; 09-23-102 (Order 09-02), § 182-12-171, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-12-171, filed 10/1/08, effective 1/1/09; 07-20-129 (Order 07-01), § 182-12-171, filed 10/3/07, effective 11/3/07; 06-11-156 (Order 06-02), § 182-12-171, filed 5/24/06, effective 6/24/06. Statutory Authority: RCW 41.05.160, 41.05.350, and 41.05.165. 05-16-046 (Order 05-01), § 182-12-171, filed 7/27/05, effective 8/27/05. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-171, filed 8/26/04, effective 1/1/05.]

WAC 182-12-205 May a retiree defer enrollment in a PEBB health plan at or after retirement? Except as stated in subsection (1)(c) of this section, if retirees defer enrollment in a PEBB health plan, they also defer enrollment for all eligible dependents. Retirees may not defer their retiree term life insurance, even if they have other life insurance.

(1) Retirees may defer enrollment in a PEBB health plan at or after retirement if continuously enrolled in other comprehensive employer sponsored medical as identified below:

(a) Beginning January 1, 2001, retirees may defer enrollment if they are enrolled in comprehensive employer-sponsored medical as an employee or the dependent of an employee.

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

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

(2) To defer health plan enrollment, the retiree must submit the appropriate forms to the PEBB program requesting to defer. The PEBB program must receive the form before health plan enrollment is deferred or no later than sixty days

after the date the retiree becomes eligible to apply for PEBB retiree insurance coverage.

(3) Retirees who defer may enroll in a PEBB health plan as follows:

(a) Retirees who defer while enrolled in comprehensive employer-sponsored medical may enroll in a PEBB health plan by submitting the appropriate forms and evidence of continuous enrollment in comprehensive employer-sponsored medical to the PEBB program:

(i) During annual open enrollment. (PEBB health plan will begin January 1st after the annual open enrollment.); or

(ii) No later than sixty days after their comprehensive employer-sponsored medical ends. (PEBB health plan will begin the first day of the month after the comprehensive employer-sponsored medical ends.)

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

(i) During annual open enrollment. (PEBB health plan will begin January 1st after the annual open enrollment.); or

(ii) No later than sixty days after the federal retiree medical ends. (Enrollment in the PEBB health plan will begin the first day of the month after the federal retiree medical ends.)

(c) Retirees who defer enrollment while enrolled in medicare Parts A and B and medicaid may enroll in a PEBB health plan by submitting the appropriate forms and evidence of continuous enrollment in creditable coverage to the PEBB program:

(i) During annual open enrollment. (Enrollment in the PEBB health plan will begin January 1st after the annual open enrollment.); or

(ii) No later than sixty days after their medicaid coverage ends (Enrollment in the PEBB health plan will begin the first day of the month after the medicaid coverage ends.); or

(iii) No later than the end of the calendar year when their medicaid coverage ends if the retiree was also determined eligible under 42 USC § 1395w-114 and subsequently enrolled in a medicare Part D plan. (Enrollment in the PEBB health plan will begin January 1st following the end of the calendar year when the medicaid coverage ends.)

(d) Retirees who defer enrollment may enroll in a PEBB health plan if the retiree receives formal notice that the department of social and health services has determined it is more cost-effective to enroll the retiree or the retiree's eligible dependent(s) in PEBB medical than a medical assistance program.

[Statutory Authority: RCW 41.05.160, 10-20-147 (Order 10-02), § 182-12-205, filed 10/6/10, effective 1/1/11; 09-23-102 (Order 09-02), § 182-12-205, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-12-205, filed 10/1/08, effective 1/1/09; 08-09-027 (Order 08-01), § 182-12-205, filed 4/8/08, effective 4/9/08; 07-20-129 (Order 07-01), § 182-12-205, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.-068, 06-23-165 (Order 06-09), § 182-12-205, filed 11/22/06, effective 12/23/06. Statutory Authority: RCW 41.05.160, 41.05.350, and 41.05.165, 05-16-046 (Order 05-01), § 182-12-205, filed 7/27/05, effective 8/27/05. Statutory Authority: RCW 41.05.160 and 41.05.165, 04-18-039, § 182-12-205, filed 8/26/04, effective 1/1/05.]

WAC 182-12-250 Insurance coverage eligibility for survivors of emergency service personnel killed in the line of duty. Surviving spouses, Washington state registered domestic partners, and dependent children of emergency service personnel who are killed in the line of duty are eligible to enroll in health plans administered by the PEBB program within HCA.

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

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

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

(a) A lawful spouse;

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

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

(d) Children. The term "children" includes children of the emergency service worker up to age twenty-six. Children with disabilities as defined in RCW 41.26.030(7) are eligible at any age. "Children" is defined as:

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

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

(iii) Legally adopted children.

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

(5) The survivor (or agent acting on their behalf) must submit the appropriate forms (to either enroll or defer enrollment in a PEBB health plan) to PEBB program no later than one hundred eighty days after the latter of:

(a) The death of the emergency service worker;

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

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

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

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

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

(b) The first of the month that is not earlier than sixty days before the date that the PEBB program receives the appropriate forms (for example, if the PEBB program

receives the appropriate forms on August 29, the survivor may request health plan enrollment to begin on July 1); or

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

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

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

(a) Enroll in a PEBB health plan:

(i) Enroll in medical; or

(ii) Enroll in medical and dental.

(iii) Survivors enrolling in dental must stay enrolled in dental for at least two years before dental can be dropped.

(iv) Dental only is not an option.

(b) Defer enrollment:

(i) Survivors may defer enrollment in a PEBB health plan if enrolled in comprehensive employer sponsored medical.

(ii) Survivors may enroll in a PEBB health plan when they lose comprehensive employer sponsored medical. Survivors will need to provide evidence that they were continuously enrolled in comprehensive employer sponsored medical when applying for a PEBB health plan, and apply within sixty days after the date their other coverage ended.

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

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

(9) Survivors may not add new dependents acquired through birth, adoption, establishment of an extended dependent, marriage, or establishment of a qualified domestic partnership.

(10) Survivors will lose their right to enroll in a PEBB health plan if they:

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

(b) Do not maintain continuous enrollment in comprehensive employer sponsored medical through an employer during the deferral period, as provided in subsection (7)(b)(i) of this section.

[Statutory Authority: RCW 41.05.160, 10-20-147 (Order 10-02), § 182-12-250, filed 10/6/10, effective 1/1/11; 09-23-102 (Order 09-02), § 182-12-250, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-12-250, filed 10/1/08, effective 1/1/09; 07-20-129 (Order 07-01), § 182-12-250, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.080, 06-20-099 (Order 06-08), § 182-12-250, filed 10/3/06, effective 11/3/06. Statutory Authority: RCW 41.05.160 and 41.05.165, 04-18-039, § 182-12-250, filed 8/26/04, effective 1/1/05.]

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

The PEBB program verifies the eligibility of all dependents and reserves the right to request documents from sub-

scribers that provide evidence of a dependent's eligibility. The PEBB program will remove a subscriber's enrolled dependents from health plan enrollment if the PEBB program is unable to verify a dependent's eligibility within a specified time.

The subscriber or dependent must notify the PEBB program, in writing, no later than sixty days after the date he or she is no longer eligible under this section. See WAC 182-12-262 for the consequences of not removing an ineligible dependent from coverage.

The following are eligible as dependents under the PEBB eligibility rules:

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

(2) Effective January 1, 2010, Washington state registered domestic partners, as defined in RCW 26.60.020(1). Former Washington state registered domestic partners are not eligible dependents upon dissolution or termination of a partnership, even if a court order requires the subscriber to provide health insurance for the former partner.

(3) Children. Children are defined as the subscriber's biological children, stepchildren, legally adopted children, children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child, children of the subscriber's Washington state registered domestic partner, or children specified in a court order or divorce decree. In addition, children include extended dependents in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or subscriber's Washington state registered domestic partner. The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. "Children" does not include foster children for whom support payments are made to the subscriber through the state department of social and health services foster care program.

Eligible children include:

(a) Children up to age twenty-six.

(b) Effective January 1, 2011, children of any age with disabilities, mental illness, or intellectual or other developmental disabilities who are incapable of self-support, provided such condition occurs before age twenty-six.

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

(ii) The subscriber must notify the PEBB program, in writing, no later than sixty days after the date that a child age twenty-six or older no longer qualifies under this subsection.

For example, children who become self-supporting are not eligible under this rule as of the last day of the month in which they become capable of self-support.

(iii) Children age twenty-six and older who become capable of self-support do not regain eligibility under (b) of this subsection if they later become incapable of self-support.

(iv) The PEBB program will certify the eligibility of children with disabilities periodically.

(4) Parents.

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

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

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

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

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

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

[Statutory Authority: RCW 41.05.160, 10-20-147 (Order 10-02), § 182-12-260, filed 10/6/10, effective 1/1/11; 09-23-102 (Order 09-02), § 182-12-260, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-12-260, filed 10/1/08, effective 1/1/09; 07-20-129 (Order 07-01), § 182-12-260, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160, 41.05.350, and 41.05.165. 05-16-046 (Order 05-01), § 182-12-260, filed 7/27/05, effective 8/27/05. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-260, filed 8/26/04, effective 1/1/05.]

WAC 182-12-262 When may subscribers enroll or remove eligible dependents? (1) Enrolling dependents in health plan coverage. Subscribers may enroll eligible dependents at the following times:

(a) **When the subscriber becomes eligible** and enrolls in PEBB insurance coverage. If enrolled, the dependent's effective date will be the same as the subscriber's effective date. Except as provided in WAC 182-12-205 (1)(c), a dependent must be enrolled in the same health plan coverage as the subscriber, and the subscriber must be enrolled to enroll his or her dependent.

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

(c) **During special open enrollment.** Subscribers may enroll dependents when the dependent becomes eligible or during another special open enrollment as described in subsections (3) and (4) of this section.

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

(a) **Subscribers are required to remove dependents** within sixty days of the date the dependent no longer meets the eligibility criteria in WAC 182-12-250 or 182-12-260. The PEBB program will remove a subscriber's enrolled dependent the last day of the month in which the dependent ceases to meet the eligibility criteria. Consequences for not submitting notice within sixty days of any dependent ceasing to be eligible may include, but are not limited to:

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

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

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

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

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

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

(ii) During a special open enrollment as described in subsections (3) and (4) of this section. The dependent will be removed the last day of the month in which the event that creates the special open enrollment occurs.

(c) **Retirees, survivors, and enrollees with PEBB continuation coverage under WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, or 182-12-148 may remove dependents** from their coverage outside of the annual open enrollment or a special open enrollment by providing written notice to the PEBB program. Unless otherwise approved by the PEBB program, the dependent will be removed from the subscriber's coverage prospectively.

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

- Health plan coverage will begin the first of the month following the event that created the special open enrollment; or in cases where the event occurs on the first day of a month, health plan coverage will begin on that date.

- Dependents will be removed from the subscriber's health plan coverage the last day of the month following the event.

- If the special open enrollment is due to the birth or adoption or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of a child, health plan coverage will begin or end the month in which the event occurs. The following changes are events that create a special open enrollment for medical and dental:

(a) Subscriber's dependent becomes eligible under PEBB rules:

(i) Through marriage or registering a domestic partnership with Washington's secretary of state;

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

(iii) Through legal custody or legal guardianship; or

(iv) When a child becomes eligible as an extended dependent;

(b) Subscriber's dependent no longer meets PEBB eligibility criteria because:

(i) Subscriber has a change in marital status or Washington state registered domestic partnership status, including legal separation documented by a court order;

(ii) A child dependent turns age twenty-six;

(iii) A child dependent ceases to be eligible as an extended dependent or as a dependent with disabilities; or

(iv) A dependent dies;

(c) Subscriber or a dependent loses coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);

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

(e) Subscriber or a dependent has a change in residence that affects health plan availability;

(f) Subscriber receives a court order or medical support order requiring the subscriber, the subscriber's spouse, or the subscriber's Washington state registered domestic partner to provide insurance coverage for an eligible dependent. (A former spouse or former registered domestic partner is not an eligible dependent.); or

(g) Subscriber or a dependent becomes eligible for a medical assistance program under the department of social and health services, including medicaid or the children's health insurance program (CHIP), or the subscriber or dependent loses eligibility in a medical assistance program.

