

Title 182 WAC

HEALTH CARE AUTHORITY

Chapters

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DISPOSITION OF CHAPTERS FORMERLY CODIFIED IN THIS TITLE

Chapter 182-18

GENERAL REQUIREMENTS FOR ALL ORGAN TRANSPLANT PROGRAMS

- 182-18-005 Purpose. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-005, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
- 182-18-010 Transplant program. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-010, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
- 182-18-020 New programs. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-020, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
- 182-18-030 Pediatric programs. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-030, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
- 182-18-040 Transplant team training and experience. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-040, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
- 182-18-050 Multiple organ transplants. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-050, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
- 182-18-060 Institutional commitment. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-060, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
- 182-18-070 Patient management. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-070, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
- 182-18-080 General recipient selection criteria for all organs. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-080, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
- 182-18-090 Liver transplant program. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-090, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
- 182-18-100 Liver transplant team training and experience. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-100, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
- 182-18-110 Kidney transplant program. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-110, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129,

- 182-18-120 filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
- 182-18-130 Kidney transplant team training and experience. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-130, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
- 182-18-140 Pancreas transplant program. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-140, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
- 182-18-150 Pancreas transplant team training and experience. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-150, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
- 182-18-160 Heart and/or heart-lung transplant program. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-160, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
- 182-18-170 Heart and/or heart-lung transplant team training and experience. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-170, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.

Chapter 182-04 WAC PUBLIC RECORDS

WAC

- 182-04-010 Purpose.
- 182-04-015 Definitions.
- 182-04-025 Public records.
- 182-04-035 Office hours.
- 182-04-040 Request for public records.
- 182-04-041 Preserving requested records.
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- 182-04-050 Exemptions.
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- 182-04-060 Protection of public records.
- 182-04-070 Request for inspection of records.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

- 182-04-030 Public records officer. [Order 01-77, § 182-04-030, filed 8/26/77.] Repealed by 97-21-125, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
- 182-04-065 Communication with the board. [Order 01-77, § 182-04-065, filed 8/26/77.] Repealed by 97-21-125, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.

WAC 182-04-010 Purpose. The purpose of this chapter shall be to insure compliance by the Washington state health care authority (HCA) with the provisions of chapter 42.17 RCW dealing with public records.

[Statutory Authority: RCW 41.05.160. 97-21-125, § 182-04-010, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-010, filed 8/26/77.]

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

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

(2) "Public record" includes any writing containing information relating to the conduct of government or the performance of any governmental agency or the performance of any governmental or proprietary information.

(3) "Writing" means all means of recording any form of communication or representation as defined in RCW 42.17-020(28).

[Statutory Authority: RCW 41.05.160. 97-21-125, § 182-04-015, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-015, filed 8/26/77.]

WAC 182-04-025 Public records. (1) All public records of the HCA as defined in WAC 182-04-015(2) shall be made available upon public request for inspection and copying pursuant to these rules, except however as provided by law.

(2) The public disclosure officer, or designee, shall respond promptly to requests for disclosure. Within five business days, the public disclosure officer, or designee shall respond by:

(a) Providing the record;

(b) Acknowledging the request and providing a reasonable estimate of the time it will take to respond to the request; or

(c) Denying the public record request.

(3) In acknowledging receipt of a public record request that is unclear, the public disclosure officer may ask the requestor to clarify what information the requestor is seeking. If the requestor fails to clarify the request, the public disclosure officer need not respond to it.

[Statutory Authority: RCW 41.05.160. 97-21-125, § 182-04-025, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-025, filed 8/26/77.]

WAC 182-04-035 Office hours. Public records shall be made available upon request only during working hours of the HCA. For the purpose of this chapter, the working hours shall be from 9:00 a.m. until noon, and from 1:00 p.m. until 4:00 p.m., Monday through Friday, excluding legal holidays.

[Statutory Authority: RCW 41.05.160. 97-21-125, § 182-04-035, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-035, filed 8/26/77.]

WAC 182-04-040 Request for public records. In accordance with the requirements of chapter 42.17 RCW that agencies prevent unreasonable invasion of privacy, and to protect public records from damage or disorganization, and to prevent excessive interference with essential functions of the agency, public records may be inspected or copied, or copies of such records may be obtained by the public, upon compliance with the following procedures:

(1) A request shall be made in writing or upon the form prescribed in WAC 182-04-070, which shall be available at the HCA. The form shall be presented to the public disclosure officer; or to any member of the agency's staff, if the public disclosure officer is not available, at the office of the agency during customary office hours. A request need merely identify with reasonable certainty the record sought to be disclosed. If the matter requested is referred to within the current index maintained by the public disclosure officer, a reference to the requested record as it is described in such current index is desirable.

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(2) In all cases in which a member of the public is making a request, it shall be the obligation of the public disclosure officer or staff member to assist the member of the public in appropriately identifying the public record requested.

(3) When the law makes a record disclosable to a specific person, a requestor may be required to provide personal identification.

[Statutory Authority: RCW 41.05.160. 97-21-125, § 182-04-040, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-040, filed 8/26/77.]

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

[Statutory Authority: RCW 41.05.160. 97-21-125, § 182-04-041, filed 10/21/97, effective 11/21/97.]

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

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

(a) Fifteen cents per page for black and white photocopies, plus sales tax; and

(b) The cost of postage, if any.

(3) The public disclosure officer is authorized to waive the foregoing costs. Factors considered in deciding whether to waive costs include, but are not limited to: Providing the copy will facilitate administering the program, and/or the expense of processing the payment exceeds the copying and postage cost.

[Statutory Authority: RCW 41.05.160. 97-21-125, § 182-04-045, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-045, filed 8/26/77.]

WAC 182-04-050 Exemptions. (1) The HCA reserves the right to determine whether a public record requested in accordance with the procedures outlined in WAC 182-04-040 is exempted under statutory provisions.

(2) Pursuant to RCW 42.17.260, the HCA reserves the right to delete identifying details when it makes available or publishes any public record, in any case where there is reason to believe that disclosure of such details would be an invasion of personal privacy or vital governmental interest protected by chapter 42.17 RCW. The public disclosure officer will fully justify such deletion in writing in such a way so that the nature of the deleted information is made known.

(3) If disclosure is denied, the requestor is entitled to a written explanation of the denial which cites the relevant exemption and an explanation of how it applies to the record being denied.

