Title 182 WAC

HEALTH CARE AUTHORITY

Chapters

Chapter 182-08 WAC
PROCEDURES

WAC

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" 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. 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 182-08-120 Employer contribution. The employers' contribution must be used to provide insurance coverage for the basic life insurance benefit, the basic long-term disability benefit, medical, and dental, and to establish a reserve for any remaining balance. There is no employer contribution available for any other insurance coverage for employees employed by state agencies.

[Statutory Authority: RCW 41.05.160. 09-23-102 (Order 09-02), § 182-08-120, filed 11/17/09, effective 1/1/10; 07-20-129 (Order 07-01), § 182-08-120, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.165. 03-17-031 (Order 02-07), § 182-08-120, filed 8/14/03, effective 9/14/03. Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-120, filed 3/29/96, effective 4/29/96; 86-16-061 (Resolution No. 86-3), § 182-08-120, filed 8/5/86; 83-22-042 (Resolution No. 6-83), § 182-08-120, filed 10/28/83; Order 3-77, § 182-08-120, filed 11/17/77; Order 7228, § 182-08-120, filed 12/8/76.]

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 of PEBB insurance coverage.

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 when eligible for life insurance conversion.

PEBB premiums 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. 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 182-08-190 The employer contribution is set by the HCA and paid to the HCA for all eligible employees. State agencies and employer groups that participate in the PEBB program under contract with the HCA must pay premium contributions to the HCA for insurance coverage for all eligible employees and their dependents.

(1) Employer contributions for state agencies set by the HCA are subject to the approval of the governor for availability of funds as specifically appropriated by the legislature for that purpose. Insurance and health care contributions for ferry employees shall be governed by RCW 47.64.270.

(2) Employer contributions must include an amount determined by the HCA to pay administrative costs to administer insurance coverage for employees of these groups.

(3) Each employee of a state agency eligible under WAC 182-12-131 or each eligible employee of a state agency on leave under the federal Family and Medical Leave Act (FMLA) is eligible for the employer contribution. The entire employer contribution is due and payable to HCA even if medical is waived.

(4) Employees of employer groups eligible under criteria stipulated under contract with the HCA are eligible for the employer contribution. The entire employer contribution is due and payable to the HCA even if medical is waived.

(5) Washington state patrol officers disabled while performing their duties as determined by the chief of the Washington state patrol are eligible for the employer contribution for PEBB benefits as authorized in RCW 43.43.040. No other retiree or disabled employee is eligible for the employer contribution for PEBB benefits unless they are an eligible employee as defined in WAC 182-12-114 or 182-12-131.

(6) The terms of payment to HCA for employer groups shall be stipulated under contract with the HCA.

[Statutory Authority: RCW 41.05.160. 09-23-102 (Order 09-02), § 182-08-190, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-08-190, filed 10/1/08, effective 1/1/09; 07-20-129 (Order 07-01), § 182-08-190, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-08-190, filed 8/26/04, effective 1/1/05; 03-17-031 (Order 02-07), § 182-08-190, filed 8/14/03, effective 9/14/03. Statutory Authority: RCW 41.05.160. 02-18-088 (Order 02-03), § 182-08-190, filed 9/3/02, effective 10/4/02. Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-190, filed 3/29/96, effective 4/29/96; 93-23-065, § 182-08-190, filed 11/16/93, effective 12/17/93; 78-02-015 (Order 2-78), § 182-08-190, filed 1/10/78; Order 3-77, § 182-08-190, filed 11/17/77.]

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 no longer available.

[Statutory Authority: RCW 41.05.160. 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; and

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

(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 FSA or 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. 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 acquires a new eligible dependent through marriage, registering a domestic partnership with Washington state, birth, adoption or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption, legal custody or legal guardianship;

(b) Subscriber's dependent child becomes eligible by fulfilling PEBB dependent eligibility criteria;

(c) Subscriber loses an eligible dependent or a dependent no longer meets PEBB eligibility criteria;

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

(e) Subscriber or a dependent loses comprehensive group health coverage;

(f) Subscriber or a dependent has a change in employment status that affects the subscriber's or a dependent's eligibility, level of benefits, or cost of insurance coverage;

(g) Subscriber or a dependent has a change in residence that affects health plan availability, benefits, or cost of insurance coverage. 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;

(h) 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;

(i) 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 in such a medical assistance program;

(j) A dependent dies;

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

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

(m) 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. 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 their election under the premium payment plan, medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP)? (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 end of the annual open enrollment. The enrollment or new election will begin 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 begin the first day of the month following approval by the administrator. For purposes of this section, an eligible dependent includes the employee's opposite sex spouse and any other person who qualifies as the employee's dependent under Section 152 of the IRC 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 under Section 152 of the IRC. The following changes are events that create a special open enrollment for purposes of an eligible employee making a change:

(a) Employee acquires a new eligible dependent;

(b) Employee's dependent child becomes eligible by fulfilling PEBB dependent eligibility criteria;

(c) Employee loses an eligible dependent or a dependent no longer meets PEBB eligibility criteria;

(d) Employee has a change in marital status, including legal separation documented by a court order;

(e) Employee or a dependent has a change in employment status that affects the employee's or a dependent's eligibility, level of benefits, or cost of insurance coverage under a plan provided by the employee's employer or the dependent's employer;

(f) Employee's or a dependent's residence changes that affects health plan availability, level of benefits, or cost of insurance coverage;

(g) 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;

(h) 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 subscriber or dependent loses eligibility in such a medical assistance program;

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

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

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

(l) In addition to (a) through (k) 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) 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. 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.]

WAC 182-08-200 Which employing agency is responsible to pay the employer contribution for eligible employees changing agency employment or for faculty employed by more than one institution of higher education? Employing agencies responsible for paying the employer contribution:

(1) **For eligible employees changing agencies:** When an eligible employee's employment relationship terminates with an employing agency at any time before the end of the month for which a premium contribution is due and that employee transfers to another agency, the losing agency is responsible for the payment of the contribution for that employee for that month. The receiving agency would not be liable for any employer contribution for that eligible employee until the month following the transfer.

(2) **For eligible faculty employed by more than one institution of higher education:**

(a) When a faculty is eligible for the employer contribution during an anticipated work period (quarter, semester or instructional year), under WAC 182-12-131(3), one institution will pay the entire cost of the employer contribution if the employee would be eligible by virtue of employment at that single institution. Otherwise:

(i) Each institution contributes based on its percentage of the employee's total work at all institutions during the anticipated work period.

(ii) The institution with the greatest percentage coordinates with the other institutions and is responsible for sending the total premium payment to HCA.