(4) **Enrollment requirements. Subscribers must submit the appropriate forms within the time frames described in this subsection.** Employees submit the appropriate forms to their employing agency. All other subscribers submit the appropriate forms to the PEBB program. In addition to the appropriate forms indicating dependent enrollment, the PEBB program may require the subscriber to provide documentation or evidence of eligibility or evidence of the event that created the special open enrollment.

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

(b) If a subscriber wants to enroll eligible dependents during the annual open enrollment, the subscriber must submit the appropriate forms no later than the last day of the annual open enrollment.

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

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

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

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

(g) If the subscriber wants to remove a dependent from enrollment during an open enrollment, the subscriber must submit the appropriate forms. Unless otherwise approved by the PEBB program, enrollment will be removed prospectively.

[Statutory Authority: RCW 41.05.160, 10-20-147 (Order 10-02), § 182-12-262, filed 10/6/10, effective 1/1/11; 09-23-102 (Order 09-02), § 182-12-262, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-12-262, filed 10/1/08, effective 1/1/09; 08-09-027 (Order 08-01), § 182-12-262, filed 4/8/08, effective 4/9/08.]

Chapter 182-16 WAC

PRACTICE AND PROCEDURE

WAC

182-16-025	Where do members appeal decisions regarding eligibility, enrollment, premium payments, or the administration of benefits?
182-16-030	How can an employee or an employee's dependent appeal a decision made by a state agency about eligibility or enrollment in benefits?
182-16-032	How can an employee, retiree, self-pay enrollee, or dependent appeal a decision made by the PEBB program regarding eligibility, enrollment, or premium payments?
182-16-050	How can an enrollee or entity request a hearing if aggrieved by a decision made by the PEBB appeals committee?

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

182-16-034	How can a PEBB enrollee appeal a decision regarding the administration of a PEBB medical plan, insured dental plan, life insurance, long-term care insurance, long-term disability insurance, or property or casualty insurance? [Statutory Authority: RCW 41.05.160, 09-23-102 (Order 09-02), § 182-16-034, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-16-034, filed 10/1/08, effective 1/1/09.] Repealed by 10-20-147 (Order 10-02), filed 10/6/10, effective 1/1/11. Statutory Authority: RCW 41.05.160.
182-16-037	How can an enrollee appeal a decision by the agency's self-insured dental plan? [Statutory Authority: RCW 41.05.160, 09-23-102 (Order 09-02), § 182-16-037, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-16-037, filed 10/1/08, effective 1/1/09.] Repealed by 10-20-147 (Order 10-02), filed 10/6/10, effective 1/1/11. Statutory Authority: RCW 41.05.160.

WAC 182-16-025 Where do members appeal decisions regarding eligibility, enrollment, premium payments, or the administration of benefits?

Note: Eligibility decisions address whether a subscriber or a subscriber's dependent is entitled to insurance coverage, as described in PEBB rules and policies. Enrollment decisions address the application for PEBB benefits as described in PEBB rules and policies including, but not limited to, the submission of proper documentation and meeting enrollment deadlines.

(1) Any employee of a state agency or his or her dependent aggrieved by a decision made by the employing state agency with regard to public employee benefits eligibility or enrollment may appeal that decision to the employing state agency by the process outlined in WAC 182-16-030.

(2) Any employee of an employer group or his or her dependent who is aggrieved by a decision made by an employer group with regard to PEBB eligibility or enrollment may appeal that decision to the employer group through the process established by the employer group.

Exception: Appeals by an employee of an employer group or his or her dependent based on eligibility or enrollment decisions regarding life insurance or long-term disability insurance must be made to the PEBB appeals committee by the process described in WAC 182-16-032.

(3) Any employee, self-pay enrollee, retiree, or dependent aggrieved by a decision made by the PEBB program with regard to public employee benefits eligibility, enroll-

ment, or premium payments may appeal that decision to the PEBB appeals committee by the process described in WAC 182-16-032.

(4) Any PEBB enrollee aggrieved by a decision regarding the administration of a PEBB medical plan, self-insured dental plan, insured dental plan, life insurance, long-term care insurance, long-term disability insurance, or property and casualty insurance may appeal that decision by following the appeal provisions of those plans, with the exception of eligibility, enrollment, and premium payment determinations.

(5) Any PEBB enrollee aggrieved by a decision regarding the medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP) offered under the state's salary reduction plan may appeal that decision by the process described in WAC 182-16-036.

[Statutory Authority: RCW 41.05.160. 10-20-147 (Order 10-02), § 182-16-025, filed 10/6/10, effective 1/1/11.]

WAC 182-16-030 How can an employee or an employee's dependent appeal a decision made by a state agency about eligibility or enrollment in benefits? (1) An eligibility or enrollment decision made by an employing state agency may be appealed by submitting a written request for review to the employing state agency. The employing state agency must receive the request for review within thirty days of the date of the initial denial notice. The contents of the request for review are to be provided in accordance with WAC 182-16-040.

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

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

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

(d) The employing state agency may reverse eligibility or enrollment decisions based only on circumstances that arose due to delays caused by the employing state agency or error(s) made by the employing state agency.

(2) Any employee or employee's dependent who disagrees with the employing state agency's decision in response to a request for review, as described in subsection (1) of this section, may appeal that decision by submitting a notice of appeal to the PEBB appeals committee. The PEBB appeals manager must receive the notice of appeal within thirty days of the date of the employing state agency's written decision on the request for review.

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

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

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

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

[Statutory Authority: RCW 41.05.160. 10-20-147 (Order 10-02), § 182-16-030, filed 10/6/10, effective 1/1/11; 09-23-102 (Order 09-02), § 182-16-030, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-16-030, filed 10/1/08, effective 1/1/09; 07-20-129 (Order 07-01), § 182-16-030, filed 10/3/07, effective 11/3/07; 97-21-128, § 182-16-030, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.010 and 34.05.250. 91-14-025, § 182-16-030, filed 6/25/91, effective 7/26/91.]

WAC 182-16-032 How can an employee, retiree, self-pay enrollee, or dependent appeal a decision made by the PEBB program regarding eligibility, enrollment, or premium payments? An eligibility, enrollment, or premium payment decision made by the PEBB program may be appealed by submitting a notice of appeal to the PEBB appeals committee. The contents of the notice of appeal are to be provided in accordance with WAC 182-16-040.

(1) The notice of appeal from an employee or employee's dependent must be received by the PEBB appeals manager within thirty days of the date of the denial notice by the PEBB program.

(2) The notice of appeal from a retiree, self-pay enrollee, or dependent of a retiree or self-pay enrollee must be received by the PEBB appeals manager within sixty days of the date of the denial notice by the PEBB program.

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

(4) The PEBB appeals committee shall render a written decision within thirty days of receiving the notice of appeal. The written decision shall be sent to the appellant.

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

[Statutory Authority: RCW 41.05.160. 10-20-147 (Order 10-02), § 182-16-032, filed 10/6/10, effective 1/1/11; 09-23-102 (Order 09-02), § 182-16-032, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-16-032, filed 10/1/08, effective 1/1/09.]

WAC 182-16-050 How can an enrollee or entity request a hearing if aggrieved by a decision made by the PEBB appeals committee? (1) Any party aggrieved by a decision of the PEBB appeals committee, may request an administrative hearing.

(2) The request must be made in writing to the PEBB appeals manager. The PEBB appeals manager must receive the request for an administrative hearing within thirty days of the date of the written decision by the PEBB appeals committee.

(3) The agency shall set the time and place of the hearing and give not less than twenty days notice to all parties.

(4) The administrator, or his or her designee, shall preside at all hearings resulting from the filings of appeals under this chapter.

(5) All hearings must be conducted in compliance with these rules, chapter 34.05 RCW and chapter 10-08 WAC as applicable.

(6) Within ninety days after the hearing record is closed, the administrator or his or her designee shall render a decision which shall be the final decision of the agency. A copy of that decision shall be mailed to all parties.

[Statutory Authority: RCW 41.05.160, 10-20-147 (Order 10-02), § 182-16-050, filed 10/6/10, effective 1/1/11; 08-20-128 (Order 08-03), § 182-16-050, filed 10/1/08, effective 1/1/09; 07-20-129 (Order 07-01), § 182-16-050, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160, 41.05.350, and 41.05.165. 05-16-046 (Order 05-01), § 182-16-050, filed 7/27/05, effective 8/27/05. Statutory Authority: RCW 41.05.160, 97-21-128, § 182-16-050, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.-010 and 34.05.250. 91-14-025, § 182-16-050, filed 6/25/91, effective 7/26/91.]

Chapter 182-20 WAC

STANDARDS FOR COMMUNITY HEALTH CLINICS

WAC

182-20-100	Administration.
182-20-160	Eligibility.

WAC 182-20-100 Administration. The authority shall contract with community health clinics to provide primary health care in the state of Washington by:

- (1) Developing criteria for the selection of community health clinics to receive funding;
- (2) Establishing statewide standards governing the granting of awards and assistance to community health clinics;
- (3) Disbursing funds appropriated for community health clinics only to those clinics meeting the criteria in WAC 182-20-160;
- (4) Distributing available state funds to community health clinics, including:
 - (a) Community health clinics that are private, nonprofit corporations classified exempt under Internal Revenue Service Rule 501 (c)(3) and governed by a board of directors including representatives from the populations served;
 - (b) Local health jurisdictions with an organized primary health clinic or division;
 - (c) Private nonprofit or public hospitals with an organized primary health clinic or department; and
 - (d) Tribal governments.
- (5) Reviewing records and conducting on-site visits of contractors or applicants as necessary to assure compliance with these rules; and
- (6) Withholding funding from a contractor or applicant until such time as satisfactory evidence of corrective action is received and approved by the authority, if the authority determines:
 - (a) Noncompliance with applicable state law or rule; or
 - (b) Noncompliance with the contract; or
 - (c) Failure to provide such records and data required by the authority to establish compliance with section 214(3), chapter 19, Laws of 1989 1st ex. sess., this chapter, and the contract; or
 - (d) The contractor or applicant provided inaccurate information in the application.

[Statutory Authority: RCW 41.05.160, 41.05.220, and 41.05.230. 10-05-046 (Order 09-04), § 182-20-100, filed 2/10/10, effective 3/13/10. Statutory Authority: RCW 41.05.160. 01-04-080 (Order 00-06), § 182-20-100, filed 2/7/01, effective 3/10/01. Statutory Authority: RCW 43.70.040. 95-12-010, § 182-20-100, filed 5/26/95, effective 6/26/95.]

WAC 182-20-160 Eligibility.

- Applicants shall:
- (1) Demonstrate private, nonprofit, tax exempt status incorporated in Washington state or public agency status under the jurisdiction of a local or county government;
 - (2) Receive other funds from at least one of the following sources:
 - (a) Section 329 of the Public Health Services Act;
 - (b) Section 330 of the Public Health Services Act;
 - (c) Community development block grant funds;
 - (d) Title V Urban Indian Health Service funds;
 - (e) Tribal governments; or
 - (f) Other public or private funds providing the clinic demonstrates:
 - (i) Fifty-one percent of total clinic population are low income;
 - (ii) Fifty-one percent or greater of funds come from sources other than programs under WAC 182-20-160;
 - (3) Operate as a community health clinic providing primary health care for at least eighteen months prior to applying for funding;
 - (4) Provide primary health care services with:
 - (a) Twenty-four-hour coverage of the clinic including provision or arrangement for medical and/or dental services after clinic hours;
 - (b) Direct clinical services provided by one or more of the following:
 - (i) Physician licensed under chapters 18.57 and 18.71 RCW;
 - (ii) Physician's assistant licensed under chapters 18.71A and 18.57A RCW;
 - (iii) Advanced registered nurse practitioner under chapter 18.79 RCW;
 - (iv) Dentist under chapter 18.32 RCW;
 - (v) Dental hygienist under chapter 18.29 RCW;
 - (c) Provision or arrangement for services as follows:
 - (i) Preventive health services on-site or elsewhere including:
 - (A) Eye and ear examinations for children;
 - (B) Perinatal services;
 - (C) Well-child services; and
 - (D) Family planning services;
 - (ii) Diagnostic and treatment services of physicians and where feasible a physician's assistant and/or advanced registered nurse practitioner, on-site;
 - (iii) Services of a dental professional licensed under Title 18 RCW on-site or elsewhere;
 - (iv) Diagnostic laboratory and radiological services on-site or elsewhere;
 - (v) Emergency medical services on-site or elsewhere;
 - (vi) Arrangements for transportation services;
 - (vii) Preventive dental services on-site or elsewhere; and
 - (viii) Pharmaceutical services, as appropriate, on-site or elsewhere;
 - (5) Demonstrate eligibility to receive and receipt of reimbursement from:
 - (a) Public insurance programs; and
 - (b) Public assistant programs, where feasible and possible;
 - (6) Have established for at least eighteen months an operating sliding scale fee schedule for adjustment of

charges, based upon the individual's ability to pay for low-income individuals;

(7) Provide health care regardless of the individual's ability to pay; and

(8) Establish policies and procedures reflecting sensitivity to cultural and linguistic differences of individuals served and provide sufficient staff with the ability to communicate with the individuals.