[Statutory Authority: RCW 41.05.160. 97-21-125, § 182-04-050, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-050, filed 8/26/77.]

WAC 182-04-055 Review of denials of public records request. (1) Any person who objects to the denial of request for public record may petition for prompt review of such decision by tendering a written request for review. The writ-

ten request shall specifically refer to the written statement by the public disclosure officer or other staff member which constituted or accompanied the denial.

(2) Following receipt of a written request for review of a decision denying a public record, the disclosure officer shall immediately consider the matter and either affirm or reverse such denial. Such review shall be deemed completed at the end of the second business day following the receipt by the disclosure officer of the request for review. This shall constitute final agency action for the purposes of judicial review, pursuant to RCW 42.17.320.

[Statutory Authority: RCW 41.05.160, 97-21-125, § 182-04-055, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-055, filed 8/26/77.]

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

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

(2) No public record shall be removed from the main office without the approval of the public disclosure officer or his/her designee;

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

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

(5) Access to file cabinets and other places where public records are kept is restricted, and shall be used by employees of the HCA.

[Statutory Authority: RCW 41.05.160, 97-21-125, § 182-04-060, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-060, filed 8/26/77.]

WAC 182-04-070 Request for inspection of records. The HCA hereby adopts for use by all persons requesting inspection and/or copying of its records, the form set out below, entitled "Request for Inspection of Records."

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

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

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

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

(2003 Ed.)

(Signed)

Date

Return the request for inspection of records to:

Public Disclosure Office
Health Care Authority
676 Woodland Square Loop S.E.
Post Office Box 42705
Olympia, Washington 98504-2705

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

Chapter 182-08 WAC PROCEDURES

- 182-08-010 Declaration of purpose.
- 182-08-015 Definitions.
- 182-08-020 Duties and responsibilities.
- 182-08-095 Waiver of coverage.
- 182-08-120 Employer contribution.
- 182-08-125 PEBB-sponsored medical and dental benefit is limited to one enrollment per individual member.
- 182-08-160 Group coverage when not in pay status.
- 182-08-165 Other group coverage option.
- 182-08-175 Group coverage while on family and medical leave.
- 182-08-180 Reimbursement payment of miscalculated premiums.
- 182-08-190 Employer contribution.
- 182-08-200 Payment of the employer contribution for eligible employees changing agency employment.
- 182-08-210 Termination of employer paid insurance benefit programs.
- 182-08-220 Advertising or promotion of PEBB sponsored benefit plans.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

- 182-08-030 Scope and construction of terms. [Order 7228, § 182-08-030, filed 12/8/76.] Repealed by 96-08-042, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.
- 182-08-040 Definitions. [Order 7228, § 182-08-040, filed 12/8/76.] Repealed by 96-08-042, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.
- 182-08-060 Approval of health maintenance organization plans. [Statutory Authority: RCW 41.05.010 and 41.05.025, 87-21-069 (Resolution No. 87-6), § 182-08-060, filed 10/19/87; Order 7228, § 182-08-060, filed 12/8/76.] Repealed by 96-08-042, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.
- 182-08-080 Employee to elect option. [Order 7228, § 182-08-080, filed 12/8/76.] Repealed by 79-11-064 (Order 2-79), filed 10/18/79. Statutory Authority: Chapter 41.05 RCW.
- 182-08-090 Transferred employee. [Order 3-77, § 182-08-090, filed 11/17/77; Order 7228, § 182-08-090, filed 12/8/76.] Repealed by 79-11-064 (Order 2-79), filed 10/18/79. Statutory Authority: Chapter 41.05 RCW.
- 182-08-110 Open enrollments. [Order 7228, § 182-08-110, filed 12/8/76.] Repealed by 96-08-042, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.
- 182-08-111 Medical plan options between open enrollments. [Statutory Authority: Chapter 41.05 RCW, 81-03-014 (Order 1-81), § 182-08-111, filed 1/9/81; 79-11-064 (Order 2-79), § 182-08-111, filed 10/18/79.] Repealed by 91-20-163, filed 10/2/91, effective 11/2/91. Statutory Authority: Chapter 41.05 RCW.
- 182-08-130 New dependents' medical coverage after enrollment. [Order 7228, § 182-08-130, filed 12/8/76.] Repealed by Order 3-77, filed 11/17/77.
- 182-08-140 New dependents' life coverage after enrollment. [Order 7228, § 182-08-140, filed 12/8/76.] Repealed by 84-09-

- 043 (Resolution No. 2-84), filed 4/16/84. Statutory Authority: Chapter 41.05 RCW.
- 182-08-150 Reduction or cancellation of optional insurance coverages. [Order 3-77, § 182-08-150, filed 11/17/77; Order 7228, § 182-08-150, filed 12/8/76.] Repealed by 84-09-043 (Resolution No. 2-84), filed 4/16/84. Statutory Authority: Chapter 41.05 RCW.
- 182-08-170 Insurance status for a reverted employee. [Statutory Authority: Chapter 41.05 RCW. 86-16-061 (Resolution No. 86-3), § 182-08-170, filed 8/5/86; 78-02-015 (Order 2-78), § 182-08-170, filed 1/10/78; Order 7228, § 182-08-170, filed 12/8/76.] Repealed by 96-08-042, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.
- 182-08-195 Retroactive employer and employee contributions restricted. [Statutory Authority: Chapter 41.05 RCW. 84-09-043 (Resolution No. 2-84), § 182-08-195, filed 4/16/84.] Repealed by 96-08-042, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.
- 182-08-300 Criteria for selection of insurance company for automobile and homeowners insurance. [Statutory Authority: Chapter 41.05 RCW. 81-03-014 (Order 1-81), § 182-08-300, filed 1/9/81.] Repealed by 96-08-042, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.

WAC 182-08-010 Declaration of purpose. The general purpose of this chapter is to establish a set of rules used by the Public Employees Benefits Board (PEBB) for designing employee and retiree eligibility and insurance benefits and for administration of these insurance plans by the Washington State Health Care Authority (HCA).

[Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-010, filed 3/29/96, effective 4/29/96; Order 7228, § 182-08-010, filed 12/8/76.]

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

(1) "Administrator" means the administrator of the HCA or designee.

(2) "Public employees benefits board" (PEBB). Established under provisions of chapter 41.05 RCW. The PEBB is created within the HCA and the administrator of the HCA shall serve as the chair of the board.