(b) When a faculty is eligible for the employer contribution during the summer or off-quarter/semester, under WAC 182-12-131 (3)(c), one institution will pay the entire cost of the employer contribution if the employee would be eligible by virtue of employment at that single institution. Otherwise:

(i) Each institution contributes based on its percentage of the employee's total work at all institutions throughout the instructional year or equivalent nine-month period.

(ii) The institution with the greatest percentage coordinates with the other institutions and is responsible for sending the total premium payment to HCA.

(c) When a faculty is eligible through two-year averaging under WAC 182-12-131 (3)(d) for the employer contribution, one institution will pay the entire cost of the employer contribution if the employee would be eligible by virtue of employment at that single institution. Otherwise:

(i) Each institution contributes to coverage based on its percentage of the employee's total work at all institutions throughout the preceding two academic years. This division of the employer contribution begins the summer quarter or semester following the second academic year and continues through that academic year or until eligibility under two-year averaging ceases.

Note: "Academic year" means summer, fall, winter, and spring quarters or summer, fall, and spring semesters, in that order.

(ii) The institution with the greatest percentage coordinates with the other institutions and is responsible for sending the total premium payment to HCA.

[Statutory Authority: RCW 41.05.160. 09-23-102 (Order 09-02), § 182-08-200, filed 11/17/09, effective 1/1/10; 07-20-129 (Order 07-01), § 182-08-200, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-08-200, filed 8/26/04, effective 1/1/05. Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-200, filed 3/29/96, effective 4/29/96; Order 3-77, § 182-08-200, filed 11/17/77.]

WAC 182-08-230 Participation in PEBB benefits by employer groups, including K-12 school districts and educational service districts. This section applies to all employer groups as defined in WAC 182-08-015.

(1) Each employer group determines employee and dependent eligibility for PEBB insurance coverage in accordance with the criteria outlined in its contract with HCA.

(2) Each employer group is responsible for premium payments and billing arrangements in accordance with the criteria outlined in its contract with HCA.

[Statutory Authority: RCW 41.05.160. 09-23-102 (Order 09-02), § 182-08-230, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-08-230, filed 10/1/08, effective 1/1/09; 07-20-129 (Order 07-01), § 182-08-230, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-08-230, filed 8/26/04, effective 1/1/05.]

Chapter 182-12 WAC
ELIGIBLE AND NONELIGIBLE EMPLOYEES

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

182-12-112 Insurance eligibility for higher education. [Statutory Authority: RCW 41.05.160. 08-20-128 (Order 08-03), § 182-12-112, filed 10/1/08, effective 1/1/09; 07-20-129 (Order 07-01), § 182-12-112, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-112, filed 8/26/04, effective 1/1/05.] Repealed by 09-23-102 (Order 09-02), filed 11/17/09, effective 1/1/10. Statutory Authority: RCW 41.05.160.

182-12-115 Eligible employees. [Statutory Authority: RCW 41.05.160. 07-20-129 (Order 07-01), § 182-12-115, filed 10/3/07, effective 11/3/07; 06-12-002 (Order 06-01), § 182-12-115, filed 5/25/06, effective 6/25/06; 05-17-132 (Order 04-04), § 182-12-115, filed 8/19/05, effective 9/2/05. Statutory Authority: RCW 41.05.160 and 41.05.165. 03-17-031 (Order 02-07), § 182-12-115, filed 8/14/03, effective 9/14/03. Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-115, filed 3/29/96, effective 4/29/96; 92-08-003, § 182-12-115, filed 3/18/92, effective 3/18/92; 91-14-084, § 182-12-115, filed 7/1/91, effective 7/1/91. Statutory Authority: RCW 41.05.065(3). 90-12-037, § 182-12-115, filed 5/31/90, effective 7/1/90. Statutory Authority: RCW 41.05.065. 89-12-045 (Resolution No. 89-2), § 182-12-115, filed 6/2/89; 89-01-053 (Resolution No. 88-6), § 182-12-115, filed 12/15/88. Statutory Authority: RCW 41.05.010. 88-19-078 (Resolution No. 88-4), § 182-12-115, filed 9/19/88; 88-12-034 (Resolution No. 88-1), § 182-12-115, filed 5/26/88, effective 7/1/88. Statutory Authority: Chapter 41.05 RCW. 86-21-042 (Resolution No. 86-6), § 182-12-115, filed 10/10/86; 83-12-007 (Order 2-83), § 182-12-115, filed 5/20/83; 80-05-016 (Order 2-80), § 182-12-115, filed 4/10/80; 78-08-071 (Order 5-78), § 182-12-115, filed 7/26/78; Order 5646, § 182-12-115, filed 2/9/76.] Repealed by 09-23-102 (Order 09-02), filed 11/17/09, effective 1/1/10. Statutory Authority: RCW 41.05.160.

182-12-121 Does a change in position or job affect eligibility status? [Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-121, filed 8/26/04, effective 1/1/05. Statutory Authority: Chapter 41.05 RCW. 80-01-082 (Order 5-79), § 182-12-121, filed 12/27/79.] Repealed by 09-23-102 (Order 09-02), filed 11/17/09, effective 1/1/10. Statutory Authority: RCW 41.05.160.

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" 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. 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) Each participating school district or educational service district must agree to collect an employee premium by health plan and family size that is not less than that paid by state employees.

(c) 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. 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 182-12-113 What are the obligations of a state agency in the application of employee eligibility? (1) All state agencies must carry out all actions, policies, and guidance issued by the PEBB program necessary for the operation of benefit plans, education of employees, claims administration, and appeals process including that described in chapters 182-08, 182-12, and 182-16 WAC. State agencies must:

(a) Use the methods provided by the PEBB program to determine eligibility and enrollment in benefits, unless otherwise approved in writing;

(b) Provide eligibility determination reports with content and in a format designed and communicated by the PEBB program or otherwise as approved in writing by the PEBB program; and

(c) Carry out corrective action and pay any penalties imposed by the authority and established by the board when the state agency's eligibility determinations fail to comply with the criteria under these rules.