[Statutory Authority: RCW 41.05.160, 41.05.220, and 41.05.230. 10-05-046 (Order 09-04), § 182-20-160, filed 2/10/10, effective 3/13/10. Statutory Authority: RCW 41.05.160. 01-04-080 (Order 00-06), § 182-20-160, filed 2/7/01, effective 3/10/01. Statutory Authority: RCW 43.70.040. 95-12-010, § 182-20-160, filed 5/26/95, effective 6/26/95.]

Chapter 182-22 WAC

WASHINGTON HEALTH PLAN AND BASIC HEALTH PLAN ADMINISTRATION

WAC

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WAC 182-22-100 Authority. The administrator's authority to promulgate and adopt rules is contained in RCW 70.47.050.

[Statutory Authority: Chapter 70.47 RCW. 10-24-062 (Order 10-03), § 182-22-100, filed 11/30/10, effective 12/31/10.]

WAC 182-22-110 Definitions. The definitions in this section apply throughout chapters 182-22, 182-23, 182-24, and 182-25 WAC.

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

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

"Basic health plan" or "BHP" means the system of enrollment and payment for subsidized basic health care services administered by the HCA through managed health care systems.

"BHP Plus" means the program of expanded benefits available to children through coordination between the department of social and health services (DSHS) and BHP. 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.

"Copayment" means a payment indicated in the schedule of benefits which is made by an enrollee to a health care provider or to the managed health care system.

"Covered services" means those services and benefits in the applicable BHP or WHP schedule of benefits (as outlined in the member handbook), which an enrollee shall be entitled to receive from a managed health care system in exchange for payment of premium and applicable copayments, coinsurance and deductible.

"Dependent," as it applies to BHP or WHP, means:

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

(b) The child of the subscriber or the subscriber's dependent spouse, whether by birth, adoption, legal guardianship, or placement pending adoption, who is younger than age twenty-six, and who has not been relinquished for adoption by the subscriber or the subscriber's dependent spouse; or

(c) A person of any age who is incapable of self-support due to disability, and who is the unmarried child of the subscriber or the subscriber's dependent spouse, whether by birth, adoption, or legal guardianship; or

(d) A child younger than age twenty-six who is residing with the subscriber under an informal guardianship agreement. For a child to be considered a dependent of the subscriber under this provision:

(i) The guardianship agreement must be signed by the child's parent;

(ii) The guardianship agreement must authorize the subscriber to obtain medical care for the child;

(iii) The subscriber must be providing at least fifty percent of the child's support; and

(iv) The child must be on the account for coverage.

"Disenrollment" means the termination of coverage for an enrollee.

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

"Eligible full-time employee" means an employee who meets all applicable eligibility requirements 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 state.

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.

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

"Employee" means one who is in the employment of an employer, as defined under RCW 50.04.080.

"Employer" means an enterprise licensed to do business in Washington state, as defined under RCW 50.04.080, with

employees in addition to the employer, whose wages or salaries are paid by the employer.

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

"Family" means an individual or an individual and eligible spouse and dependents. For purposes of eligibility determination and enrollment, an individual cannot be a member of more than one family.

"Financial sponsor" means a person, organization or other entity, approved by the administrator, that is responsible for payment of all or a designated portion of the monthly premiums on behalf of a subscriber and any dependents.

"Health care authority" or "HCA" means the Washington state health care authority.

"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).

"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.

"Institutionalized" means to be confined, voluntarily or involuntarily, by court order or health status, in an institution, as defined in 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.

"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.

"Managed health care system" or "MHCS" means:

(a) 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 health care services; or

(b) A self-funded or self-insured method of providing insurance coverage to subsidized enrollees provided under RCW 41.05.140 and subject to the limitations under RCW 70.47.100(7).

"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.

"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.

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

"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.

"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.

"Participating employer" means an employer who has been approved for enrollment as an employer group.

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

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

(b) Medication was prescribed or recommended for the enrollee; or

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

"Premium" means a periodic payment, determined under RCW 70.47.060(2), which an individual, an employer, a financial sponsor, or other entity makes for enrollment in BHP or WHP.

"Program" means BHP, WHP, BHP Plus, maternity benefits through medical assistance, or other such category of enrollment specified within chapters 182-22 through 182-24 WAC.

"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.

"Rate" means the amount, including administrative charges and any applicable premium and prepayment tax imposed under RCW 48.14.0201, negotiated by the administrator with and paid to a managed health care system, to provide BHP or WHP health care benefits to enrollees.

"Schedule of benefits" means the health care services adopted and from time to time amended by the administrator for BHP or WHP, as applicable, which an enrollee shall be entitled to receive from a managed health care system in exchange for payment of premium and applicable copayments, as described in the member handbook.

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

"Subscriber" is a person who applies for coverage on his/her own behalf or on behalf of his/her dependents, if any, who is responsible for payment of premiums and to whom the

administrator sends notices and communications. The subscriber may be an enrollee or the spouse, parent, or guardian of an enrolled dependent and may or may not be enrolled for coverage. Notices to a subscriber and, if applicable, a financial sponsor or employer shall be considered notice to the subscriber and his/her enrolled dependents.

"Washington health program" means the system of enrollment and payment for nonsubsidized basic health care services administered by the HCA through managed health care systems.

"Washington state resident" or "resident" means a person who physically resides and maintains a residence in the state of Washington.

(a) To be considered a Washington resident, enrollees who are temporarily out of Washington state for any reason:

(i) May be required to demonstrate their intent to return to Washington state; and

(ii) May not be out of Washington state for more than three consecutive calendar months.

(b) Dependent children who are attending school out-of-state may be considered to be residents if they are out-of-state during the school year, provided their primary residence is in Washington state and they return to Washington state during holidays and scheduled breaks. Dependent children attending school out-of-state may also be required to provide proof that they pay out-of-state tuition at an accredited secondary school, college, university, technical college, or school of nursing, vote in Washington state and file their federal income taxes using a Washington state address.

(c) "Residence" may include, but is not limited to:

(i) A home the person owns or is purchasing or renting;

(ii) A shelter or other physical location where the person is staying in lieu of a home; or

(iii) Another person's home.

[Statutory Authority: Chapter 70.47 RCW, 10-24-062 (Order 10-03), § 182-22-110, filed 11/30/10, effective 12/31/10.]

WAC 182-22-210 Employer groups. (1) BHP and WHP may accept applications for group enrollment from business owners, their spouses and eligible dependents, and on behalf of their eligible full-time and/or part-time employees, their spouses and eligible dependents.

(2) With the exception of home care agencies, the employer must enroll at least seventy-five percent of all eligible employees within a classification of employees, and the employer must not offer other health care coverage to the same classification of employees. For purposes of this section, a "classification of employees" means a subgroup of employees (for example, part-time employees, full-time employees or bargaining units). Employees who demonstrate in the application process that they have health care coverage from other sources, such as their spouse or a federal program, shall be excluded from the minimum participation calculation.

(3) BHP and WHP may require a minimum financial contribution from the employer for each enrolled employee.

(4) The employer will provide the employees the complete choice of managed health care systems available within the employee's county of residence.

(5) The employer will pay all or a designated portion of the premium, as determined by the administrator, on behalf

of the enrollee. It is the employer's responsibility to collect the employee's portion of the premium and remit the entire payment to BHP or WHP, as applicable, and to notify BHP or WHP of any changes in the employee's account.

(6) In the event that an employer group will be disenrolled, all affected employee(s) will be notified prior to the disenrollment, and will be informed of the opportunity to convert their BHP or WHP group membership to individual account(s).

(7) Employees enrolling in BHP or WHP must meet all eligibility requirements.

[Statutory Authority: Chapter 70.47 RCW, 10-24-062 (Order 10-03), § 182-22-210, filed 11/30/10, effective 12/31/10.]

WAC 182-22-220 Home care agencies. BHP and WHP will accept applications from home care agencies under contract with the department of social and health services (DSHS) for group enrollment, with premiums paid by the home care agency or DSHS or a designee, under the provisions for employer groups with the following exceptions or additions:

(1) To qualify for premium reimbursement through DSHS, home care agencies who enroll under the provisions of this section must be under current contract with DSHS as a home care agency, as defined by DSHS.

(2) Home care agencies need not enroll at least seventy-five percent of all eligible employees in BHP or WHP, and home care agencies may offer other coverage to the same classification of employees.

(3) Home care agencies need not make a minimum financial contribution for each enrolled employee.

(4) Home care agencies are not subject to WAC 182-22-210(5).

(5) Individual home care providers may enroll in BHP or WHP as individuals.

[Statutory Authority: Chapter 70.47 RCW, 10-24-062 (Order 10-03), § 182-22-220, filed 11/30/10, effective 12/31/10.]

WAC 182-22-230 Financial sponsors. (1) A third party may, with the approval of the administrator, become a financial sponsor to BHP or WHP enrollees. Financial sponsors may not be a state agency or a managed health care system.

(2) BHP and WHP may require a minimum financial contribution from financial sponsors who are paid to deliver BHP or WHP services. Sponsors who meet the following criteria will be exempt from the minimum contribution:

(a) Organizations that are not paid to perform any function related to the delivery of BHP or WHP services, and do not receive contributions from other organizations paid to deliver BHP or WHP services;

(b) Charitable, fraternal or government organizations (other than state agencies) that are not paid to perform any function related to the delivery of BHP or WHP services, who receive contributions from other individuals or organizations who may be paid to deliver BHP or WHP services, if the organization can demonstrate all of the following:

(i) Organizational autonomy (the organization's governance is separate and distinct from any organization that is paid to deliver BHP services);

(ii) Financial autonomy and control over the funds contributed (contributors relinquish control of the donated funds);

(iii) Sponsored enrollees are selected by the sponsoring organization from all persons within the geographic boundaries established by the sponsor organization who meet the selection criteria agreed upon by the sponsor organization and the HCA; and

(iv) There is no direct financial gain to the sponsoring entity.

(c) Charitable, fraternal, or government organizations (other than state agencies) that are paid to perform a health care function related to the delivery of BHP services, if the organization can demonstrate all of the following:

(i) The organization's primary purpose is not the provision of health care or health care insurance, including activities as a third-party administrator or holding company;

(ii) There is organizational and financial autonomy (the organization's governance and funding of sponsored enrollees is separate and distinct from the function that is paid to deliver BHP services);

(iii) The selection of sponsored enrollees is made by the organization separate and distinct from the function that is paid to deliver BHP services, and sponsored enrollees are selected from all eligible persons who meet the selection criteria agreed upon by the sponsor organization and the HCA, who live within the geographic boundaries established by the sponsor organization; and

(iv) There is no direct financial gain to the sponsoring entity.

(3) The financial sponsor will establish eligibility for participation in that particular financial sponsor group; however, sponsored enrollees must meet all eligibility requirements.

(4) The financial sponsor will pay all or a designated portion of the premium on behalf of the sponsored enrollee. The financial sponsor must collect the enrollee's portion of the premium, if any, and remit the entire payment to BHP or WHP and to notify BHP or WHP of any changes in the sponsored enrollee's account.

(5) A financial sponsor must inform sponsored enrollees and BHP or WHP of the minimum time period for which they will act as sponsor. At least sixty days before the end of that time period, the financial sponsor must notify sponsored enrollees and BHP or WHP if the sponsorship will or will not be extended.

(6) A financial sponsor must not discriminate for or against potential group members based on health status, race, color, creed, political beliefs, national origin, religion, age, sex or disability.

(7) A financial sponsor must disclose to the sponsored enrollee all the managed health care systems within the enrollee's county of residence, the estimated premiums for each of them, and the BHP or WHP toll-free information number.

(8) BHP and WHP may periodically conduct a review of the financial sponsor group members to verify the eligibility of all enrollees.