(3) "Open enrollment" means a time period designated by the administrator during which enrollees may apply to transfer their enrollment from one health plan to another, enroll in a medical plan if the enrollee had previously waived coverage or add dependents.

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

(5) "Subscriber" means the enrollee who has been designated by the HCA as the individual to whom the HCA and the health plan will issue all notices, information, requests and premium bills on behalf of all enrolled family members.

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

[Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-015, filed 3/29/96, effective 4/29/96.]

WAC 182-08-020 Duties and responsibilities. (1) The HCA's duties include, but are not limited to, the following:

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(a) To promulgate and adopt rules consistent with RCW 41.05.021 and 41.04.160;

(b) Administer insurance benefits as designed by the PEBB and authorized under RCW 41.05.065;

(c) To analyze state-purchased health care programs and to explore options for cost containment and delivery alternatives for those programs that are consistent with the purposes of those programs;

(d) To analyze areas of public and private health care interaction;

(e) To provide information and technical administrative assistance to the PEBB;

(f) To review and approve or deny applications from counties, municipalities, eligible nonemployees, and other political subdivisions and to set the premium contribution for approved groups;

(g) To establish a competitive insurance contract bidding and evaluation process;

(h) To provide benefit plans designed by the PEBB through contracts with insurance entities or self-insurance;

(i) To appoint a health care policy technical advisory committee; and

(j) To establish billing procedures and collect funds from subscriber.

(2) The following shall be the duties and responsibilities of the PEBB:

(a) To promulgate and adopt rules for the conduct of its business;

(b) To study all matters connected with the provision of health care coverage, life insurance, liability insurance, accidental death and dismemberment insurance and disability income insurance on the best basis possible with relation to the welfare of the employees and the state. Liability insurance shall not be made available to dependents;

(c) To review and approve property and/or casualty insurance for state employees through payroll deduction. Any approved carriers must be financially sound, licensed in the state of Washington and have at least a B+ Best rating;

(d) To design and approve benefit plans and determine the terms and conditions of employee participation and coverage, including establishment of eligibility criteria;

(e) To authorize premium contributions for an employee and the employee's dependents.

[Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-020, filed 3/29/96, effective 4/29/96; Order 7228, § 182-08-020, filed 12/8/76.]

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

Employees whose medical coverage is waived will remain enrolled in a PEBB dental plan. Employees will also

remain enrolled in PEBB life and long term disability coverage.

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

[Statutory Authority: RCW 41.05.160 and 41.05.065. 01-24-048 (Order 01-05), § 182-08-095, filed 11/29/01, effective 12/30/01. Statutory Authority: RCW 41.05.160. 99-19-029 (Order 99-03), § 182-08-095, filed 9/8/99, effective 10/9/99; 97-21-126, § 182-08-095, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-095, filed 3/29/96, effective 4/29/96.]

WAC 182-08-120 Employer contribution. The PEBB has utilized the employers' contribution to provide coverage for the basic life insurance benefit, a basic long term disability benefit, medical coverage, and dental coverage, and to establish a reserve for any remaining balance. There is no employer contribution available for any other insurance coverages.

[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 182-08-125 PEBB-sponsored medical and dental benefit is limited to one enrollment per individual member. (1) Effective January 1, 2002, individuals that have more than one source of eligibility for enrollment in PEBB-sponsored medical and dental benefits (called "dual eligibility") are limited to one enrollment.

(2) The following three examples describe typical situations of dual eligibility. These are not the only situations where dual eligibility may arise and are provided as illustrations only.

(a) A husband and wife who are both employed by PEBB-participating employers, such as state agencies, may enroll only in medical or dental as an employee and not also as a dependent. That is, the husband may enroll only under his employing agency and the wife may enroll only under her employing agency.

(b) A dependent child that is eligible for coverage under two or more parents or stepparents who are employed by PEBB-participating employers, may be enrolled as a dependent under the coverage of one parent or stepparent, but not more than one.

(c) An employee employed in an insurance-eligible position by more than one PEBB-participating employer may enroll only under one employer. The employee may choose to enroll in insurance under the employer that:

- (i) Offers the most favorable cost-sharing arrangement; or
- (ii) Employed the employee for the longer period of time.

[Statutory Authority: RCW 41.05.160 and 41.05.065. 01-24-048 (Order 01-05), § 182-08-125, filed 11/29/01, effective 12/30/01.]

WAC 182-08-160 Group coverage when not in pay status. Employees covered by a PEBB health plan have options for providing continued coverage for themselves and their dependents during temporary or permanent loss of eligibility. With the exception of approved family and medical leave, employees not in pay status for at least 8 hours per month are ineligible to receive the employer premium contribution:

(1) When an employee loses eligibility as an active employee, PEBB group coverage, except long-term disability, may be continued at the group premium rate by self-paying premiums for medical coverage only, or for medical and dental combined, or for dental only, and on life insurance for a maximum of 29 months. With respect to medical and dental coverage, the maximum time shall be reduced by the number of months of self-pay allowed under COBRA and the number of employer-paid months allowed under family and medical leave. Part-time faculty may self-pay for group coverage between periods of active employee eligibility for a maximum of 18 months. If an employee is temporarily not in pay status for any of the following reasons, he or she may continue PEBB group coverage by self-paying the premium:

- (a) The employee is on authorized leave without pay;
- (b) The employee is laid off because of a reduction in force (RIF);
- (c) The employee is receiving time-loss benefits under workers' compensation;
- (d) The employee is awaiting hearing for a dismissal action;
- (e) The employee is applying for disability retirement.

(2) The federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) gives enrollees the right to continue group coverage for a period of 18 to 36 months.

(3) The Family and Medical Leave Act of 1993 gives the enrollee the opportunity to extend eligibility with employer contribution toward premium for up to 12 weeks, see WAC 182-08-175.

(4) Enrollees have the right to convert to individual medical coverage when continuation of group medical coverage is no longer possible.

(5) The dependents of employees also have options for continuing coverage for themselves following loss of eligibility.

(6) Employees who revert to a previously held position and do not regain pay status during the last month in which their employer contribution is made may continue their PEBB-sponsored health and life coverage, by self-paying premium for up to 18 months (and in some cases up to 29 months).