(2) All state agencies must determine employee eligibility for PEBB benefits and employer contribution according to the criteria in WAC 182-12-114 and 182-12-131. State agencies must:

(a) Notify newly hired employees of PEBB rules and guidance for eligibility and appeal rights;

(b) Provide written notice to faculty who are potentially eligible for benefits and employer contribution of their potential eligibility under WAC 182-12-114(3) and 182-12-131;

(c) Inform an employee in writing whether or not he or she is eligible for benefits upon employment. The written communication must include a description of any hours that are excluded in determining eligibility and information about the employee's right to appeal eligibility and enrollment decisions;

(d) Routinely monitor all employees' eligible work hours to establish eligibility and maintain the employer contribution toward insurance coverage;

(e) Make eligibility determinations based on the criteria of the eligibility category that most closely describes the employee's work circumstances per the PEBB program's direction;

(f) Identify when a previously ineligible employee becomes eligible or a previously eligible employee loses eligibility; and

(g) Inform an employee in writing whether or not he or she is eligible for benefits and the employer contribution whenever there is a change in work patterns such that the employee's eligibility status changes. At the same time, state agencies must inform employees of the right to appeal eligibility and enrollment decisions.

[Statutory Authority: RCW 41.05.160. 09-23-102 (Order 09-02), § 182-12-113, filed 11/17/09, effective 1/1/10.]

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.** PEBB benefits begin on the first day of the month following the date an employee becomes eligible. If the employee becomes eligible on the first working day of a month, 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.** PEBB benefits begin on the first day of the month following the day the employee becomes eligible. If the employee becomes eligible on the first working day of a month, 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 may be considered consecutive quarters/semesters when first establishing eligibility.

(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. 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) **PEBB benefits begin.**

(i) PEBB benefits 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, PEBB benefits begin on that date.

(ii) For faculty hired on a quarter/semester to quarter/semester basis under (a)(ii) of this subsection, PEBB benefits begin the first day of the month following the beginning of the second 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, 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) **PEBB benefits begin.** PEBB benefits for an eligible employee begin on the first day of the month following the day he or she becomes eligible. If the employee becomes eligible on the first working day of a month, 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) **PEBB benefits begin.** PEBB benefits for an eligible employee begin on the first day of the month following the day he or she becomes eligible. If the employee becomes eligible on the first working day of a month, PEBB benefits begin on that date.

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

WAC 182-12-116 Who is eligible to participate in the state's salary reduction plan? (1) Employees of state agencies are eligible to participate in the state's salary reduction plan provided they are eligible for PEBB benefits as defined in WAC 182-12-114 and they elect to participate within the time frames described in WAC 182-08-197 or 182-08-199.

(2) Employees of employer groups, as defined in WAC 182-12-109, are not eligible to participate in the state's salary reduction plan.

[Statutory Authority: RCW 41.05.160. 09-23-102 (Order 09-02), § 182-12-116, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-12-116, filed 10/1/08, effective 1/1/09; 07-20-129 (Order 07-01), § 182-12-116, filed 10/3/07, effective 11/3/07; 06-11-156 (Order 06-02), § 182-12-116, 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), § 182-12-116, filed 7/27/05, effective 8/27/05.]

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 stack to establish or maintain eligibility under WAC 182-12-114(3) with two or more state

institutions of higher education will be enrolled according to WAC 182-08-200(2).

[Statutory Authority: RCW 41.05.160. 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, with the exception of adult dependents who may enroll in a health plan if the employee has waived medical coverage.

(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 changes are events that create a special open enrollment:

(a) Employee acquires a new eligible dependent through marriage, registering a domestic partnership with Washington state, birth, adoption or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption, legal custody or legal guardianship;

(b) Employee's dependent child becomes eligible by fulfilling PEBB dependent eligibility criteria;

(c) Employee loses an eligible dependent or a dependent no longer meets PEBB eligibility criteria;

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

(e) Employee or a dependent loses comprehensive group insurance coverage;

(f) Employee or a dependent has a change in employment status that affects the employee's or a dependent's eligibility, level of benefits, or cost of insurance coverage;

(g) Employee or a dependent has a change in place of residence that affects the employee's or a dependent's eligibility, level of benefits, or cost of insurance coverage;

(h) Employee receives a court order or medical support enforcement order requiring the employee, spouse, or qualified domestic partner to enroll an eligible dependent;

(i) 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 month in which the event occurs.

[Statutory Authority: RCW 41.05.160. 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 182-12-129 What happens when an employee moves from an eligible to an otherwise ineligible position or job due to a layoff? This section applies to employees employed by state agencies (as defined in this chapter), including benefits-eligible seasonal employees, and is intended to address situations where an employee moves from one position or job to another due to a layoff, as defined in WAC 182-12-109. This section does not apply to employees with an anticipated end date.

If an employee moves from an eligible to an otherwise ineligible position due to layoff, the employee may retain his or her eligibility for the employer contribution toward insurance coverage for each month that the employee is in pay status for at least eight hours. To maintain eligibility using this section the employee must:

- Be hired into a position with a state agency within twenty-four months of the original eligible position ending; and
- Upon hire, notify the employing agency that he or she is potentially eligible to use this section.

This section ceases to apply if the employee is employed in a position eligible for PEBB benefits under WAC 182-12-114 within twenty-four months of leaving the original position.

After the twenty-fourth month, the employee must reestablish eligibility under WAC 182-12-114.

[Statutory Authority: RCW 41.05.160. 09-23-102 (Order 09-02), § 182-12-129, filed 11/17/09, effective 1/1/10.]

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 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. 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 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. Employees may continue any combination of medical, dental and life insurance; however, only employees on approved educational leave 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. 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 182-12-136 May an employee on approved educational leave waive continuation coverage? In order to avoid duplication of group health plan coverage, the following shall apply to employees during any period of approved educational leave. Employees eligible for continuation coverage provided in WAC 182-12-133 who obtain comprehensive health plan coverage under another group plan may waive continuance of such coverage for each full calendar month in which they maintain coverage under the other comprehensive group health plan. These employees have the right to reenroll in a PEBB health plan effective the first day of the month after the date the other comprehensive group health plan coverage ends, provided evidence of such other comprehensive group health plan coverage is provided to the PEBB program upon application for reenrollment.

[Statutory Authority: RCW 41.05.160. 09-23-102 (Order 09-02), § 182-12-136, filed 11/17/09, effective 1/1/10; 07-20-129 (Order 07-01), § 182-12-136, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-136, filed 8/26/04, effective 1/1/05.]

WAC 182-12-138 What options are available if an employee is approved for the federal Family and Medical Leave Act (FMLA)? (1) Employees on approved leave under the federal Family and Medical Leave Act (FMLA) may continue to receive the employer contribution toward insurance coverage in accordance with the federal FMLA. These employees may also continue current optional life and long-term disability. The employee's employing agency is responsible for determining if the employee is eligible for leave under FMLA and the duration of such leave. 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) If an employee exhausts the period of leave approved under FMLA, insurance coverage may be continued by self-

paying the full premium set by the HCA, with no contribution from the employer, under WAC 182-12-133(1) while on approved leave.