[Statutory Authority: Chapter 70.47 RCW, 10-24-062 (Order 10-03), § 182-22-230, filed 11/30/10, effective 12/31/10.]

WAC 182-22-310 Where to find instructions for filing an appeal. (1) WAC 182-22-320 and 182-22-330 cover appeals submitted by or on behalf of BHP and WHP 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 chapter 388-526 WAC.

(2) WAC 182-22-320 covers appeals of decisions made by the health care authority, such as decisions regarding 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 182-22-330 covers appeals of decisions made by the enrollee's managed health care system (MHCS), such as decisions regarding coverage disputes or benefits interpretation.

[Statutory Authority: Chapter 70.47 RCW, 10-24-062 (Order 10-03), § 182-22-310, filed 11/30/10, effective 12/31/10.]

WAC 182-22-320 How to appeal health care authority (HCA) decisions. (1) HCA decisions regarding the following may be appealed under this section:

- (a) Eligibility;
- (b) Premiums;
- (c) Premium adjustments or penalties;
- (d) Enrollment;
- (e) Suspension;
- (f) Disenrollment; or
- (g) Selection of managed health care system (MHCS).

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

- (a) The name, mailing address, and BHP or WHP 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;
- (d) A statement explaining why the appealing party believes the decision was incorrect, outlining the facts surrounding the decision and including supporting documentation; and
- (e) If the appealing party is not an enrollee or the subscriber on the account, a signed agreement from the enrollee, authorizing the appealing party to act on his/her behalf.

(3) When an appeal is received, the HCA will send a notice to the appealing party, confirming that the appeal has been received and indicating when a decision can be expected. If the appealing party is not an enrollee on the affected account, the notice will also be sent to the subscriber.

(4) **Initial HCA decisions:** The HCA will conduct appeals according to RCW 34.05.485. The HCA appeals

committee or a single presiding officer designated by the HCA will review and decide the appeal. The appealing party may request an opportunity to be present in person or by telephone to explain his or her view. If the appealing party does not request an opportunity to be present to explain, the HCA appeals committee or presiding officer will review and decide the appeal based on the information and documentation submitted.

(5) The HCA will give priority handling to appeals regarding a loss of coverage for an enrollee with an urgent medical need that could seriously jeopardize the enrollee's life, health, or ability to regain maximum function, provided:

(a) The appeal is received within ten business days of the effective date of the loss of coverage; and

(b) The enrollee has clearly stated in the letter of appeal or has otherwise notified the HCA that he or she has an urgent medical need.

(6) For all other appeals, the HCA will send the appealing party written notice of the initial HCA decision within sixty days of receiving the letter of appeal. If the appealing party is not an enrollee on the affected account, the notice will also be sent to the subscriber. The notice will include the reasons for the initial decision and instructions on further appeal rights.

(7) **Review of initial HCA decision:** The initial HCA decision becomes the final agency decision unless the HCA receives a valid request for a review from the appealing party.

(a) To be a valid request for review, the appealing party's request may be either verbal or in writing, but must:

(i) Be received within thirty days of the date of the initial HCA decision.

(ii) Include a summary of the initial HCA decision being appealed and state why the appealing party believes the decision was incorrect; and

(iii) Provide any additional information or documentation that the appealing party would like considered in the review.

(b) Requests for review of an initial HCA decision regarding a disenrollment for nonpayment will be reviewed by the office of administrative hearings through a hearing conducted under chapter 34.12 RCW and RCW 34.05.488 through 34.05.494.

(c) All other requests for review of an initial HCA decision will be reviewed by a presiding officer designated by the HCA according to the requirements of RCW 34.05.488 through 34.05.494, with the following exception: These review decisions will be based on the record and documentation submitted, unless the presiding officer decides that an in-person or telephone hearing is needed. If an in-person or telephone hearing is needed, the presiding officer will decide whether to conduct the hearing as an informal hearing or formal adjudicative proceeding.

(d) The presiding officer will issue a written notice of the review decision, giving reasons for the decision, within twenty-one days of receiving the request for review, unless the presiding officer finds that additional time is needed for the decision.

(8) Enrollees who appeal a disenrollment decision that was based on eligibility issues and not related to premium payments may remain enrolled during the appeal process, provided:

(a) The appeal was submitted according to the requirements of this section; and

(b) The enrollee:

(i) Remains otherwise eligible;

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

(iii) 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) Enrollees who appeal 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: Chapter 70.47 RCW. 10-24-062 (Order 10-03), § 182-22-320, filed 11/30/10, effective 12/31/10.]

WAC 182-22-330 How to appeal a managed health care system (MHCS) decision. (1) Enrollees who are appealing an MHCS decision, including decisions related to coverage disputes; denial of claims; benefits interpretation; or resolution of complaints must follow their MHCS's complaint/appeals process.

(2) Each MHCS must maintain a complaint/appeals process for enrollees and must provide enrollees with instructions for filing a complaint and/or appeal. This complaint/appeals process must comply with the requirements of chapters 48.43 RCW and 284-43 WAC.

(3) On the request of the enrollee, the HCA may assist an enrollee by:

(a) Attempting to informally resolve complaints against the enrollee's MHCS;

(b) Investigating and resolving MHCS contractual issues; and

(c) Providing information and assistance to facilitate review of the decision by an independent review organization.

[Statutory Authority: Chapter 70.47 RCW. 10-24-062 (Order 10-03), § 182-22-330, filed 11/30/10, effective 12/31/10.]

WAC 182-22-410 Producers. 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 HCA's training program, will be paid a commission for assisting eligible applicants to enroll.

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

(2) Group policy commission: Subject to availability of funds, and as a pilot program, fees paid for the sale of 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.

(3) Insurance brokers or agents must provide the prospective applicant with the BHP or WHP toll-free information number and inform them of BHP or WHP benefits, limitations, exclusions, waiting periods, cost sharing, all MHCSs available to the applicant within his/her county of residence and the estimated premium for each of them.

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

(5) HCA will not pay renewal commissions.

[Statutory Authority: Chapter 70.47 RCW, 10-24-062 (Order 10-03), § 182-22-410, filed 11/30/10, effective 12/31/10.]

WAC 182-22-420 Application processing. Except as otherwise provided, applications for enrollment will be reviewed by HCA 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.

[Statutory Authority: Chapter 70.47 RCW, 10-24-062 (Order 10-03), § 182-22-420, filed 11/30/10, effective 12/31/10.]

WAC 182-22-430 Open enrollment. 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.

[Statutory Authority: Chapter 70.47 RCW, 10-24-062 (Order 10-03), § 182-22-430, filed 11/30/10, effective 12/31/10.]

WAC 182-22-450 MHCS duties. When an MHCS assists applicants in the enrollment process, it must provide them with the toll-free number for BHP or WHP and information on all MHCS available within the applicant's county of residence and the estimated premiums for each available MHCS.

[Statutory Authority: Chapter 70.47 RCW, 10-24-062 (Order 10-03), § 182-22-450, filed 11/30/10, effective 12/31/10.]

Chapter 182-23 WAC

WASHINGTON HEALTH PLAN

WAC

182-23-010	Definitions.
182-23-020	Eligibility.
182-23-040	Washington health benefits.
182-23-050	Premiums and cost sharing.
182-23-060	Enrollment in the plan.
182-23-070	Disenrollment from WHP.

WAC 182-23-010 Definitions. "Standard health questionnaire" or "SHQ" has the same meaning as described in RCW 48.43.018.

"WHP enrollee" or "nonsubsidized enrollee" means an individual who enrolls in WHP, as the subscriber or depen-

dent, and who pays or on whose behalf is paid the full costs for participation in WHP, without subsidy from the HCA.

[Statutory Authority: Chapter 70.47 RCW, 10-24-062 (Order 10-03), § 182-23-010, filed 11/30/10, effective 12/31/10.]

WAC 182-23-020 Eligibility. (1) To be eligible for enrollment in WHP, an individual may have any income level and must:

(a) Not be eligible for free or purchased medicare;

(b) Not be receiving medical assistance from the department of social and health services (DSHS);

(c) Not be enrolled in BHP;

(d) Not be confined or residing in a government-operated institution, unless he or she meets eligibility criteria adopted by the administrator;

(e) Be accepted for enrollment by the administrator as provided in RCW 48.43.018, either because the potential enrollee cannot be required to complete the standard health questionnaire or SHQ under RCW 48.43.018, or, based upon the results of the SHQ, the potential enrollee would not qualify for coverage under the Washington state health insurance pool;

(f) Reside in an area of the state served by a managed health care system participating in the plan;

(g) Choose to obtain coverage from a particular managed health care system; and

(h) Pay or have paid on their behalf the full costs for participation in the plan, including the cost of administration, without any subsidy from HCA.

(2) Persons not meeting these criteria, as evidenced by information submitted on the application for enrollment or otherwise obtained by WHP, will not be enrolled. An enrollee who is no longer a Washington resident or who is later determined to have failed to meet WHP's eligibility criteria at the time of enrollment, will be disenrolled.

[Statutory Authority: Chapter 70.47 RCW, 10-24-062 (Order 10-03), § 182-23-020, filed 11/30/10, effective 12/31/10.]

WAC 182-23-040 Washington health benefits. (1)

The administrator shall design and from time to time may revise WHP benefits, according to the requirements of chapter 70.47 RCW, as amended. These benefits will include physician services, prescription drugs and medications, and inpatient and outpatient hospital services, mental health care services, limited chemical dependency services, limited organ transplant services, and all services necessary for prenatal, postnatal and well-child care, and will emphasize proven preventive and primary care services. WHP benefits may include copayments, waiting periods, limitations and exclusions that the administrator determines are appropriate and consistent with the goals and objectives of the plan. WHP benefits will be subject to a nine-month waiting period for preexisting conditions. Exceptions (for example, children up to age nineteen, maternity, prescription drugs, services for a newborn or newly adopted child) are outlined in the schedule of benefits. Credit toward the waiting period will be given for any continuous period of time for which an enrollee was covered under similar health coverage if that coverage was in effect at any time during the three-month period immediately preceding the date of application for coverage under WHP. Similar coverage includes BHP; all DSHS programs administered by

the medical assistance administration which have the medic-aid scope of benefits; the DSHS program for the medically indigent; Indian health services; most coverages offered by health carriers; and most self-insured health plans. A list of WHP benefits, including copayments, waiting periods, limitations and exclusions, will be provided to the subscriber.

(2) In designing and revising WHP benefits, the administrator will consider the effects of particular benefits, copayments, limitations and exclusions on access to necessary health care services, as well as the cost to the enrollees and to the state, and also will consider generally accepted practices of the health insurance and managed health care industries.

(3) Before enrolling, WHP will provide each applicant with a written description of covered benefits. This includes a description of all copayments, waiting periods, limitations and exclusions. WHP will advise individuals how to access information on the services, providers, facilities, hours of operation, and information about the managed health care system(s) available to enrollees in a given service area.

(4) WHP will send to all subscribers written notice of any changes in the scope of benefits provided under WHP, or program changes that will affect premiums and member cost sharing at least thirty days prior to the due date of the premium payment for the month in which such revisions are to take effect. The administrator may make available a separate schedule of benefits for children, eighteen years of age and younger, for those dependent children in the plan.

[Statutory Authority: Chapter 70.47 RCW. 10-24-062 (Order 10-03), § 182-23-040, filed 11/30/10, effective 12/31/10.]

WAC 182-23-050 Premiums and cost sharing. (1) Subscribers or their employer or financial sponsor shall be responsible for paying the full monthly premium to WHP, on behalf of the subscriber and all enrolled dependents, according to the most current premium schedule.

(2) Once WHP has determined that an applicant and his/her dependents (if any) are eligible for enrollment, the applicant or employer or financial sponsor will be informed of the amount of the first month's premium for the applicant and his/her enrolled dependents. New enrollees will not be eligible to receive covered services on the effective date of enrollment specified by WHP unless the premium has been paid by the due date given. Thereafter, WHP will bill each subscriber or employer or financial sponsor monthly.

(3) Full payment for premiums due must be received by WHP by the date specified on the premium statement. If WHP does not receive full payment of a premium by the date specified on the premium statement, WHP shall issue a notice of delinquency to the subscriber, at the subscriber's last address on file with WHP or, in the case of group or financial sponsor coverage, to the employer or financial sponsor. If full payment is not received by the date specified in the delinquency notice, the subscriber and enrolled family members will be suspended from coverage for one month. If payment is not received by the due date on the notice of suspension, the subscriber and enrolled family members will be disenrolled effective the date of the initial suspension. If an enrollee's coverage is suspended more than two times in a twelve-month period, the enrollee will be disenrolled for non-payment as set forth herein. Partial payment of premiums due, payment which for any reason cannot be applied to the

correct WHP enrollee's account, or payment by check which is not signed, cannot be processed, or is returned due to non-sufficient funds will be regarded as nonpayment.