(7) If a dependent(s) loses eligibility due to the death of the employee, the dependent(s) may continue coverage under a retiree plan provided the dependent(s) will immediately begin receiving a monthly benefit from any state of Washing-

ton-sponsored retirement system. The employee's spouse may continue coverage indefinitely; other dependents may continue coverage until they lose eligibility under PEBB rules. Application for surviving dependent coverage must be made within 60 days from the death of the employee. If a dependent is not eligible for a monthly retirement income benefit, or a lump-sum payment because the monthly pension payment would be less than \$50, the dependent may be eligible for continued coverage under COBRA.

(8) An employee may retain long-term disability coverage by self-payment of premium up to twenty-four months during an authorized leave without pay, but only if such leave is an approved educational leave.

[Statutory Authority: RCW 41.05.160. 97-21-126, § 182-08-160, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-160, filed 3/29/96, effective 4/29/96; 93-23-065, § 182-08-160, filed 11/16/93, effective 12/17/93; 86-16-061 (Resolution No. 86-3), § 182-08-160, filed 8/5/86; 83-22-042 (Resolution No. 6-83), § 182-08-160, filed 10/28/83; 80-01-082 (Order 5-79), § 182-08-160, filed 12/27/79; 78-03-021 (Order 3-78), § 182-08-160, filed 2/14/78; Order 7228, § 182-08-160, filed 12/8/76.]

WAC 182-08-165 Other group coverage option. The following shall apply to employees during any period of approved educational leave. In order to avoid duplication of group medical coverage, such employees who obtain coverage under another group medical plan may interrupt continuance of their PEBB self-pay medical/dental coverage for each full calendar month in which they maintain coverage under the other group medical plan, with the right to reinstate PEBB self-pay medical/dental coverage in the month following termination of the other group medical coverage. Provided, that the furnishing of evidence of such other group medical coverage may be required by the Washington state health care authority. Provided further, that the option to continue self-pay dental coverage shall be suspended for the same period that PEBB self-pay medical is suspended.

[Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-165, filed 3/29/96, effective 4/29/96. Statutory Authority: RCW 41.05.065. 89-05-013 (Resolution No. 89-1), § 182-08-165, filed 2/9/89.]

WAC 182-08-175 Group coverage while on family and medical leave. Employees on leave under the federal Family and Medical Leave Act of 1993, and regulations implementing that act, shall continue to receive up to twelve weeks of employer-paid group medical, dental, basic life, and basic long-term disability insurance while on family and medical leave and may self-pay their optional life and long-term disability. If an employee fails to return to work after expiration of family and medical leave for a reason other than the continuation, recurrence, or onset of a serious health condition or other circumstance beyond the control of the employee, the employer may recover the premiums paid to maintain the employee's insurance coverage from the employee.

[Statutory Authority: RCW 41.05.160. 97-21-126, § 182-08-175, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. 93-23-065, § 182-08-175, filed 11/16/93, effective 12/17/93.]

WAC 182-08-180 Reimbursement payment of miscalculated premiums. Premiums miscalculated will be

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adjusted by returning the excess charged premium to the employer or subscriber. Errors producing an underpayment will be reimbursed by the employer or subscriber. The HCA will develop a repayment plan that will not create undue hardship on the employer or subscriber.

[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 Employer contribution. (1) Every department, division, or agency of state government, and such county, municipal or other political subdivisions as are covered under the PEBB plans, shall provide premium contributions to the HCA for insurance benefits for its employees and their dependents. State employer contributions shall be set by the HCA and are subject to the approval of the governor. Employer contributions shall include an amount determined by the HCA to pay administrative costs to administer the plans for employees of these groups. Each eligible state employee in pay status for eight or more hours during a calendar month or for each eligible employee on family and medical leave shall be eligible for the employer contribution.

(2) For the period of July 1, 2002, to June 30, 2003, eligible state employees placed on temporary unpaid leave in order to implement the 2002 supplemental appropriations act are not required to have eight hours of pay status in order to maintain eligibility for the employer contribution for each month that they are on mandatory leave.

[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 182-08-200 Payment of the employer contribution for eligible employees changing agency employment. When an eligible employee's employment ceases with an agency at any time prior to the end of the month for which a premium contribution is due and 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.

[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 182-08-210 Termination of employer paid insurance benefit programs. Coverage for a terminated employee, spouse and dependent children under the PEBB coverage medical, dental, and life insurance ceases at 12:00 midnight, the last day of the month in which the employee is in pay status. Long term disability ceases at 12:00 midnight the date your employment terminates.

[Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-210, filed 3/29/96, effective 4/29/96; Order 3-77, § 182-08-210, filed 11/17/77.]

WAC 182-08-220 Advertising or promotion of PEBB sponsored benefit plans. In order to assure equal and unbiased representation of PEBB sponsored or approved benefit plans, any promotion of these plans shall comply with the following:

(1) All materials describing PEBB plan benefits are to be prepared by or approved by the HCA.

(2) Distribution or mailing of all plan benefit descriptions is to be performed by or under the direction of the HCA.

(3) All media announcements or advertising by a carrier which include any mention of the "Public Employees Benefits Board," "health care authority" or any reference to coverage for "state employees or retirees" or any group of employees covered by PEBB plans, must receive the advance written approval of the HCA.

Failure to comply with these requirements by a PEBB contracted plan or plan subcontractor may result in contract termination by the HCA and/or HCA refusal to consider continued or renewed contracting with the noncomplying party.

[Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-220, filed 3/29/96, effective 4/29/96; 91-20-163, § 182-08-220, filed 10/2/91, effective 11/2/91; 86-16-061 (Resolution No. 86-3), § 182-08-220, filed 8/5/86.]