[Statutory Authority: RCW 41.05.160. 09-23-102 (Order 09-02), § 182-12-138, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-12-138, filed 10/1/08, effective 1/1/09; 07-20-129 (Order 07-01), § 182-12-138, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-138, filed 8/26/04, effective 1/1/05.]

WAC 182-12-141 If I revert from an eligible position to another position, what happens to my insurance coverage? (1) If you have reverted for reasons other than a layoff and are not eligible for the employer contribution toward insurance coverage under this chapter, you 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 you are reverted due to a layoff:

(a) You may be eligible for the employer contribution toward insurance coverage under the criteria of WAC 182-12-129; or

(b) You 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. 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, during their off-season(s). 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. 09-23-102 (Order 09-02), § 182-12-142, filed 11/17/09, effective 1/1/10.]

WAC 182-12-146 What options for continuation coverage are available to subscribers and dependents who become eligible under COBRA? (1) Employees and eligible dependents who become ineligible for the employer contribution toward PEBB insurance coverage and who qualify for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) may continue their medical and dental by self-paying the full premium set by the HCA in accordance with COBRA statutes and regulations.

(2) An employee or an employee's dependent who is no longer eligible for continuation coverage as described in WAC 182-12-133, 182-12-138, 182-12-141, 182-12-142, or 182-12-148, but who has not used the maximum number of months allowed under COBRA, may continue medical and dental for the remaining difference in months by self-paying the premium under COBRA as described in subsection (1) of this section.

(3) Retired and disabled employees who become ineligible for PEBB retiree insurance because an employer group, with the exception of school districts and educational service districts, ceases participation in PEBB insurance coverage may continue their medical and dental by self-paying the full premium set by the HCA, in accordance with COBRA statutes and regulations.

[Statutory Authority: RCW 41.05.160. 09-23-102 (Order 09-02), § 182-12-146, filed 11/17/09, effective 1/1/10; 07-20-129 (Order 07-01), § 182-12-146, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-146, filed 8/26/04, effective 1/1/05.]

WAC 182-12-148 What options for continuation coverage are available to employees during their appeal of dismissal? (1) Employees awaiting hearing of a dismissal action before any of the following may continue their insurance coverage by self-paying the full premium set by the HCA, with no contribution from the employer, on the same terms as an employee who is granted leave as described in WAC 182-12-133:

(a) The personnel resources board;

(b) An arbitrator; or

(c) A grievance or appeals committee established under a collective bargaining agreement for union represented employees.

(2) If the dismissal is upheld, all insurance coverage will end at the end of the month in which the decision is entered, or the date to which premiums have been paid, whichever is earlier, with the exception described in subsection (3) of this section.

(3) If the dismissal is upheld and the employee is eligible under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), the employee may continue medical and dental for the remaining months available under COBRA. See WAC 182-12-146 for information on COBRA. The number of months the employee self-paid premiums during the appeal will count toward the total number of months allowed under COBRA.

(4) If the board, arbitrator, committee, or court sustains the employee in the appeal and directs reinstatement of employer paid insurance coverage retroactively, the employ-

ing agency must forward to HCA the full employer contribution for the period directed by the board, arbitrator, committee, or court and collect from the employee the employee's share of premiums due, if any.

(a) HCA will refund to the employee any premiums the employee paid that may be provided for as a result of the reinstatement of the employer contribution only if the employee makes retroactive payment of any employee contribution amounts associated with the insurance coverage. In the alternative, at the request of the employee, HCA may deduct the employee's contribution from the refund of any premiums self-paid by the employee during the appeal period.

(b) All optional life and long-term disability insurance which was in force at the time of dismissal shall be reinstated retroactively only if the employee makes retroactive payment of premium for any such optional coverage which was not continued by self-payment during the appeal process. If the employee chooses not to pay the retroactive premium, evidence of insurability will be required to restore such optional coverage.

[Statutory Authority: RCW 41.05.160. 09-23-102 (Order 09-02), § 182-12-148, filed 11/17/09, effective 1/1/10; 07-20-129 (Order 07-01), § 182-12-148, 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), § 182-12-148, filed 7/27/05, effective 8/27/05. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-148, filed 8/26/04, effective 1/1/05.]

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 182-12-115) 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. 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 182-12-175 May a local government entity or tribal government entity applying for participation in PEBB insurance coverage include their retirees in the transfer unit? Local government or tribal government entities applying for participation in PEBB insurance coverage under WAC 182-12-111(2), may request inclusion of retired employees who are covered under their retiree health plan at the time of application. The PEBB program will use the following criteria for approval of these requests for inclusion of retirees.

(1) The local government or tribal government retiree health plan must have existed at least three years before the date of application for participation in PEBB health plans.

(2) Eligibility for coverage under the local government's or tribal government's retiree health plan must have required immediate enrollment in retiree health plan coverage upon termination of employee coverage.

(3) The retiree must have maintained continuous enrollment in their local government or tribal government retiree health plan.

(4) To protect the integrity of the risk pool, if total local government or tribal government retiree enrollment exceeds ten percent of the total PEBB retiree population, the PEBB program may:

(a) Stop approving inclusion of retirees with local government or tribal government unit transfers; or

(b) May adopt a new rating methodology reflective of the cost of covering local government or tribal government retirees.

(5) Retirees and dependents included in the transfer unit are subject to the enrollment and eligibility rules outlined in chapters 182-08, 182-12 and 182-16 WAC.

(6) Employees eligible for retirement subsequent to the local government or tribal government transferring to PEBB health plan coverage must meet retiree eligibility as outlined in chapter 182-12 WAC.

[Statutory Authority: RCW 41.05.160. 09-23-102 (Order 09-02), § 182-12-175, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-12-175, filed 10/1/08, effective 1/1/09; 07-20-129 (Order 07-01), § 182-12-175, 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), § 182-12-175, filed 7/27/05, effective 8/27/05.]

WAC 182-12-200 May a retiree who is enrolled as a dependent in a PEBB health plan or a Washington state K-12 school district sponsored health plan defer enrollment in a PEBB retiree health plan? Retirees who are enrolled in a PEBB or Washington state K-12 school district sponsored medical plan as a dependent may defer enrollment in a PEBB retiree health plan. Retirees who defer enrollment in medical cannot remain enrolled in dental. Retirees who defer may later enroll themselves and their dependents in PEBB retiree medical, or medical and dental, if they provide evidence of continuous enrollment in a PEBB or K-12 school district sponsored medical plan. Continuous enrollment must be from the date the retiree deferred enrollment in retiree insurance. Retirees may enroll:

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

(2) No later than sixty days after enrollment in the PEBB or K-12 school district sponsored medical plan ends. (Enrollment in the PEBB health plan will begin the first day of the

month after the PEBB or K-12 school district health plan ends.)