(4) Enrollees shall be responsible for paying any required copayment, coinsurance, or deductible directly to the provider of a covered service or directly to the MHCS.

[Statutory Authority: Chapter 70.47 RCW. 10-24-062 (Order 10-03), § 182-23-050, filed 11/30/10, effective 12/31/10.]

WAC 182-23-060 Enrollment in the plan. (1) Any individual applying for enrollment in WHP must submit a signed, completed WHP application and SHQ. Applications for enrollment of children under the age of eighteen must be signed by the child's parent or guardian, who shall also be held responsible for payment of premiums due on behalf of the child and for completion of the SHQ. 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.

(a) Applicants for enrollment must provide evidence of Washington state residence, for example, a valid Washington state driver's license number, a copy of a current utility bill or rent receipt. Other documentation may be accepted if the applicant does not have a physical residence, for example, a signed statement from a person or other entity who is providing temporary shelter.

(b) WHP may request additional information from applicants for purposes of establishing or verifying eligibility, premium responsibility, or MHCS selection.

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

(2) Each member may be enrolled in only one WHP account. Each family applying for enrollment must designate an MHCS 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 MHCS (with the exception of cases in which a subscriber who is paying for WHP coverage for his/her dependent who lives in a different service area). No applicant will be enrolled for whom designation of an MHCS has not been made as part of the application for enrollment. Procedures for the selection of MHCS are set forth in the WHP member handbook.

(3) Generally, enrollees may change from one MHCS to another only during open enrollment.

(a) If an enrollee moves to a new location in Washington state and their current MHCS is no longer available, they must choose an MHCS in their new service area (county). Until the family is enrolled in a new MHCS, only emergency services are covered in their new location.

(b) Enrollees meeting the requirements of (a) of this subsection are not required to reapply or complete the SHQ so long as there is not a gap in coverage longer than one month.

(4) Enrollees may change between the maximum benefit limits, but only when the subscriber completes a new application and SHQ. All individuals on an account are required to have the same maximum benefit limit.

(5)(a) Not all family members are required to apply for enrollment in WHP; however, any family member for whom application for enrollment is not made at the same time that other family members may apply at any time provided they complete and pass the SHQ, and are otherwise eligible.

(b) Addition of an eligible newborn child or a child newly placed for adoption provided WHP 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.

(6) Subscribers must notify WHP within thirty days of any changes that could affect their eligibility or their dependents' eligibility.

(7) Enrollees must annually submit documentation satisfactory to WHP. This process is called recertification and includes the following:

(a) Washington state residence;

(b) Medicare ineligibility for enrollees age sixty-five or over and enrollees who have been receiving Social Security disability benefits for twenty-four consecutive months or more;

(c) Enrollees who fail to comply with a recertification request will be disenrolled.

[Statutory Authority: Chapter 70.47 RCW, 10-24-062 (Order 10-03), § 182-23-060, filed 11/30/10, effective 12/31/10.]

WAC 182-23-070 Disenrollment from WHP. (1) An enrollee or employer group may disenroll effective the first day of any month by giving WHP at least ten days prior notice of the intention to disenroll.

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

(a) Failure to meet the WHP eligibility requirements;

(b) Nonpayment of premium;

(c) Changes in MHCS or program availability 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;

(d) Fraud, intentional misrepresentation of information or withholding information that the enrollee knew or should have known was material or necessary to accurately determine their eligibility or premium responsibility, failure to provide requested verification of eligibility, or knowingly providing false information;

(e) Abuse or intentional misconduct;

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

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

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

(4) At least ten days prior to the effective date of disenrollment, WHP 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 chapter 182-22 WAC.

(b) A 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.

(5) Enrollees who are notified that they will be disenrolled due to incomplete recertification documents shall not be disenrolled if they submit complete documents within thirty days after the disenrollment letter is mailed.

(6) Under the provisions of this subsection, WHP will suspend or disenroll enrollees and groups who do not pay their premiums when due. Partial payment or payment by check which cannot be processed or is returned due to non-sufficient funds will be regarded as nonpayment.

(a) At least ten days before coverage will lapse, WHP 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 final due date and a notice that WHP coverage will lapse unless payment is received by the final 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 final due date, as shown on the delinquency notice. WHP will send written notice of suspension to the subscriber, which will include:

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

(iv) Instructions for filing an appeal as provided in chapter 182-22 WAC.

(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, which will include:

(i) The effective date of the disenrollment; and

(ii) Instructions for filing an appeal as provided in WAC 182-22-310.

(7)(a) Unless otherwise specified, enrollees who voluntarily disenroll or are disenrolled from WHP may not reenroll

for a period of twelve months from the date their coverage ended and until all other requirements for enrollment have been satisfied. An exception to the twelve-month wait period will be made for:

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

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

(iii) Enrollees who were disenrolled by WHP 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, provided all enrollment requirements are met, if an MHCS begins accepting enrollment for their program in their area or if they become eligible and apply for another HCA program; and

(iv) Enrollees who were disenrolled for failing to provide requested documentation of eligibility for recertification or as otherwise requested by WHP, who provide all required documentation within six months of disenrollment and are eligible to reenroll. Reenrollment in the plan will not be retroactive and shall take place within forty-five days of WHP receiving complete reenrollment documents that verify eligibility.

(b) An enrollee who is required to wait twelve months for reenrollment under (a) of this subsection may not reenroll prior to the end of the required twelve-month wait.

[Statutory Authority: Chapter 70.47 RCW, 10-24-062 (Order 10-03), § 182-23-070, filed 11/30/10, effective 12/31/10.]

Chapter 182-24 WAC BASIC HEALTH PLAN

WAC

182-24-010	Definitions.
182-24-020	Eligibility.
182-24-025	How is income calculated?
182-24-030	Failure to report correct income.
182-24-040	BHP benefits.
182-24-050	Premiums and copayments.
182-24-060	Enrollment in the plan.
182-24-070	Disenrollment from BHP.

WAC 182-24-010 Definitions. The following definitions apply throughout this chapter.

"BHP enrollee," "subsidized enrollee," or "reduced premium enrollee" means an individual who is not a full-time student who has received a temporary visa to study in the United States and who otherwise meets the criteria in (a), (b), or (c) of this subsection.

(a) 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.

(b) An individual who enrolls in BHP, either as the subscriber or an eligible dependent, and who is a foster parent licensed under chapter 74.15 RCW and whose current gross family income does not exceed three hundred percent of 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.

(c) To the extent that state funds are specifically appropriated for this purpose, with a corresponding federal match, "subsidized enrollee" also means an individual who enrolls in BHP, either as the subscriber or an eligible dependent, whose current gross family income is more than two hundred percent, but less than two hundred fifty-one percent, of 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.

"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: Chapter 70.47 RCW, 10-24-062 (Order 10-03), § 182-24-010, filed 11/30/10, effective 12/31/10.]

WAC 182-24-020 Eligibility. (1) To be eligible for enrollment in BHP, unless otherwise specified elsewhere in this chapter, an individual must be a Washington state resident who:

(a) Is not eligible for free or purchased medicare;

(b) Is not receiving medical assistance from the department of social and health services (DSHS);

(c) Is not enrolled in WHP;

(d) Is not confined or residing in a government-operated institution, unless he or she meets eligibility criteria adopted by the administrator;

(e) Is not a full-time student who has received a temporary visa to study in the United States;

(f) Resides in an area of the state served by a managed health care system participating in the plan;

(g) Chooses to obtain coverage from a particular managed health care system;

(h) Pays or has paid on their behalf their portion of the costs for participation in the plan; and

(i) Whose gross family income at the time of enrollment meets the definition of a subsidized enrollee.

(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 or who is later determined to have failed to meet BHP's eligibility criteria at the time of enrollment, will be disenrolled.

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

(4)(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 BHP also may be denied enrollment if no managed health care system(s) is accepting new enrollment in that program or from the geographic area where the applicant lives.

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

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

(ii) Employees of a home care agency group enrolled or applying for coverage under WAC 182-22-220;

(iii) Eligible individual home care providers;

(iv) Licensed foster care workers;

(v) Persons who disenrolled from BHP in order to enroll in medicaid, and subsequently became ineligible for medicaid;

(vi) Limited enrollment of new employer groups;

(vii) Members of the Washington National Guard and Reserves who served in Operation Enduring Freedom, Operation Iraqi Freedom, or Operation Noble Eagle, and their spouses and dependents; 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 182-24-070 (7)(b) 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 enrollment, applicants for BHP who are not in any of the categories in (b) of this subsection may reserve space on a waiting list to be processed according to the date the waiting list request or application is received by BHP. When enrollment is reopened by the administrator, applicants whose names appear on the waiting list will be notified by BHP of the opportunity to enroll. BHP may require new application forms and documentation from applicants on the waiting list, or may contact applicants to verify continued interest in applying, before determining their eligibility.

[Statutory Authority: Chapter 70.47 RCW, 10-24-062 (Order 10-03), § 182-24-020, filed 11/30/10, effective 12/31/10.]

WAC 182-24-025 How is income calculated? "Gross family income" means total cash receipts, as defined in subsection (1) of this section, before taxes, from all sources, for subscriber and dependents regardless of whether they are enrolled in BHP, with the exceptions noted in subsection (2) of this section. An average of documented income received over a period of several months will be used for purposes of eligibility determination, unless documentation submitted confirms a change in circumstances so that an average would not be an accurate reflection of current income. A twelve-month average will be used when calculating gambling income, lump-sum payments, and income from capital gains. A twelve-month history of receipts and expenses will be

required for calculating self-employment or rental income unless the applicant or enrollee has not owned the business for at least twelve months.

(1) Income includes:

(a) Wages, tips, and salaries before any deductions;

(b) Net receipts from nonfarm self-employment (receipts from a person's own business, professional enterprise, or partnership, after deductions for business expenses). A net loss from self-employment will not be used to offset other income sources. In calculating net self-employment income, deductions will not be allowed for noncash-flow items such as depreciation, amortization, or business use of home, except that:

(i) A deduction for business use of the home may be allowed in cases where the enrollee has documented that more than fifty percent of their home is used for the business for the majority of the year; or

(ii) A deduction for business use of the home may be allowed in cases where the enrollee has documented that they maintain a separate building located on the same property as their home that is used exclusively for the business;

(c) 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). In calculating net self-employment income, deductions will not be allowed for noncash-flow items such as depreciation, amortization, or business use of home, and a net loss from self-employment will not be used to offset other income sources;

(d) Periodic payments from Social Security, railroad retirement, military pension or retirement pay, military disability pensions, military disability payments, government employee pensions, private pensions, unemployment compensation, workers' compensation, and strike benefits from union funds;

(e) Payments for punitive damages;

(f) Public assistance, alimony, child support, and military family allotments;

(g) Work study, assistantships, or training stipends;

(h) Dividends and interest accessible to the enrollee without a penalty for early withdrawal;

(i) Net rental income, net royalties, and net gambling or lottery winnings;

(j) Lump sum inheritances and periodic receipts from estates or trusts; and

(k) Short-term capital gains, such as from the sale of stock or real estate.

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

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

(b) Tax refunds, gifts, loans, one-time insurance payments, other than for punitive damages, and one-time payments or winnings received more than one month prior to application;

(c) Noncash receipts, 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, goods or services received due to payments a trust

makes to a third party, and such noncash benefit programs as medicare, medicaid, food stamps, school lunches, state supplementary payment income that is specifically dedicated to reimburse for services received, and housing assistance;

(d) Income earned by dependent children with the exception of distributions from a corporation, partnership, or business;

(e) 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;

(f) College or university scholarships, grants, and fellowships;

(g) Payments from the department of social and health services adoption support program authorized under RCW 26.33.320 and 74.13A.005 through 74.13A.080;

(h) Long-term capital gains;

(i) Crime victims' compensation;

(j) 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:

(i) The subscriber and the spouse listed as a dependent on the account, if any, must be employed or attending school during the time the child care expenses were paid; and

(ii) Payment may not be paid to a parent or stepparent of the child or to a dependent child of the subscriber or his/her spouse.