Chapter 182-12 WAC

ELIGIBLE AND NONELIGIBLE EMPLOYEES

WAC

182-12-110	Purpose.
182-12-111	Eligible entities and individuals.
182-12-115	Eligible employees.
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182-12-118	Insurance eligibility for surviving dependents of emergency service personnel killed in the line of duty.
182-12-119	Eligible dependents.
182-12-121	Change in eligibility status.
182-12-132	Waiving or deferring coverage.
182-12-145	Insurance eligibility for higher education.
182-12-190	Retirees changing medical plans at retirement.
182-12-200	Retirees may change enrollment in approved PEBB health plans.
182-12-215	Continued PEBB medical/dental coverage under COBRA.
182-12-220	Eligibility during appeal of dismissal.
182-12-230	Employer groups.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

182-12-120	Noneligible employees. [Order 5646, § 182-12-120, filed 2/9/76.] Repealed by 88-12-034 (Resolution No. 88-1), filed 5/26/88, effective 7/1/88. Statutory Authority: RCW 41.05.010.
182-12-122	Surviving dependents eligibility. [Statutory Authority: Chapter 41.05 RCW. 86-16-061 (Resolution No. 86-3), § 182-12-122, filed 8/5/86; 80-05-016 (Order 2-80), § 182-12-122, filed 4/10/80; 78-08-071 (Order 5-78), § 182-12-122, filed 7/26/78.] Repealed by 96-08-043, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.
182-12-125	Employee or dependents become ineligible for state group coverage. [Statutory Authority: Chapter 41.05 RCW. 84-09-043 (Resolution No. 2-84), § 182-12-125, filed 4/16/84; Order 5646, § 182-12-125, filed 2/9/76.] Repealed by 84-14-058 (Order 5-84), filed 6/29/84. Statutory Authority: Chapter 41.05 RCW.
182-12-126	Extension of retiree dependents' eligibility. [Statutory Authority: Chapter 41.05 RCW. 86-16-061 (Resolution No. 86-3), § 182-12-126, filed 8/5/86.] Repealed by 87-21-069 (Resolution No. 87-6), filed 10/19/87. Statutory Authority: RCW 41.05.010 and 41.05.025.
182-12-127	Extension of retiree dependents' eligibility. [Statutory Authority: RCW 41.05.065. 89-12-045 (Resolution No. 89-2), § 182-12-127, filed 6/2/89. Statutory Authority: RCW 41.05.010. 88-19-078 (Resolution No. 88-4), § 182-12-127, filed 9/19/88. Statutory Authority: RCW 41.05.010 and 41.05.025. 87-21-069 (Resolution No. 87-6), § 182-12-127, filed 10/19/87.] Repealed by 91-11-010, filed 5/3/91, effective 6/3/91. Statutory Authority: RCW 41.05.010 and 41.05.025.

182-12-130	Retirees eligible for Medicare. [Statutory Authority: Chapter 41.05 RCW. 91-14-084, § 182-12-130, filed 7/1/91, effective 7/1/91; 80-05-016 (Order 2-80), § 182-12-130, filed 4/10/80; Order 4-77, § 182-12-130, filed 11/17/77; Order 5646, § 182-12-130, filed 2/9/76.] Repealed by 96-08-043, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.
182-12-135	Eligibility for employees on leave without pay. [Order 4-77, § 182-12-135, filed 11/17/77; Order 5646, § 182-12-135, filed 2/9/76.] Repealed by 80-05-016 (Order 2-80), filed 4/10/80. Statutory Authority: Chapter 41.05 RCW.
182-12-140	New eligible employees. [Order 4-77, § 182-12-140, filed 11/17/77; Order 5646, § 182-12-140, filed 2/9/76.] Repealed by 89-05-013 (Resolution No. 89-1), filed 2/9/89. Statutory Authority: RCW 41.05.065.
182-12-150	Husband and wife are eligible employees. [Order 5646, § 182-12-150, filed 2/9/76.] Repealed by Order 4-77, filed 11/17/77.
182-12-151	Dependent life insurance. [Order 01-77, § 182-12-151, filed 8/26/77.] Repealed by 96-08-043, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.
182-12-155	Classified employee eligible for employer contribution. [Order 5646, § 182-12-155, filed 2/9/76.] Repealed by Order 4-77, filed 11/17/77.
182-12-160	Elected officials. [Statutory Authority: Chapter 41.05 RCW. 86-06-003 (Resolution No. 86-1), § 182-12-160, filed 2/20/86; Order 5646, § 182-12-160, filed 2/9/76.] Repealed by 96-08-043, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.
182-12-165	State contribution for permanent employees appointed to instructional year or seasonal positions. [Statutory Authority: RCW 41.05.010. 88-12-034 (Resolution No. 88-1), § 182-12-165, filed 5/26/88, effective 7/1/88; Order 7228, § 182-12-165, filed 12/8/76.] Repealed by 96-08-043, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.
182-12-170	State contributions for Medicare for actively employed. [Order 7228, § 182-12-170, filed 12/8/76.] Repealed by 83-22-042 (Resolution No. 6-83), filed 10/28/83. Statutory Authority: Chapter 41.05 RCW.
182-12-210	Extended self-pay medical and dental coverage. [Statutory Authority: RCW 41.05.065. 89-12-045 (Resolution No. 89-2), § 182-12-210, filed 6/2/89. Statutory Authority: RCW 41.05.010. 88-19-078 (Resolution No. 88-4), § 182-12-210, filed 9/19/88. Statutory Authority: Chapter 41.05 RCW. 87-07-034 (Resolution No. 87-2), § 182-12-210, filed 3/13/87; 86-16-061 (Resolution No. 86-3), § 182-12-210, filed 8/5/86.] Repealed by 91-11-010, filed 5/3/91, effective 6/3/91. Statutory Authority: RCW 41.05.010 and 41.05.025.

WAC 182-12-110 Purpose. The purpose of this chapter is to establish criteria of employee eligibility for and effective date of enrollment in the public employees benefits board (PEBB) approved plans.

[Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-110, filed 3/29/96, effective 4/29/96; Order 5646, § 182-12-110, filed 2/9/76.]

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

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

Employees of technical colleges previously enrolled in a benefits trust may terminate PEBB coverage by January 1, 1996, or the expiration of the current collective bargaining

agreements, whichever is later. Employees electing to terminate PEBB coverage have a one-time re-enrollment option after a five year wait. Employees of a bargaining unit may terminate only as an entire bargaining unit. All administrative or managerial employees may terminate only as an entire unit.

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

(2) Employee organizations. Employee organizations representing state civil service employees, and, effective October 1, 1995, employees of employee organizations currently pooled with employees of school districts for the purpose of purchasing insurance benefits, may participate in PEBB-sponsored benefits at the option of each employee organization provided:

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

(b) The PEBB medical plans are the only employer sponsored medical plans available to all eligible employees.

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

(d) The legislative authority or the board of directors agrees to maintain its PEBB plan participation for a minimum of one full year, and then through the end of the plan year.

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

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

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

(3) Blind vendors 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 depart-

ment of services for the blind may voluntarily participate in PEBB insurance programs.