[Statutory Authority: RCW 41.05.160. 09-23-102 (Order 09-02), § 182-12-200, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-12-200, filed 10/1/08, effective 1/1/09; 07-20-129 (Order 07-01), § 182-12-200, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-200, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160. 01-17-041 (Order 01-00), § 182-12-200, filed 8/9/01, effective 9/9/01; 97-21-127, § 182-12-200, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-200, filed 3/29/96, effective 4/29/96; Order 4-77, § 182-12-200, filed 11/17/77.]

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 and for adult dependents as defined in WAC 182-12-260 (3)(d), 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. 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 182-12-207 When can a retiree or eligible dependent's insurance coverage be canceled by HCA? A retiree or eligible dependent's insurance coverage can be canceled by HCA for the following reasons:

(1) Failure to comply with the PEBB program's procedural requirements, including failure to provide information or documentation requested by the due date in written requests from the PEBB program;

(2) Knowingly providing false information;

(3) Failure to pay the premium when due or an underpayment of premium;

(4) Misconduct. If a retiree's insurance coverage is canceled for misconduct, insurance coverage will not be reinstated at a later date. Examples of such termination include, but are not limited to the following:

(a) Fraud, intentional misrepresentation or withholding of information the subscriber knew or should have known was material or necessary to accurately determine eligibility or the correct premium; or

(b) Abusive or threatening conduct repeatedly directed to an HCA employee, a health plan or other HCA contracted vendor providing insurance coverage on behalf of the HCA, its employees, or other persons.

If a retiree's insurance coverage is canceled by HCA for the above reasons, insurance coverage for all of the retiree's eligible dependents is also canceled.

[Statutory Authority: RCW 41.05.160. 09-23-102 (Order 09-02), § 182-12-207, filed 11/17/09, effective 1/1/10; 07-20-129 (Order 07-01), § 182-12-207, filed 10/3/07, effective 11/3/07.]

WAC 182-12-208 May a retiree enroll only in dental? If an enrollee is enrolled in retiree insurance coverage, he or she may not enroll in dental unless he or she is also enrolled in medical.

[Statutory Authority: RCW 41.05.160. 09-23-102 (Order 09-02), § 182-12-208, filed 11/17/09, effective 1/1/10; 07-20-129 (Order 07-01), § 182-12-208, filed 10/3/07, effective 11/3/07.]

WAC 182-12-209 Who is eligible for retiree life insurance? Eligible employees who participate in PEBB life insurance as an employee and meet qualifications for retiree insurance coverage as provided in WAC 182-12-171 are eligible for PEBB retiree life insurance. They must submit the appropriate forms to the PEBB program no later than sixty days after the date their PEBB employee life insurance ends.

(1) Employees whose life insurance premiums are being waived under the terms of the life insurance contract are not eligible for retiree term life insurance until their waiver of premium benefit ends.

(2) Retirees may not defer enrollment in retiree term life insurance.

(3) If a retiree returns to active employee status in an employing agency, he or she must continue to self-pay retiree life insurance premiums in order to maintain retiree term life insurance (even while participating in PEBB employee life insurance).

[Statutory Authority: RCW 41.05.160. 09-23-102 (Order 09-02), § 182-12-209, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-12-209, filed 10/1/08, effective 1/1/09; 07-20-129 (Order 07-01), § 182-12-209, filed 10/3/07, effective 11/3/07.]

WAC 182-12-211 If department of retirement systems makes a formal determination of retroactive eligibility, may the retiree enroll in PEBB retiree insurance coverage? (1) When the Washington state department of retirement systems (DRS) makes a formal determination that a person is retroactively eligible for pension benefits that person may apply for enrollment in a PEBB health plan only if application is made within sixty days after the date of notice from DRS.

(2) All premiums due from the date of eligibility established by DRS or the date of the DRS decision letter, at the option of the retiree, must be sent with the application to the PEBB program.

(3) The administrator may make an exception to the date PEBB retiree insurance coverage commences or payment of premiums; however, such requests must demonstrate extraordinary circumstances beyond the control of the retiree.

[Statutory Authority: RCW 41.05.160. 09-23-102 (Order 09-02), § 182-12-211, filed 11/17/09, effective 1/1/10; 07-20-129 (Order 07-01), § 182-12-211, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-211, 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 unmarried children of the emergency service worker who are under the age of twenty-five. 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). For children age twenty through age twenty-four who enroll and are not students under the age of twenty-four attending high school or registered at an accredited secondary school, college, university, vocational school, or school of nursing: The adult dependent premium 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, 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. 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 periodically and reserves the right to request documents from subscribers 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) Unmarried children through age nineteen.

(b) Married children through age nineteen who qualify as dependents of the subscriber under the Internal Revenue Code.

(c) Students: Unmarried children age twenty through age twenty-three who are attending high school or are registered students at an accredited secondary school, college, university, vocational school, or school of nursing. A married child is eligible as a student if the child is a dependent of the subscriber under the Internal Revenue Code.

(i) A child is eligible as a student or can maintain eligibility as a student when not registered for courses through the summer or off quarter/semester as long as the child meets all other eligibility requirements and is in any one of the following circumstances:

• The child attended the three consecutive quarters or two consecutive semesters before the off quarter/semester.

• The child recently graduated. Graduation is defined as the successful completion of studies to earn a degree or cer-

tificate, not the date of the graduation ceremony. The child is eligible for the three month period following graduation.

(ii) For student dependents who are not eligible for the summer or off quarter/semester according to (c)(i) of this subsection, student eligibility begins the first day of the month of the quarter or semester for which the child is registered, and eligibility ends the last day of the month in which the student is registered or in which the quarter or semester ends, whichever is first.

Exception: If a student becomes seriously ill or injured and requires a medically necessary leave of absence from attending school, his or her coverage may continue if qualified under and in accordance with the federal Michelle's Law (Public Law 110-381).

(d) Adult dependents: Unmarried children age twenty through age twenty-four.

Subscriber must pay the adult dependent premium for adult dependents whom the subscriber has enrolled.

Adult dependents must enroll in the same health plan as the subscriber.

Exception: The adult dependent may enroll in a different health plan than the subscriber if the dependent does not reside within the subscriber's plan service area or the subscriber has waived or deferred medical.

(e) Children of any age with disabilities, developmental disabilities, mental illness or mental retardation who are incapable of self-support, provided such condition occurs before age twenty or during the time the dependent was eligible as a student under (c) of this subsection.