[Statutory Authority: Chapter 70.47 RCW, 10-24-062 (Order 10-03), § 182-24-025, filed 11/30/10, effective 12/31/10.]

WAC 182-24-030 Failure to report correct income.

(1) If BHP determines that the enrollee has received a subsidy overpayment due to failure to report income correctly, BHP may:

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

(b) If the overpayment was due to fraud, intentional misrepresentation of information, or withholding information that the enrollee knew or should have known was material or necessary to accurately determine the premium, impose civil penalties of up to two hundred percent of the subsidy overpayment.

(2) Any BHP determination under subsection (1) of this section is subject to the enrollee appeal provisions in chapter 182-22 WAC.

(3) When a decision under subsection (1)(a) of this section is final, BHP may establish a payment schedule and, for enrollees who remain enrolled in BHP, will collect the amount owed through future premium statements. Enrollees who disenroll prior to paying the full amount of the subsidy overpayment may continue the payment plan previously approved by BHP or may be billed for the entire amount due. BHP may charge interest for the amount past due, at the rate specified under RCW 43.17.230 and rules promulgated under that section. The payment schedule will be for a period of no more than six months, unless BHP approves an alternative payment schedule requested by the enrollee. When a payment schedule is established, BHP 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 182-24-070 (2)(b).

(4) When a final decision is made under subsection (1)(b) of this section, BHP will send the enrollee notice that payment of the civil penalty is due in full within thirty days after the decision becomes final, unless BHP 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 182-24-070 (2)(b).

(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 BHP has approved a payment schedule and all other requirements for enrollment have been met.

(6) BHP will take all necessary and appropriate administrative and legal actions to collect the unpaid amount of any subsidy overpayment or civil penalty, including recovery from the enrollee's estate.

(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 BHP 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 182-24-070 (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 182-22-210(2).

[Statutory Authority: Chapter 70.47 RCW, 10-24-062 (Order 10-03), § 182-24-030, filed 11/30/10, effective 12/31/10.]

WAC 182-24-040 BHP benefits. (1) The administrator shall design and from time to time may revise BHP benefits, according to the requirements of chapter 70.47 RCW, as amended. These benefits will include physician services, prescription drugs and medications, and inpatient and outpatient hospital services, mental health care services, limited chemical dependency services, limited organ transplant services, and all services necessary for prenatal, postnatal and well-child care, and will emphasize proven preventive and primary care services. The medicaid scope of benefits may be provided by BHP as the BHP Plus program through coordination with DSHS for children under the age of nineteen, who are found to be medicaid eligible. BHP benefits may include copayments, waiting periods, and limitations and exclusions which the administrator determines are appropriate and consistent with the goals and objectives of the plan. BHP benefits will be subject to a nine-month waiting period for preexisting conditions. Exceptions (for example, maternity, prescription drugs, services for a newborn or newly adopted child, dependent children up to age nineteen) are outlined in the schedule of benefits. Credit toward the waiting period will be given for any continuous period of time for which an enrollee was covered under similar health coverage if that coverage was in effect at any time during the three-month period immediately preceding the date of reservation or application for coverage

under BHP. Similar coverage includes BHP, WHP, all DSHS programs administered by the medical assistance administration which have the medicaid scope of benefits, the DSHS program for the medically indigent, Indian health services, most coverages offered by health carriers, and most self-insured health plans. A list of BHP benefits, including copayments, waiting periods, and limitations and exclusions will be provided to the subscriber.

(2) In designing and revising BHP benefits, the administrator will consider the effects of particular benefits, copayments, limitations and exclusions on access to necessary health care services, as well as the cost to the enrollees and to the state, and will also consider generally accepted practices of the health insurance and managed health care industries.

(3) Prior to enrolling in BHP, each applicant will be given a written description of covered benefits, including all copayments, waiting periods, limitations and exclusions, and be advised how to access information on the services, providers, facilities, hours of operation, and other information descriptive of the managed health care system(s) available to enrollees in a given service area.

(4) BHP will provide to all subscribers written notice of any changes in the scope of benefits provided under BHP, or program changes that will affect premiums and copayments at least thirty days prior to the due date of the premium payment for the month in which such revisions are to take effect. This subsection does not apply to premium changes that are the result of changes in income or family size. The administrator may make available a separate schedule of benefits for children, eighteen years of age and younger, for those dependent children in the plan.

[Statutory Authority: Chapter 70.47 RCW, 10-24-062 (Order 10-03), § 182-24-040, filed 11/30/10, effective 12/31/10.]

WAC 182-24-050 Premiums and copayments. (1)

Subscribers or their employer or financial sponsor are responsible for paying the full monthly premium to BHP, on behalf of the subscriber and all enrolled dependents, according to the most current premium schedule. A third party may, with the approval of the administrator, become a financial sponsor and pay all or a designated portion of the premium on behalf of a subscriber and dependents, if any.

(2) The amount of premium due from or on behalf of a subsidized enrollee will be based upon the subscriber's gross family income, the managed health care system selected by the subscriber, rates payable to managed health care systems, and the number and ages of individuals in the subscriber's family.

(3) Once BHP has determined that an applicant and his/her dependents (if any) are eligible for enrollment, the applicant or employer or financial sponsor will be informed of the amount of the first month's premium for the applicant and his/her enrolled dependents. New enrollees will not be eligible to receive covered services on the effective date of enrollment specified by BHP unless the premium has been paid by the due date given. Thereafter, BHP will bill each subscriber or employer or financial sponsor monthly.

(4) Full payment for premiums due must be received by BHP by the date specified on the premium statement. If BHP does not receive full payment of a premium by the date specified on the premium statement, BHP shall issue a notice of

delinquency to the subscriber, at the subscriber's last address on file with BHP or, in the case of group or financial sponsor coverage, to the employer or financial sponsor. If full payment is not received by the date specified in the delinquency notice, the subscriber and enrolled family members will be suspended from coverage for one month. If payment is not received by the due date on the notice of suspension, the subscriber and enrolled family members will be disenrolled effective the date of the initial suspension. If an enrollee's coverage is suspended more than two times in a twelve-month period, the subscriber and enrolled family members will be disenrolled for nonpayment under the provisions of WAC 182-24-060(2). Partial payment of premiums due, payment which for any reason cannot be applied to the correct BHP enrollee's account, or payment by check which is not signed, cannot be processed, or is returned due to nonsufficient funds, will be regarded as nonpayment.

(5) Enrollees shall be responsible for paying any required copayment, coinsurance, or deductible directly to the provider of a covered service or directly to the MHCS.

(6) Monthly premiums due for foster parents with gross family income up to two hundred percent of the federal poverty level will be set at the minimum premium amount charged to enrollees with income below sixty-five percent of the federal poverty level. Monthly premiums due for foster parents with gross family income between two hundred percent and three hundred percent of the federal poverty level will not exceed one hundred dollars per month.

[Statutory Authority: Chapter 70.47 RCW, 10-24-062 (Order 10-03), § 182-24-050, filed 11/30/10, effective 12/31/10.]

WAC 182-24-060 Enrollment in the plan. (1) Any individual applying for enrollment must submit a signed, completed application for enrollment. Applications for enrollment of children under the age of eighteen must be signed by the child's parent or 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 BHP Plus enrollment on behalf of children under the age of nineteen will be referred to the department of social and health services for medicaid eligibility determination.

(2) Each BHP or BHP Plus applicant must list all eligible dependents, regardless of whether the dependents will be enrolled, and must supply other information and documentation as required and where applicable by BHP and DSHS medical assistance.

(a) Applicants for BHP enrollment must provide documentation showing the amount and sources of their gross family income. Income documentation must include a copy of the applicant's most recently filed federal income tax form or verification of nonfiling status, and copies of pay stubs or other documents showing income for the most recent thirty days or complete calendar month as of the date of application. Applicants who were not required to file a federal income tax return may be required to provide other documentation showing year-to-date income. As described in WAC 182-22-210(5), BHP may use an average of documented income when determining eligibility.

(b) Applicants for BHP enrollment must provide documentation of Washington state residence, displaying the applicant's name and current address, for example, a copy of a current utility bill or rent receipt. Other documentation may be accepted if the applicant does not have a physical residence, for example, a signed statement from a person or other entity who is providing temporary shelter.

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

(d) Submission of incomplete or inaccurate information may delay or prevent an applicant's enrollment in BHP. Intentional submission of false information will 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 an MHCS 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 MHCS (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 an MHCS has not been made as part of the application for enrollment. Procedures for the selection of MHCS are set forth in the BHP member handbook. Generally, enrollees may change from one MHCS to another only during open enrollment or if they are able to show good cause for the transfer, for example, when enrollees move to an area served by a different MHCS or where they would be billed a higher premium for their current MHCS.

(4) When an MHCS 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) Except as otherwise provided in this chapter, applications for enrollment will be reviewed by BHP within thirty business 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.

(6)(a) 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:

(i) 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

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

(b) In the event a waiting list is implemented, eligible applicants will be enrolled in accordance with WAC 182-24-020.

(7) 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.

(8) 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;

(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; or

(d) Addition of a family member who was not previously eligible for coverage, and who has become eligible.

(9) Subscribers must notify BHP of any changes that could affect their eligibility or subsidy or their dependents' eligibility or subsidy:

(a) Within thirty days of the end of the first month of receiving an increased income; or

(b) Within thirty days of a change other than an income change (for example, a change in family size or address).

(10) BHP will verify the continuing eligibility of BHP enrollees through the recertification process at least once every twelve months. The recertification period begins upon completion of the previous recertification process. Upon request of BHP, subsidized enrollees must submit evidence satisfactory to BHP, proving their continued eligibility for enrollment and for the premium subsidy they are receiving.

(a) BHP will verify enrollees' income through comparison with other state and federal agency records or other third-party sources.

(b) If the enrollee's income on record with other agencies or third-party source differs from the income the enrollee has reported to BHP, or if questions arise concerning the documentation submitted, BHP will require updated documentation from the enrollee to prove continued eligibility for the subsidy they are receiving. At that time, BHP may also require updated documentation of residence to complete the recertification process.

(c) Enrollees who have been enrolled in BHP six months or more and have not provided updated income documentation for at least six months will be required to submit new income documentation if their wage or salary income cannot be compared to an independent source for verification. The six-month period begins upon completion of the previous recertification process.

(d) Enrollees who have documented that they are not required to file a federal income tax return for previous years will not be required to provide additional verification of non-

filing unless their circumstances appear to have changed or other information received indicates they have filed a federal income tax return.

(11) In addition to verification of income, BHP enrollees must annually submit documentation satisfactory to BHP of the following:

- (a) Washington state residence;
- (b) Full-time student status for dependent students age nineteen through twenty-five attending school out-of-state; and
- (c) Medicare ineligibility for enrollees age sixty-five or over and for enrollees who have been receiving Social Security disability benefits for twenty-four consecutive months or more.

(12) When determining eligibility for BHP enrollment, noncitizens may be required to provide proof of immigration status, to verify whether they are here on a temporary visa to study in the United States.

(13) For good cause such as, but not limited to, when information received indicates a change in income or a source of income the enrollee has not reported, BHP may require enrollees to provide verification required in subsections (10) and (11) of this section more frequently, regardless of the length of time since their last recertification.

(14) Enrollees who fail to comply with a recertification request will be disenrolled, according to the provisions of WAC 182-24-070 (2)(d).

(15) 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 182-24-030.

[Statutory Authority: Chapter 70.47 RCW, 10-24-062 (Order 10-03), § 182-24-060, filed 11/30/10, effective 12/31/10.]

WAC 182-24-070 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 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 BHP eligibility requirements;
- (b) Nonpayment of premium under the provisions of subsection (7) of this section;
- (c) Changes in MHCS or program availability 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;
- (d) Fraud, intentional misrepresentation of information, or withholding information that the enrollee knew or should have known was material or necessary to accurately determine their eligibility or premium responsibility, failure to provide requested verification of eligibility or income, or knowingly providing false information;
- (e) Abuse or intentional misconduct;
- (f) Danger or threat to the safety or property of the MHCS or the health care authority or their staff, providers, patients or visitors; and
- (g) Refusal to accept or follow procedures or treatment determined by an 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.

(3) 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.

(4) At least ten days before the effective date of disenrollment under subsection (2)(a) and (c) through (g) of this section, BHP will send the enrollee 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 chapter 182-22 WAC.

(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.

(5) 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 remain eligible for those programs.