(a) Vendors that do not enroll when first eligible may enroll during the annual open enrollment period offered by the health care authority or first of the month following loss of other 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 programs.

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

(4) Local governments: Employees of a county, municipality, or other political subdivision of the state may participate in PEBB insurance programs provided:

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

(b) The PEBB medical plans are the only employer sponsored medical plans available to all eligible employees.

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

(d) The legislative authority or the board of directors agrees to maintain its PEBB plan participation for a minimum of one full year, and then through the end of the plan year.

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

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

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

(5) K-12 school districts and educational service districts: Employees of school districts or educational service districts may participate in PEBB insurance programs provided:

(a) All eligible employees of the entity transfer to PEBB plan coverage as a unit. If the K-12 school district or educational service district meets the minimum size standards established by HCA, bargaining units may elect to participate separately from the whole group. For the purpose of enrolling by bargaining unit, all nonrepresented employees will be considered a single bargaining unit.

(b) The school district or educational service district must submit an application together with employee census data and, if available, prior claims experience of the entity to the HCA. The application to participate in the PEBB plans is subject to the approval of the HCA.

(c) The school district or educational service district obligates itself to participate in all PEBB insurance plans. The PEBB medical plans are the only employer sponsored medical plans available to all eligible employees.

(d) The school district or educational service district agrees to maintain its PEBB plan participation for a minimum of one full year, and then through the end of the plan year.

(e) School districts or educational service districts that begin participation on or after September 1, 2002, will pay the same composite rate as state agencies. The premium charged to eligible employees will be the same as that charged to state employees. The eligibility requirements for employees will be the same as those for state employees as defined in WAC 182-12-115.

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

(g) The school district or educational district shall provide the HCA written notice of its intent to terminate PEBB plan participation no later than thirty days prior to the effective date of termination.

(6) Eligible nonemployees:

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

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

[Statutory Authority: RCW 41.05.160, 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 182-12-115 Eligible employees. The following employees of state government, higher education, K-12 school districts, educational service districts, political subdivisions and employee organizations representing state civil service workers are eligible to apply for coverage by PEBB plans. For purposes of defining eligible employees of school districts, and educational service districts, the collective bargaining agreement will supersede all definitions provided under this rule if approved by the PEBB and/or the HCA.

(2003 Ed.)

(1) "Permanent employees." Those who work at least half-time per month and are expected to be employed for more than six months. Coverage begins on the first day of the month following the date of employment. If the date of employment is the first working day of a month, coverage begins on the date of employment.

(2) "Nonpermanent employees." Those who work at least half-time and are expected to be employed for no more than six months. Coverage begins on the first day of the seventh month following the date of employment.

(3) "Seasonal employees." Those who work at least half-time per month during a designated season for a minimum of three months but less than nine months per year and who have an understanding of continued employment season after season. Coverage begins on the first day of the month following the date of employment. If the date of employment is the first working day of a month, coverage begins on the date of employment. However, seasonal employees are not eligible for the employer contribution during the break between seasons of employment but may be eligible to continue coverage by self-paying premiums.

(4) "Career seasonal/instructional employees" Employees who work half-time or more on an instructional year (school year) or equivalent nine-month seasonal basis. Coverage begins on the first day of the month following the date of employment. If the date of employment is the first working day of the month, coverage begins on the date of employment. These employees are eligible to receive the employer contribution for insurance during the off-season following each period of seasonal employment.

(5) "Part-time faculty." Faculty who are employed on a quarter/semester to quarter/semester basis become eligible to apply for coverage beginning with the second consecutive quarter/semester of half-time or more employment at one or more state institutions of higher education. Coverage begins on 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, coverage begins at the beginning of the second consecutive quarter/semester.

Employers of part-time faculty must:

(a) Consider spring and fall as consecutive quarters/semesters when determining eligibility; and

(b) Determine "halftime or more employment" based on each institution's definition of "full-time"; and

(c) At the beginning of each quarter/semester notify, in writing, all current and newly hired part-time faculty of their potential right to benefits under this section. The employee shall have the responsibility, each quarter, to notify the employers, in writing, of the employee's multiple employment. In no case will there be a requirement for retroactive coverage or employer contribution if a part-time faculty member fails to inform all of his/her employing institutions about employment at all institutions within the current quarter; and

(d) Where concurrent employment at more than one state higher education institution is used to determine total part-time faculty employment of half-time or more, the employing institutions will arrange to prorate the cost of the employer insurance contribution based on the employment at each

institution. However, if the part-time faculty member would be eligible by virtue of employment at one institution, that institution will pay the entire cost of the employer contribution regardless of other higher education employment. In cases where the cost of the contribution is prorated between institutions, one institution will forward the entire contribution monthly to HCA; and

(e) Once enrolled, if a part-time faculty member does not work at least a total of half-time in one or more state institutions of higher education, eligibility for the employer contribution ceases.

(6) "Appointed and elected officials." Legislators are eligible to apply for coverage on the date their term begins. All other elected and full-time appointed officials of the legislative and executive branches of state government are eligible to apply for coverage on the date their term begins or they take the oath of office, whichever occurs first. Coverage for legislators begins on the first day of the month following the date their term begins. If the term begins on the first working day of the month, coverage begins on the first day of their term. Coverage begins for all other elected and full-time appointed officials of the legislative and executive branches of state government on the first day of the month following the date their term begins, or the first day of the month following the date they take the oath of office, whichever occurs first. If the term begins, or oath of office is taken, on the first working day of the month, coverage begins on the date the term begins, or the oath of office is taken.

(7) "Judges." Justices of the supreme court and judges of the court of appeals and the superior courts become eligible to apply for coverage on the date they take the oath of office. Coverage begins on the first day of the month following the date their term begins, or the first day of the month following the date they take oath of office, whichever occurs first. If the term begins, or oath of office is taken, on the first working day of a month, coverage begins on the date the term begins, or the oath of office is taken.

[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.]