The subscriber must provide evidence that such disability occurred as stated below:

(i) For a child enrolled in PEBB insurance coverage, the subscriber must provide evidence of the disability within sixty days of the child's attainment of age twenty.

(ii) For a child enrolled in PEBB insurance coverage as a student under (c) of this subsection, the subscriber must provide evidence of the disability within sixty days after the student is no longer eligible under (c) of this subsection.

(iii) For a child, age twenty or older, who is a new dependent or for a child, age twenty or older, who is a dependent of a newly eligible subscriber, the child may be enrolled as a dependent child with disabilities if the subscriber provides evidence that the condition occurred before the child reached age twenty or evidence that when the condition occurred the child would have satisfied PEBB eligibility for student coverage under (c) of this subsection had the subscriber been eligible for PEBB benefits at the time.

The subscriber must notify the PEBB program, in writing, no later than sixty days after the date that a child age twenty 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. The child may be eligible to continue enrollment as an adult dependent, as per (d) of this subsection, or in a PEBB health plan under provisions of WAC 182-12-270.

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

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. 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. The subscriber must be enrolled to enroll his or her dependent.

Exceptions:
- Adult dependents may enroll in a health plan if the employee has waived medical coverage or the retiree has deferred enrollment in PEBB retiree insurance in accordance with PEBB rule;

OR

- Eligible dependents of a retiree may enroll in a health plan if the retiree deferred PEBB retiree insurance coverage due to the retiree's enrollment in medicare and creditable medicaid under WAC 182-12-205 (1)(c).

(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 after the dependent lost eligibility;

(iii) The subscriber may not be able to recover subscriber-paid insurance premiums that included 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 subsection (3) of this section. The dependent will be removed the last day of the month following the date corresponding to the event that creates the special open enrollment.

(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 acquires an eligible dependent through marriage, registering a domestic partnership with Washington state, birth, adoption or when a subscriber has assumed a legal obligation for total or partial support in anticipation of adoption, legal custody or legal guardianship;

(b) A dependent becomes eligible by fulfilling PEBB dependent eligibility criteria under WAC 182-12-250 or 182-12-260;

(c) Subscriber loses an eligible dependent or a dependent no longer meets PEBB eligibility criteria;

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

(e) Subscriber or a dependent loses comprehensive group health insurance coverage;

(f) Subscriber or a dependent has a change in employment status that affects the subscriber's or a dependent's eligibility, level of benefits, or cost of insurance coverage;

(g) Subscriber or a dependent has a change in place of residence that affects the subscriber's or a dependent's eligibility, level of benefits, or cost of insurance coverage;

(h) Subscriber receives a court order or medical support enforcement order requiring the subscriber, their 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.);

(i) Subscriber 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 subscriber or dependent loses eligibility in such a medical assistance program; or

(j) Subscriber or dependent dies.

(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 end 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 or older as a child with disabilities, the subscriber must submit the appropriate enrollment form(s) required to certify the dependent's eligibility within the relevant time frame described in WAC 182-12-250(3) or 182-12-260(3).

(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. 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.]

WAC 182-12-265 What options for continuing health plan enrollment are available to widows, widowers and dependent children if the employee or retiree dies? The surviving dependent of an eligible employee or retiree who meets the eligibility criteria in subsection (1), (2), or (3) of this section is eligible to enroll in PEBB retiree insurance coverage as a surviving dependent. An eligible surviving spouse, Washington state registered domestic partner, or child must enroll in or defer enrollment in a PEBB medical plan no later than sixty days after the date of the employee's or retiree's death.

(1) Dependents who lose eligibility due to the death of an eligible employee may continue enrollment in a PEBB health plan enrollment as a survivor under retiree insurance coverage provided they immediately begin receiving a monthly retirement benefit from any state of Washington sponsored retirement system.

(a) The employee's spouse or Washington state registered domestic partner may continue health plan enrollment until death.

(b) Children may continue health plan enrollment until they lose eligibility under PEBB rules.

(c) If a surviving spouse, Washington state registered domestic partner, or child of an eligible employee is not eligible for a monthly retirement benefit (or a lump-sum payment because the monthly pension payment would be less than the minimum amount established by the department of retirement systems) the dependent is not eligible for PEBB retiree insurance as a survivor. However, the dependent may continue health plan enrollment under provisions of the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) or WAC 182-12-270.

(d) The two federal retirement systems, Civil Service Retirement System and Federal Employees Retirement System, shall be considered a Washington sponsored retirement system for Washington State University extension service employees who were covered under PEBB insurance coverage at the time of death.

(2) Dependents who lose eligibility due to the death of a PEBB eligible retiree may continue health plan enrollment under retiree insurance.

(a) The retiree's spouse or Washington state registered domestic partner may continue health plan enrollment until death.

(b) Children may continue health plan enrollment until they lose eligibility under PEBB rules.

(c) Dependents, who are not enrolled in a PEBB health plan at the time of the retiree's death, are eligible to enroll or defer enrollment in PEBB retiree insurance. A form to enroll or defer PEBB health plan enrollment must be hand-delivered or mailed to the PEBB program no later than sixty days after the retiree's death. To enroll in a PEBB health plan, the dependent must provide satisfactory evidence of continuous enrollment in other medical coverage from the most recent open enrollment for which enrollment in PEBB was deferred.

(3) Surviving spouses, Washington state registered domestic partners, or eligible children of a deceased school district or educational service district employee who were not enrolled in PEBB insurance coverage at the time of the subscriber's death may enroll in a PEBB health plan provided the employee died on or after October 1, 1993, and the dependent(s) immediately began receiving a retirement benefit allowance under chapter 41.32, 41.35 or 41.40 RCW.

(a) The employee's spouse or Washington state registered domestic partner may continue health plan enrollment until death.

(b) Children may continue health plan enrollment until they lose eligibility under PEBB rules.

(4) Surviving dependents must notify the PEBB program of their decision to enroll or defer enrollment in a PEBB health plan no later than sixty days after the date of death of the employee or retiree. If PEBB health plan enrollment ended due to the death of the employee or retiree, PEBB will reinstate health plan enrollment without a gap subject to payment of premium. In order to avoid duplication of group medical coverage, surviving dependents may defer enrollment in a PEBB health plan under WAC 182-12-200 and 182-12-205. To notify the PEBB program of their intent to enroll or defer enrollment in a PEBB health plan, the surviving dependent must submit the appropriate forms to the PEBB program no later than sixty days after the date of death of the employee or retiree.