(6) Enrollees who are notified that they will be disenrolled due to incomplete recertification documents shall not be disenrolled if they submit complete documents within thirty days after the disenrollment letter is mailed.

(7) 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, if any. Partial payment or payment by check which cannot be processed or is returned due to non-sufficient 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 final due date and a notice that BHP coverage will lapse unless payment is received by the final 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 final due date, as shown on the delinquency notice. BHP will send written notice of suspension to the subscriber, which will include:

- (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) Notification that the subscriber and any enrolled dependents will be disenrolled if payment is not received by the final due date; and
- (iv) Instructions for filing an appeal under WAC 182-22-310.

(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, which will include:

- (i) The effective date of the disenrollment; and
- (ii) Instructions for filing an appeal under WAC 182-22-310.

(8)(a) Unless otherwise specified in this chapter, and subject to the provisions of WAC 182-22-430, enrollees who voluntarily disenroll or are disenrolled from BHP may not reenroll for a period of twelve months from the date their coverage ended and until all other requirements for enrollment have been satisfied. An exception to this provision may 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;

(iii) Persons enrolling in BHP, who had enrolled and subsequently disenrolled from WHP under subsection (1) or (2)(b) of this section while on a waiting list for BHP, if otherwise eligible;

(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, provided all enrollment requirements are met, if an MHCS begins accepting enrollment for their program in their area or if they become eligible and apply for another HCA program; and

(v) Enrollees who were disenrolled for failing to provide requested documentation of income or eligibility for recertification or as otherwise requested by BHP, who provide all required documentation within six months of disenrollment and are eligible to reenroll. Reenrollment in the plan will not be retroactive and shall take place within forty-five days of BHP receiving complete reenrollment documents that verify eligibility; subject to the provisions of WAC 182-24-050.

(b) An enrollee who is required to wait twelve months for reenrollment under (a) of this subsection may not reenroll before the end of the required twelve-month wait. If an enrollee satisfies the required twelve-month wait after applying for BHP and while waiting to be offered coverage, enrollment will not be completed until funding is available to enroll him or her.

[Statutory Authority: Chapter 70.47 RCW. 10-24-062 (Order 10-03), § 182-24-070, filed 11/30/10, effective 12/31/10.]

Chapter 182-25 WAC

WASHINGTON BASIC HEALTH PLAN

WAC

182-25-120 Basic health plan coverage for health coverage tax credit eligible enrollees.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

182-25-001	Authority. [Statutory Authority: RCW 70.47.050. 96-15-024, § 182-25-001, filed 7/9/96, effective 8/9/96.] Repealed by 10-24-062 (Order 10-03), filed 11/30/10, effective 12/31/10. Statutory Authority: Chapter 70.47 RCW.
182-25-010	Definitions. [Statutory Authority: RCW 70.47.050. 07-20-079 (Order 07-04), § 182-25-010, filed 10/1/07, effective 11/1/07; 06-11-158 (Order 05-06), § 182-25-010, filed 5/24/06, effective 7/1/06. Statutory Authority: RCW 70.47.050 and 2005 c 188. 05-17-078 (Order 05-03), § 182-25-010, filed 8/12/05, effective 9/12/05. Statutory Authority: RCW 70.47.050 and 2004 c 192. 04-23-012 (Order 04-03), § 182-25-010, filed 11/5/04, effective 1/1/05. Statutory Authority: RCW 70.47.050, 70.47.020(4) and 70.47.060 (5) and (9). 03-18-039 (Order 02-01), § 182-25-010, filed 8/27/03, effective 10/1/03. Statutory Authority: RCW 70.47.050, 70.47.020 (4) and (5), 70.47.060 (9) and (10), 74.08A.100 and 2002 c 371. 02-24-051 (Order 02-06), § 182-25-010, filed 12/3/02, effective 1/1/03. Statutory Authority: RCW 70.47.050. 01-09-001 (Order 00-08), § 182-25-010, filed 4/4/01, effective 5/5/01. Statutory Authority: RCW 70.47.050 and 70.47.020 as revised by E2SSB 6067. 01-01-134 (Order 00-04), § 182-25-010, filed 12/20/00, effective 1/20/01. 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.] Repealed by 10-24-062 (Order 10-03), filed 11/30/10, effective 12/31/10. Statutory Authority: Chapter 70.47 RCW.
182-25-020	BHP benefits. [Statutory Authority: RCW 70.47.050 and 70.47.090. 02-19-053 (Order 01-08), § 182-25-020, filed 9/12/02, effective 10/13/02. Statutory Authority: RCW 70.47.050 and 70.47.060. 00-23-037, § 182-25-020, filed 11/9/00, effective 1/1/01. Statutory Authority: RCW 70.47.050. 98-07-002, § 182-25-020, filed 3/5/98, effective 4/5/98; 97-15-003, § 182-25-020, filed 7/3/97, effective 8/3/97; 96-15-024, § 182-25-020, filed 7/9/96, effective 8/9/96.] Repealed by 10-24-062 (Order 10-03), filed 11/30/10, effective 12/31/10. Statutory Authority: Chapter 70.47 RCW.
182-25-030	Eligibility. [Statutory Authority: RCW 70.47.050. 07-23-109 (Order 07-07), § 182-25-030, filed 11/21/07, effective 11/21/07. Statutory Authority: RCW 70.47.050 and 2006 c 343. 06-18-055 (Order 06-05), § 182-25-030, filed 8/31/06, effective 10/1/06. Statutory Authority: RCW 70.47.050 and 2004 c 192. 04-23-012 (Order 04-03), § 182-25-030, filed 11/5/04, effective 1/1/05. Statutory Authority: RCW 70.47.050 and 70.47.020 as revised by E2SSB 6067. 01-01-134 (Order 00-04), § 182-25-030, filed 12/20/00, effective 1/20/01. 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.] Repealed by 10-24-062 (Order 10-03), filed 11/30/10, effective 12/31/10. Statutory Authority: Chapter 70.47 RCW.
182-25-040	Enrollment in the plan. [Statutory Authority: RCW 70.47.050. 07-23-109 (Order 07-07), § 182-25-040, filed 11/21/07, effective 11/21/07; 06-11-158 (Order 05-06), § 182-25-040, filed 5/24/06, effective 7/1/06. Statutory Authority: RCW 70.47.050 and 2005 c 188. 05-17-078 (Order 05-03), § 182-25-040, filed 8/12/05, effective 9/12/05. Statutory Authority: RCW 70.47.050 and 2004 c 192. 04-23-012 (Order 04-03), § 182-25-040, filed 11/5/04, effective 1/1/05. Statutory Authority: RCW 70.47.050. 04-15-109 (Order 04-05), § 182-25-040, filed 7/20/04, effective 8/20/04. Statutory Authority: RCW 70.47.050, 70.47.060(9), and 2002 c 371 § 212(5). 02-19-054 (Order 01-07), § 182-25-040, filed

- 9/12/02, effective 10/13/02. 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.] Repealed by 10-24-062 (Order 10-03), filed 11/30/10, effective 12/31/10. Statutory Authority: Chapter 70.47 RCW.
- 182-25-050 Employer groups. [Statutory Authority: RCW 70.47-050. 96-15-024, § 182-25-050, filed 7/9/96, effective 8/9/96.] Repealed by 10-24-062 (Order 10-03), filed 11/30/10, effective 12/31/10. Statutory Authority: Chapter 70.47 RCW.
- 182-25-060 Home care agencies. [Statutory Authority: RCW 70.47.050. 96-15-024, § 182-25-060, filed 7/9/96, effective 8/9/96.] Repealed by 10-24-062 (Order 10-03), filed 11/30/10, effective 12/31/10. Statutory Authority: Chapter 70.47 RCW.
- 182-25-070 Financial sponsors. [Statutory Authority: RCW 70.47-050. 98-07-002, § 182-25-070, filed 3/5/98, effective 4/5/98; 96-15-024, § 182-25-070, filed 7/9/96, effective 8/9/96.] Repealed by 10-24-062 (Order 10-03), filed 11/30/10, effective 12/31/10. Statutory Authority: Chapter 70.47 RCW.
- 182-25-080 Premiums and copayments. [Statutory Authority: RCW 70.47.050. 07-20-079 (Order 07-04), § 182-25-080, filed 10/1/07, effective 11/1/07. Statutory Authority: RCW 70.47.050 and 2004 c 192. 04-23-012 (Order 04-03), § 182-25-080, filed 11/5/04, effective 1/1/05. Statutory Authority: RCW 70.47.050 and 70.47.090. 02-19-053 (Order 01-08), § 182-25-080, filed 9/12/02, effective 10/13/02. Statutory Authority: RCW 70.47.050. 98-07-002, § 182-25-080, filed 3/5/98, effective 4/5/98; 96-15-024, § 182-25-080, filed 7/9/96, effective 8/9/96.] Repealed by 10-24-062 (Order 10-03), filed 11/30/10, effective 12/31/10. Statutory Authority: Chapter 70.47 RCW.
- 182-25-085 Enrollees' failure to report correct income. [Statutory Authority: RCW 70.47.050, 70.47.060(9), and 2002 c 371 § 212(5). 02-19-054 (Order 01-07), § 182-25-085, filed 9/12/02, effective 10/13/02. 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.] Repealed by 10-24-062 (Order 10-03), filed 11/30/10, effective 12/31/10. Statutory Authority: Chapter 70.47 RCW.
- 182-25-090 Disenrollment from BHP. [Statutory Authority: RCW 70.47.050. 09-21-008 (Order 09-01), § 182-25-090, filed 10/8/09, effective 11/8/09. Statutory Authority: RCW 70.47.050 and 2004 c 192. 04-23-012 (Order 04-03), § 182-25-090, filed 11/5/04, effective 1/1/05. Statutory Authority: RCW 70.47.050. 03-24-040 (Order 03-05), § 182-25-090, filed 11/26/03, effective 12/27/03. Statutory Authority: RCW 70.47.050, 70.47.060(9), and 2002 c 371 § 212(5). 02-19-054 (Order 01-07), § 182-25-090, filed 9/12/02, effective 10/13/02. 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.] Repealed by 10-24-062 (Order 10-03), filed 11/30/10, effective 12/31/10. Statutory Authority: Chapter 70.47 RCW.
- 182-25-100 Where to find instructions for filing an appeal. [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.] Repealed by 10-24-062 (Order 10-03), filed 11/30/10, effective 12/31/10. Statutory Authority: Chapter 70.47 RCW.
- 182-25-105 How to appeal health care authority (HCA) decisions. [Statutory Authority: RCW 70.47.050. 01-23-095 (Order 00-01), § 182-25-105, filed 11/21/01, effective 1/1/02; 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.] Repealed by 10-24-062 (Order 10-03), filed 11/30/10, effective 12/31/10. Statutory Authority: Chapter 70.47 RCW.
- 182-25-110 How to appeal a managed health care system (MHCS) decision. [Statutory Authority: RCW 70.47.050. 01-23-095 (Order 00-01), § 182-25-110, filed 11/21/01, effective 1/1/02; 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.] Repealed by 10-24-062 (Order 10-03), filed 11/30/10, effective 12/31/10. Statutory Authority: Chapter 70.47 RCW.

WAC 182-25-120 Basic health plan coverage for health coverage tax credit eligible enrollees. (1) "Health coverage tax credit eligible enrollee" or "HCTC enrollee" means an individual or qualified dependent determined by the federal Department of the Treasury to be eligible for a tax credit, as defined under RCW 70.47.020 (3) and (4). In the event that the federal health coverage tax credit program is no longer available, HCTC enrollment in BHP will end.

(2) Eligibility for HCTC enrollment, as subscriber or dependent, is determined by the federal Health Coverage Tax Credit program. HCTC enrollees must provide proof of eligibility for HCTC enrollment, but are not required to also meet the eligibility criteria in WAC 182-23-020 or 182-24-020.

(3) Unless the enrollee has applied for, is eligible, and has enrolled as a BHP enrollee, the monthly premium due from or on behalf of an HCTC enrollee will be the full cost charged by the MHCS for coverage, plus the administrative cost of providing BHP coverage and the premium tax under RCW 48.14.0201.

(4) HCTC enrollees may pay the full premium for coverage to BHP or, if they are claiming the HCTC advance tax credit, may pay their portion of the premium to the federal HCTC program of the Internal Revenue Service (IRS) by the date required by the IRS.

(5) With the exception of subsections (3) and (7) of this section, BHP enrollees who are HCTC eligible will be subject to the rules for BHP enrollees.