WAC 182-12-117 Eligible retirees. (1) Eligible employees who terminate state service after becoming vested in a Washington state sponsored retirement system are eligible for retiree medical and dental coverages provided:

(a) The retiree and covered dependent(s) are eligible for Medicare, elects Medicare Parts A and B if the retiree retired after July 1, 1991; and

(b) The person submits an application form to enroll or waive PEBB medical and dental coverage within sixty days after active employer or continuous Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage ends and is

eligible under one or more of the programs described in (c), (d), (e), (f), or (g) of this subsection;

(c) Except as provided in (c)(vii) of this subsection, the person immediately begins receiving a monthly retirement income benefit from one or more of the following retirement systems:

(i) Law enforcement officers' and fire fighters' retirement system plan 1 or 2;

(ii) Public employees' retirement system plan 1 or 2;

(iii) School employees' retirement system plan 2;

(iv) State judges/judicial retirement system;

(v) Teachers' retirement system plan 1 or 2; or

(vi) Washington state patrol retirement system.

(vii) Provided, however, that a lump-sum payment may be received in lieu of a monthly retiree income benefit payment under RCW 41.26.425(1), 41.32.762(1), 41.32.870(1), 41.35.410(1), 41.35.670(1), 41.40.625(1) or 41.40.815(1).

(d) The person is at least fifty-five years of age with at least ten years service credit and a member of one of the following retirement systems:

(i) Public employees' retirement system plan 3;

(ii) School employees' retirement system plan 3; and

(iii) Teachers' retirement system plan 3.

(e) The person is a member of state of Washington higher education retirement plan, and is:

(i) At least fifty-five years of age with at least ten years service; or

(ii) At least sixty-two years of age; or

(iii) Immediately begins receiving a monthly retirement income benefit.

(f) If not retiring under the public employees' retirement system, the person would have been eligible for a monthly retirement income benefit because of age and years of service had the person been employed under the provisions of public employees retirement system 1 or 2 for the same period of employment.

(g) The person is an elected official as defined under WAC 182-12-115(6) who has voluntarily or involuntarily left a public office, whether or not they receive a benefit from a state retirement system.

(2) Eligible employees who participate in the public employees' benefits board (PEBB) sponsored life insurance as an active employee and meet qualifications for retiree medical benefits as provided in subsection (1) of this section are eligible for PEBB sponsored retiree life insurance if they apply to the health care authority within sixty days after the date their active PEBB life insurance terminates and their premium is not being waived for any PEBB life insurance plan at the time of application for retiree life insurance.

(3) The following retired and disabled school district and educational service district employees are eligible to participate in PEBB medical and dental plans only, provided they meet the enrollment criteria stated below and if eligible for Medicare, are also enrolled in Medicare Parts A and B:

(a) Persons receiving a retirement allowance under chapter 41.32, 41.35 or 41.40 RCW as of September 30, 1993, and who enroll in PEBB plans not later than the end of the open enrollment period established by the authority for the plan year beginning January 1, 1995;

(b) Persons who separate from employment with a school district or educational service district due to a total and permanent disability, and are eligible to receive a deferred retirement allowance under chapter 41.32, 41.35 or 41.40 RCW. Such persons must enroll in PEBB plans not later than the end of the open enrollment period established by the authority for the plan year beginning January 1, 1995, or sixty days following retirement, whichever is later.

(4) Employees who are permanently and totally disabled and eligible for a deferred monthly retirement income benefit are eligible for medical, dental and life insurance benefits as provided in subsection (2) of this section, provided they apply for retiree coverage before their PEBB active employee coverage ends.

(5) With the exception of the Washington state patrol, retirees and disabled employees are not eligible for an employer premium contribution.

(6) The Federal Civil Service Retirement System shall be considered a Washington state sponsored retirement system for Washington State University cooperative extension service employees who hold a federal civil service appointment and who are covered under the PEBB program at the time of retirement or disability.

[Statutory Authority: RCW 41.05.160, 01-17-042 (Order 01-01), § 182-12-117, filed 8/9/01, effective 9/9/01; 97-21-127, § 182-12-117, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW, 96-08-043, § 182-12-117, filed 3/29/96, effective 4/29/96.]

WAC 182-12-118 Insurance eligibility for surviving dependents of emergency service personnel killed in the line of duty. Surviving dependents of emergency service personnel who were killed in the line of duty on or after January 1, 1998, are eligible to participate in medical and dental coverage administered by the health care authority and sponsored by the public employee's benefits board.

(1) This rule applies to the dependents of emergency service personnel "killed in the line of duty" as determined consistent with Title 51 RCW by the department of labor and industries.

(2) "Emergency service personnel" is defined as law enforcement officers, fire fighters and reserve officers, fire fighters as defined in RCW 41.26.030 and 41.24.010.

(3) "Surviving dependent" is defined as:

(a) A lawful spouse or ex-spouse as defined in RCW 41.26.162; and

(b) Dependent children. The term "children" includes unmarried natural children, stepchildren and legally adopted children under the age of twenty or under the age of twenty-four for a dependent student attending high school or an accredited secondary school full-time. Disabled dependents as defined in RCW 41.26.020(7) are eligible at any age.

(4) Premium rates will be subsidized consistent with rates established by the health care authority for non-Medicare retirees under RCW 41.05.022 and for Medicare-eligible retirees under RCW 41.05.085.

(5) Surviving dependents that are Medicare-eligible must enroll in both parts A and B of Medicare.

(6) The surviving dependent must send a completed enrollment application to the health care authority no later than sixty days after:

(a) The last day of any coverage extended by the employing agency of the emergency service employee who died in the line of duty; or

(b) The last day of coverage extended through the Consolidated Omnibus Budget Reconciliation Act (COBRA) from any employing agency.

(7) Surviving dependents must choose one of the following two options for maintaining eligibility for participation under public employee's benefits board sponsored medical and dental coverage:

(a) Enroll in coverage:

(i) Enrollment in a medical plan is required.

(ii) Enrollment in dental coverage is optional. Once enrolled in dental the member must maintain enrollment in a dental plan for a minimum of two years before dental can be dropped.

(iii) Dental only coverage is not available.

(b) Waive enrollment:

(i) Surviving dependents may waive enrollment in public employee's benefits board sponsored medical and dental coverage if they are enrolled in employer sponsored medical through their employment.

(ii) Surviving dependents may enroll in public employee's benefits board sponsored medical and dental when their employer sponsored coverage ends. Proof of their continuous enrollment in employer sponsored coverage must be submitted with their application for enrollment to the health care authority within sixty days of the date that their coverage ended.

(8) Enrollees may change their medical or dental plan selection during the annual open enrollment period held by the health care authority. In addition to the annual open enrollment period, enrollees may change plans if they move out of their plan's service area or into a service area where a plan that was not previously offered is now available.