[Statutory Authority: RCW 41.05.160. 09-23-102 (Order 09-02), § 182-12-265, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-12-265, filed 10/1/08, effective 1/1/09; 07-20-129 (Order 07-01), § 182-12-265, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.068. 06-23-165 (Order 06-09), § 182-12-265, 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), § 182-12-265, filed 7/27/05, effective 8/27/05. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-265, filed 8/26/04, effective 1/1/05.]

WAC 182-12-270 What options for continuation coverage are available to dependents who cease to meet the eligibility criteria in WAC 182-12-260? If eligible, dependents may continue health plan enrollment under one of the continuation coverage options in subsection (1) or (2) of this section by self-paying the full premiums set by the HCA, with no contribution from the employer, following their loss of eligibility under the subscriber's health plan coverage. The PEBB program must receive the appropriate forms as outlined in the *PEBB Initial Notice of COBRA and Continuation Coverage Rights*. Options for continuing health plan enrollment are based on the reason that eligibility was lost.

(1) Spouses, Washington state registered domestic partners, or children who lose eligibility due to the death of an employee or retiree may be eligible to continue health plan enrollment under provisions of WAC 182-12-250 or 182-12-265; or

(2) Dependents who lose eligibility because they no longer meet the eligibility criteria in WAC 182-12-260 are eligible to continue health plan enrollment under provisions of the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). See WAC 182-12-146 for more information on COBRA.

Exception: A qualified domestic partner who loses eligibility because he or she no longer meets the eligibility criteria in WAC 182-12-260 may continue health plan enrollment under an extension of PEBB insurance coverage for a maximum of thirty-six months.

No PEBB continuation coverage will be offered unless the PEBB program is notified through hand-delivery or United States Postal Service mail of the qualifying event as outlined in the *PEBB Initial Notice of COBRA and Continuation Coverage Rights*.

[Statutory Authority: RCW 41.05.160. 09-23-102 (Order 09-02), § 182-12-270, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-12-270, filed 10/1/08, effective 1/1/09; 07-20-129 (Order 07-01), § 182-12-270, 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), § 182-12-270, filed 7/27/05, effective 8/27/05. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-270, filed 8/26/04, effective 1/1/05.]

Chapter 182-16 WAC
PRACTICE AND PROCEDURE

WAC

WAC 182-16-020 Definitions. As used in this chapter the term:

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

"Agency" means the health care authority;

"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.

"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.

"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.

"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.

"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.

"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 (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.

"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.

[Statutory Authority: RCW 41.05.160. 09-23-102 (Order 09-02), § 182-16-020, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-16-020, filed 10/1/08, effective 1/1/09; 07-20-129 (Order 07-01), § 182-16-020, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.010 and 34.05.250. 91-14-025, § 182-16-020, filed 6/25/91, effective 7/26/91.]

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? Any employee or employee's dependent aggrieved by a decision made by a state agency with regard to public employee benefits eligibility or enrollment may appeal that decision to the state agency. Any dependent aggrieved by a decision made by the PEBB program may appeal the decision by submitting an appeal to the PEBB appeals committee in the same manner as a self-pay enrollee as described in WAC 182-16-032.

Any employer group employee or employee's dependent aggrieved by a decision with regard to PEBB eligibility,

enrollment or premium payment may appeal that decision to the employer group. Appeals to employer groups are not subject to this rule.

Note: Eligibility decisions address whether an employee or an employee'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.

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

(1) Any employee or employee's dependent aggrieved by an eligibility or enrollment decision made by a state agency may appeal the decision by submitting a written request for review to the state agency. The 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 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 state agency may hold a formal meeting or hearing, but is not required to do so.

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

(2) Any employee or employee's dependent who disagrees with the 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 state agency's written decision on the request for review.

As well, any employee or employee's dependent may appeal a decision about premium payments 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 denial notice. 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. 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 a retiree, self-pay enrollee, or dependent appeal a decision made by the PEBB program regarding eligibility, enrollment or premium payments? Any retiree, self-pay enrollee, or dependent aggrieved by a decision made by the PEBB program with regard to public employee benefit eligibility, enrollment, or premium payments may appeal the decision to the PEBB appeals committee.

Note: Eligibility decisions address whether a retiree, self-pay enrollee or their 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, enrollment deadlines, and premium related issues.

The PEBB appeals manager must receive the notice of appeal within sixty days of the date of the denial notice by the PEBB program. The contents of the notice of appeal are to be provided in accordance with WAC 182-16-040.

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

(2) 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.

(3) 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. 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 182-16-034 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? Any PEBB enrollee aggrieved by 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 and casualty insurance may appeal that decision by following the appeal provisions of those plans. Those appeals are not subject to this chapter, except for eligibility, enrollment and premium payment determinations. Employees and their dependents should refer to WAC 182-16-030 for eligibility, enrollment and premium payment appeals. Retirees, self-pay enrollees, and their dependents should refer to WAC 182-16-032 for eligibility, enrollment and premium payment appeals.

[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.]

WAC 182-16-036 How can an enrollee appeal a decision regarding the administration of benefits offered under the state's salary reduction plan? (1) Any enrollee aggrieved by a decision regarding the medical FSA and DCAP offered under the state's salary reduction plan may appeal that decision to the third-party administrator contracted to administer the plan.

(2) Any enrollee who disagrees with a decision in response to an appeal filed with the third-party administrator that administers the medical FSA and DCAP under the state's salary reduction plan may appeal to the PEBB appeals com-

mittee. The PEBB appeals manager must receive the notice of appeal within thirty days of the date of the appeal decision by the third-party administrator that administers the medical FSA and DCAP offered under the state's salary reduction plan. 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.

(3) Any enrollee aggrieved by a decision regarding the administration of the premium payment plan offered under the state's salary reduction plan may appeal that decision to the PEBB appeals committee. The PEBB appeals manager must receive the notice of appeal within thirty days of the date of the denial notice by the PEBB program. 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. 09-23-102 (Order 09-02), § 182-16-036, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-16-036, filed 10/1/08, effective 1/1/09.]

WAC 182-16-037 How can an enrollee appeal a decision by the agency's self-insured dental plan? Any enrollee aggrieved by a decision by the agency's self-insured dental plan (Uniform Dental Plan) may appeal that decision to the PEBB appeals committee. The PEBB appeals manager must receive the notice of appeal within thirty days of the date of the denial notice by the agency's self-insured dental plan. The contents of the notice of appeal are to be provided in accordance with WAC 182-16-040.

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

(2) 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.

(3) 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. 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.]