(6) Notice of disenrollment will be sent to the HCTC enrollees for whom the premium has not been paid. This notice will be sent before the month of coverage, but will not be subject to the notification requirements in WAC 182-24-070(7). If payment is received no later than the first day of the month of coverage, the enrollee's coverage for that month will be reinstated.

(7) The nine-month waiting period for treatment of pre-existing conditions will be waived for HCTC enrollees who have had three months or more of creditable coverage, as defined under Public Law 104-191, without a break in coverage of more than sixty-two consecutive days at the time of application. Subsidized enrollees who are HCTC eligible, who provide proof of that eligibility to their MHCS, will be treated as HCTC enrollees for purposes of determining whether the preexisting condition waiting period can be waived.

(8) HCTC enrollees who disenroll may return to HCTC enrollment without being subject to the provisions of WAC 182-24-070(8).

(9) Because eligibility for the HCTC program is determined by the federal HCTC program at the Internal Revenue Service, BHP will not review appeals of eligibility for the HCTC program. Instructions on appealing an HCTC eligibil-

ity determination are available through the HCTC customer contact center.

[Statutory Authority: Chapter 70.47 RCW, 10-24-062 (Order 10-03), § 182-25-120, filed 11/30/10, effective 12/31/10. Statutory Authority: RCW 70.47.050 and 2004 c 192, 04-23-012 (Order 04-03), § 182-25-120, filed 11/5/04, effective 1/1/05.]

Chapter 182-26 WAC
WASHINGTON HEALTH INSURANCE
PARTNERSHIP (HIP) PROGRAM

WAC

182-26-100	Definitions.
182-26-230	Small employer one-time exception to monthly group premium payment deadline.
182-26-305	Applying for a HIP premium subsidy.
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182-26-350	What does the HIP count as income?

WAC 182-26-100 Definitions. "Administrator" means the administrator of the Washington state health care authority established under chapter 41.05 RCW.

"Appeal" means a formal written request to the HIP or its designee for resolution of problems or concerns that cannot be resolved informally. For the purposes of this chapter, "appeal" applies only to HIP decisions regarding subsidy determinations and employer eligibility for the HIP.

"Applicant" means:

- An eligible partnership participant who applies for a premium subsidy through the HIP on behalf of the eligible partnership participant and his or her dependents; or
- An eligible partnership participant who applies or reapplies for premium subsidy through the HIP on behalf of the eligible partnership participant and his or her dependents during the annual subsidy application and renewal period as described in WAC 182-26-320.

"Application" means a form developed by the administrator that an applicant must sign, complete, and submit to the administrator to apply for a premium subsidy through the HIP. To be considered complete, the application must be accompanied by all supporting documents as required and determined by the administrator.

"Benchmark health benefit plan" or "benchmark plan" means a health benefit plan selected by the board and upon which the subsidy scale shall be determined and from which the administrator will calculate an eligible partnership participant's premium subsidy.

"Board" or "HIP board" means the health insurance partnership board established under RCW 70.47A.100.

"Carrier" or "insurance carrier" means the same as defined in RCW 48.43.005.

"The department of social and health services" or "DSHS" means the department of social and health services as defined in RCW 43.20A.020.

"Dependent," for the purpose of determining subsidy eligibility, "dependent" means:

- (a) An eligible partnership participant's spouse, as defined under RCW 70.47A.901; or
- (b) The child of the partnership participant or participant's dependent spouse, whether by birth, adoption, legal guardianship, or placement pending adoption, and not given up for adoption, who is:

(i) Younger than age twenty-six; or

(ii) Is of any age, is not able to take care of himself or herself due to disability, and is under legal guardianship of the partnership participant or the participant's dependent spouse.

(c) A dependent may be placed on only one HIP account at any given time.

"Designated health benefit plan" means a health benefit plan selected by the board as eligible for offer through the HIP.

"Disenroll" or "disenrollment" means the termination of a partnership participants' enrollment in the HIP program. Decisions regarding eligibility or enrollment status for insurance coverage will be made by the carrier.

"Eligible partnership participant" means a partnership participant who:

- Is a resident of the state of Washington;
- Has a family income that does not exceed two hundred percent of the federal poverty level, as determined annually by the federal Department of Health and Human Services; and
- Is a health plan eligible employee as defined in this section that is enrolled or is applying to enroll in the participating small employer's offered coverage.

"Employee" has the same meaning as defined in RCW 48.43.005.

"Employer agreement" means a form developed by the administrator that a small employer must complete, sign, and submit to the administrator to request enrollment in the HIP.

"Health insurance partnership" or "HIP" means the health insurance partnership established in RCW 70.47A.-030.

"Health plan eligible employee" means an individual who meets the participating small employer's enrollment criteria.

"HIP account" means an account maintained by the administrator for each partnership participant that includes but is not limited to:

- Demographic information for participants and dependents, if any;
- Subsidy status;
- Carrier and plan enrollment status; and
- Other information as required by the administrator.

"Income" or "family gross income" means total cash receipts, as defined in WAC 182-26-345, before taxes, for participants and all dependents.

"Individual health benefit plan selection." Reserved.

The "office of the insurance commissioner" or "OIC" means the insurance commissioner as defined in RCW 48.02.010.

"Open enrollment" means a designated time period during which partnership participants may enroll additional dependents or make other changes to their employer-sponsored health benefit plan coverage.

"Participating small employer" means a small employer who:

- Enters into a written agreement with the HIP to purchase a designated health benefit plan through the HIP;
- Attests at the date of the agreement that the employer does not currently offer coverage, including insurance purchased through the small group and association health plan

markets, self-funded plans, and multiple employer welfare arrangements; and

- Attests at the date of the agreement that at least fifty percent of its employees are low-wage workers, as defined by the board.

"Partnership participant" means:

- A participating small employer as defined in this section;

- An employee of a participating small employer;
- A former employee of a participating small employer who chooses to continue coverage through the HIP following separation from employment, to the extent the employee is eligible for continuation of coverage under 29 U.S.C. Sec. 1161 et seq.; and

- A former employee of a participating small employer who chooses to continue coverage through HIP following separation from employment, to the extent determined by the board.

"Philanthropy" means a person, organization or other entity, approved by the administrator that is responsible for payment of all or part of the monthly premium obligation on behalf of a partnership participant.

"Premium" has the same meaning as described in RCW 48.43.005.

"Premium subsidy" or "subsidy" means payment to or reimbursement by the HIP on behalf of an eligible partnership participant toward the purchase of a designated health benefit plan.

"Qualifying change in family status" is defined in WAC 182-26-325.

"Section 125 plan" means a cafeteria plan compliant with section 125 of the federal Internal Revenue Code that enables employees to use pretax dollars to pay their share of their health benefit plan premium.

"Small employer" or "employer" as used in this chapter means an employer who meets the definition of "small employer" in RCW 48.43.005.

"Subsidy application and renewal period" means an annual period that lasts at least sixty days, during which:

- All partnership participants may apply for premium subsidies for themselves and their dependents; and
- All partnership participants receiving a subsidy are required to provide proof of their continuing eligibility for a premium subsidy.

The subsidy application and renewal period will begin ninety days before the employer-sponsored health benefit plan open enrollment period begins.

"Surcharge" means an amount, determined by the administrator, that may be added to a partnership participant's premium as provided for in WAC 182-26-500. The surcharge is not part of the premium and applies only to coverage purchased through the HIP.

"Washington state resident" means:

(a) A person who physically resides in and maintains a residence in the state of Washington.

(b) To be considered a Washington resident, individuals who are temporarily out of Washington state for any reason may be required to demonstrate their intent to return to Washington state.

(c) "Residence" may include, but is not limited to:

(i) A home the person owns or is purchasing or renting;

(ii) A shelter or other physical location where the person stays; or

(iii) Another person's home.

[Statutory Authority: RCW 41.05.160 and chapter 70.47A RCW. 10-22-039 (Order 10-04), § 182-26-100, filed 10/27/10, effective 11/27/10. Statutory Authority: RCW 70.47A.060. 08-22-041 (Order 08-02), § 182-26-100, filed 10/31/08, effective 12/1/08.]

WAC 182-26-230 Small employer one-time exception to monthly group premium payment deadline. The HIP program may grant small employers a one-time exception to the monthly group premium payment deadline as specified and agreed upon in the HIP employer agreement. Small employers are allowed to utilize the exception only once. To utilize the one-time exception, the small employer must satisfy all of the following three steps:

(1) The participating small employer must make a request to the HIP, in writing or over the phone, of its intent to utilize the one-time exception to the monthly group premium payment deadline.

(2) The participating small employer receives written acknowledgment from the HIP that its one-time payment deadline is approved; the exception must be received and approved by the last business day of the month preceding coverage.

(3) The participating small employer makes the full monthly group premium payment to the HIP by the 10th day of the month of coverage.

[Statutory Authority: RCW 41.05.160 and chapter 70.47A RCW. 10-22-039 (Order 10-04), § 182-26-230, filed 10/27/10, effective 11/27/10.]

WAC 182-26-305 Applying for a HIP premium subsidy. (1) To receive a HIP subsidy, an applicant must submit a complete application and all supporting documents as described in WAC 182-26-310 to the HIP.

(2) On a subsidy application, an applicant must list all eligible dependents up to age nineteen. The applicant must also provide other information and documents as required by the HIP.

(3) An applicant is not required to list dependents aged nineteen or over and under twenty-six on the application, but if they are listed on the application, the HIP will include the dependents' income for purposes of subsidy eligibility and calculation.

(4) An applicant is not required to apply for a subsidy for all of his or her dependents. However, any dependent that does not apply for a subsidy at the same time that the other family members apply must wait to apply as a dependent until the next subsidy application and renewal period.

[Statutory Authority: RCW 41.05.160 and chapter 70.47A RCW. 10-22-039 (Order 10-04), § 182-26-305, filed 10/27/10, effective 11/27/10. Statutory Authority: RCW 70.47A.060. 08-22-041 (Order 08-02), § 182-26-305, filed 10/31/08, effective 12/1/08.]

WAC 182-26-340 How does the HIP determine the premium subsidy amount? (1) The HIP will apply a sliding scale subsidy schedule based on the partnership participant's family gross income and family size to determine the percentage of the employee's premium obligation the state will pay.

(2) The percentage in subsection (1) of this section will be applied to the health benefit plan employee premium share, including the amount due for dependents' coverage, remaining after deducting the employer contribution and a philanthropic contribution if applicable from the total premium amount for that participant.

(3) If a participating small employer chooses a health benefit plan with a higher premium than the benchmark plan, the subsidy will not exceed the amount applicable to the benchmark plan.

(4) In no case will the subsidy percentage exceed ninety percent of the plan employee's premium share after all contributions.

(5) Once enrolled in the HIP, the subsidy percentage will not change until the next subsidy application and renewal period, even if the total premium share changes because of a qualifying change in family status.

[Statutory Authority: RCW 41.05.160 and chapter 70.47A RCW. 10-22-039 (Order 10-04), § 182-26-340, filed 10/27/10, effective 11/27/10. Statutory Authority: RCW 70.47A.060. 08-22-041 (Order 08-02), § 182-26-340, filed 10/31/08, effective 12/1/08.]

[Statutory Authority: RCW 41.05.160 and chapter 70.47A RCW. 10-22-039 (Order 10-04), § 182-26-350, filed 10/27/10, effective 11/27/10. Statutory Authority: RCW 70.47A.060. 08-22-041 (Order 08-02), § 182-26-350, filed 10/31/08, effective 12/1/08.]

WAC 182-26-350 What does the HIP count as income? Income includes all of the following, before any deductions (gross income):

Source	Received by the participant, spouse, child dependent aged nineteen or over and under twenty-six, or adult dependent	Received by a dependent child under age nineteen
Wages, tips, and salaries	Yes	No
Taxable interest	Yes	Yes
Ordinary dividends	Yes	Yes
Taxable refunds, credits, or offsets of state and local income taxes	Yes	Yes
Alimony received	Yes	N/A
Business income or loss	Yes	Yes
Capital gain or loss	Yes	Yes
Other gains or losses	Yes	Yes
IRA distributions	Yes	Yes
Pensions and annuities	Yes	N/A
Rental real estate, royalties, partnerships, S corporations	Yes	Yes
Farm income	Yes	Yes
Unemployment compensation	Yes	No
Social Security benefits	Yes	Yes
Other income	Yes	Yes