Chapter 182-20 WAC
STANDARDS FOR COMMUNITY HEALTH CLINICS

WAC

WAC 182-20-600 Community health care collaborative program. The purpose of this chapter is to establish procedures for the community health care collaborative grant program. The authority is responsible for disbursing funds to further the efforts of community-based organizations that address:

(1) Access to medical treatment;

(2) Efficient use of health care resources; or

(3) Improve quality of care.

The program is a two-year grant. The continuation of disbursement of funds for the second year of the grant is determined upon recipients' satisfactory performance measures reported for the first year.

The authority may also subcontract administrative activities with a statewide community health care organization that can facilitate program policy regarding best practices and standardized performance measures among grantees.

[Statutory Authority: RCW 41.05.220 and 41.05.230. 09-23-100 (Order 09-03), § 182-20-600, filed 11/17/09, effective 12/18/09. Statutory Authority: RCW 41.05.160, 41.05.220, 41.05.230, and 2006 c 67. 07-02-055 (Order 06-07), § 182-20-600, filed 12/28/06, effective 1/28/07.]

WAC 182-20-610 Administration. The authority is responsible for:

(1) Grant development, including:

(a) Setting criteria for the selection of community-based organizations to receive grant funding;

(b) Determining equitable standards governing the granting of awards;

(c) Determining nature and format of the application and process.

(2) Award determinations, including:

(a) Accepting grant applications;

(b) Selecting recipients based upon documented health care access and quality improvement goals aligned with state health priorities;

(c) Reviewing and making final determination based upon the applicant's ability to:

(i) Meet the eligibility criteria;

(ii) Meet the program goals; and

(iii) Best utilize funds and resources available to meet the goals of the program;

(d) Conducting on-site visits to ensure applicant's ability to achieve grant objectives and performance measures identified in the application;

(e) Contracting with successful applicants; and

(f) Disbursing grant funds according to program policy.

(3) Post-award actions, including:

(a) Reviewing periodic progress reports from contractors;

(b) Conducting on-site visits of contractors to provide assistance and ensure compliance of grant objectives as necessary;

(c) Reviewing and approving distribution of the second half of a grant based upon satisfactory performance reports; and

(d) Compiling periodic reports as requested by the governor and legislature, which may include:

(i) Description of organizations and programs funded;

(ii) Description and analysis of results achieved;

(iii) Recommendations for improvements to the program; and

(iv) Highlights best practices that can be replicated statewide.

[Statutory Authority: RCW 41.05.220 and 41.05.230. 09-23-100 (Order 09-03), § 182-20-610, filed 11/17/09, effective 12/18/09. Statutory Authority: RCW 41.05.160, 41.05.220, 41.05.230, and 2006 c 67. 07-02-055 (Order 06-07), § 182-20-610, filed 12/28/06, effective 1/28/07.]

WAC 182-20-620 Application process. (1) Eligibility.

(a) Applicants must meet the application requirements prescribed by the authority.

(b) Applicants must be able to show:

(i) Evidence of private, nonprofit, tax exempt status incorporated in Washington state or public agency status under the jurisdiction of a local, county, or tribal government;

(ii) Evidence of the specific geographic region served;

(iii) Evidence of a formal collaborative governance structure and decision-making process that demonstrates structure, operation, and accountability to the region served;

(iv) Evidence of representation from hospitals, public health, behavioral health, community health centers, rural health clinics, and private practitioners that serve low-income persons in the region, unless there are no such providers within the region, or providers decline or refuse to participate or place unreasonable conditions on their participation;

(v) Amount of funds requested and how the dollars will be spent;

(vi) Data to evaluate program progress and ability to meet grant objectives.

(c) Applicants will be evaluated competitively on their ability to:

(i) Address documented health care access and quality improvement goals aligned with state policy priorities and health care needs in the specific region served;

(ii) Document engagement of key community members;

(iii) Document evidence of matching funds of at least two dollars for each grant dollar requested. All matching fund contributions must meet the criteria determined by the administrator and the application guidelines;

(iv) Address how the grant will enhance long-term capacity and sustainability of programs;

(v) Show innovation in program approaches that could be replicated throughout the state;

(vi) Make efficient and cost-effective use of funds by simplifying administration affecting the health care delivery system;

(vii) Clearly describe size of organization, program objectives, and populations served.

(d) Application access.

(i) The call for grant applications will be made by posting the announcement to the authority's official web site and by notification sent to interested parties.

(ii) To be placed on the interested parties' distribution list, send contact information, including mailing and e-mail addresses to community health care collaboration at Washington State Health Care Authority, P.O. Box 42721, Olympia, Washington 98504-2721.

(2) The guidelines and application forms will be available on the authority's official web site and included with the published guidelines distributed by e-mail to those who request an application. The application will be available in hard copy and sent by United States mail upon request. Applications must be completed and submitted in the format and filed by the deadlines prescribed by the authority and published in the guidelines.

[Statutory Authority: RCW 41.05.220 and 41.05.230. 09-23-100 (Order 09-03), § 182-20-620, filed 11/17/09, effective 12/18/09. Statutory Authority: RCW 41.05.160, 41.05.220, 41.05.230, and 2006 c 67. 07-02-055 (Order 06-07), § 182-20-620, filed 12/28/06, effective 1/28/07.]

Chapter 182-25 WAC
WASHINGTON BASIC HEALTH PLAN

WAC

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

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

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

(b) Nonpayment of premium under the provisions of subsection (6) 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) Repeated failure to pay copayments, coinsurance, or other cost-sharing in full on a timely basis;

(e) 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;

(f) Abuse or intentional misconduct;

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

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

(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 prior to the effective date of disenrollment under subsection (2)(a) and (c) through (h) of this section, BHP will send enrollees written notice of disenrollment.

(a) The notice of disenrollment will:

(i) State the reason for the disenrollment;

(ii) State the effective date of the disenrollment;

(iii) Describe the procedures for disenrollment; and

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

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

(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 nonsufficient funds will be regarded as nonpayment.

(a) At least ten days before coverage will lapse, BHP will send a delinquency notice to each subscriber whose premium payment has not been received by the due date. The delinquency notice will include a 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 182-25-105.

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

(d) Enrollees who are suspended and do not pay the premium for the next coverage month by the due date on the notice of suspension will be immediately disenrolled and issued a notice of disenrollment, which will include:

(i) The effective date of the disenrollment; and

(ii) Instructions for filing an appeal under WAC 182-25-105.

(8)(a) Unless otherwise specified in this chapter, and subject to the provisions of WAC 182-25-030, 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 will be made for:

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

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

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

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

(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 182-25-080.

(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. If an enrollee satisfies the required twelve-month wait after applying for subsidized coverage and while waiting to be offered coverage, enrollment will not be completed until funding is available to enroll him or her.

[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.]