(9) Surviving dependents will forfeit their right to enroll in public employee's benefits board sponsored medical and dental coverage if they:

(a) Do not make application to the health care authority before the date specified in subsection (6) of this section; or

(b) Do not maintain continuous medical coverage during the waiver period enrollment for public employee's benefits board sponsored medical, as provided in subsection (7)(a)(ii) of this section.

[Statutory Authority: RCW 41.05.160 and 41.05.065, 01-24-047 (Order 01-04), § 182-12-118, filed 11/29/01, effective 12/30/01.]

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

(1) Lawful spouse or "qualified domestic partner" (same sex domestic partner qualified through the declaration certificate issued by the health care authority).

(2) Dependent children through age nineteen. The term "children" includes the subscriber's natural children, stepchildren, legally adopted children, children for whom the subscriber has assumed a legal obligation for total or partial support of a child in anticipation of adoption of the child, children of the subscriber's qualified domestic partner, or children specified in a court order or divorce decree. Married

children who qualify as dependents of the subscriber under the Internal Revenue Code, and extended dependents approved by the HCA are included. To qualify for HCA approval, the subscriber must demonstrate legal custody for the child with a court order, and:

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

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

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

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

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

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

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

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

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

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

(6) Surviving dependents.

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

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

(ii) If a surviving dependent of a PEBB employee is not eligible for a monthly retirement income benefit, or lump-

sum payment because the monthly pension payment would be less than \$50, the dependent may be eligible for continued coverage under COBRA.

(iii) Dependents of retirees enrolled in the retiree's PEBB plan or waiving coverage under a PEBB plan while eligible for an employer sponsored medical plan at the time of the retiree's death are eligible to continue PEBB retiree coverage.

(iv) Surviving spouses and/or eligible dependent children of a deceased school district or educational service district employee who were not enrolled in a PEBB plan at the time of death may continue coverage provided the employee died on or after October 1, 1993 and the dependent(s) immediately began receiving a retirement benefit allowance under chapter 41.32 or 41.40 RCW.

(b) Application for surviving dependent(s) coverage must be made in writing on the enrollment form approved by the health care authority within sixty days from the date of death of the employee or retiree. Coverage is retroactive to the date the employee or retiree coverage terminated subject to the payment of the premium. In order to avoid duplication of group medical coverage, surviving dependents may defer or waive their enrollment in the PEBB coverage each full calendar month in which they maintain coverage under an employer sponsored medical plan. Notice of intent to waive PEBB coverage must be sent in writing to the Washington state health care authority. When an employer sponsored medical plan ends, surviving dependent(s) must submit an application to enroll in a PEBB plan within sixty days of the last day of coverage under the employer sponsored medical plan. Satisfactory evidence of continuous enrollment in an employer sponsored medical plan will be required by the Washington state health care authority prior to enrollment in a PEBB plan. The employee's or retiree's spouse or qualified domestic partner may continue coverage indefinitely; other dependents may continue coverage until they lose eligibility under PEBB rules.

[Statutory Authority: RCW 41.05.160. 02-18-087 (Order 02-02), § 182-12-119, filed 9/3/02, effective 10/4/02; 01-01-126 (Order 00-02), § 182-12-119, filed 12/19/00, effective 1/19/01; 99-19-028 (Order 99-04), § 182-12-119, filed 9/8/99, effective 10/9/99; 97-21-127, § 182-12-119, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-119, filed 3/29/96, effective 4/29/96.]

WAC 182-12-121 Change in eligibility status.

Employees who voluntarily move from an eligible to an otherwise noneligible position shall retain their eligibility for the employer contribution each month in which they are in pay status eight hours or more, provided, (1) the new position is one in which the employee is scheduled to work half time or more, and (2) the employee did not terminate state service before taking the new position. Layoff because of reduction in force is not considered termination of state service. Proviso (1) above does not apply to employees who are on reduction in force status.

[Statutory Authority: Chapter 41.05 RCW. 80-01-082 (Order 5-79), § 182-12-121, filed 12/27/79.]

WAC 182-12-132 Waiving or deferring coverage.

Beginning January 1, 2001, retirees may waive PEBB medical and dental coverage for themselves and all dependents if they are covered under another comprehensive employer

sponsored medical plan. (Other coverage may be attained through the retiree's reemployment or the spouse's employment.) In order to continue retiree term life coverage, coverage must be selected upon retirement and premiums must continue to be paid during reemployment status. In order to waive medical and dental coverage, the retiree must submit a PEBB enrollment form indicating their desire to waive coverage to the health care authority. This must be accomplished prior to the date coverage is waived or within sixty days of the date they are eligible to apply for PEBB sponsored retiree benefits. When the retiree again ceases active employment, the retiree may enroll in PEBB medical and dental coverage with evidence of continuous coverage within sixty days of the loss of coverage. Coverage will become effective the first of the month following the date other coverage ended.

[Statutory Authority: RCW 41.05.160. 02-18-087 (Order 02-02), § 182-12-132, filed 9/3/02, effective 10/4/02; 01-01-126 (Order 00-02), § 182-12-132, filed 12/19/00, effective 1/19/01; 97-21-127, § 182-12-132, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-132, filed 3/29/96, effective 4/29/96; 80-05-016 (Order 2-80), § 182-12-132, filed 4/10/80.]

WAC 182-12-145 Insurance eligibility for higher education. For the purpose of insurance eligibility, the PEBB considers the higher education personnel board, the council for post secondary education, and the state board for community colleges to be higher education agencies.

[Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-145, filed 3/29/96, effective 4/29/96; Order 5646, § 182-12-145, filed 2/9/76.]

WAC 182-12-190 Retirees changing medical plans at retirement. Retirees eligible to continue their medical coverage after retirement may elect to change medical plans at the time of retirement.

[Statutory Authority: Chapter 41.05 RCW. 80-05-016 (Order 2-80), § 182-12-190, filed 4/10/80; Order 4-77, § 182-12-190, filed 11/17/77.]

WAC 182-12-200 Retirees may change enrollment in approved PEBB health plans. A retiree, whose spouse is enrolled as an eligible employee in a PEBB or Washington state school district-sponsored health plan, may defer enrollment in PEBB retiree medical and dental plans and enroll in the spouse's PEBB or school district-sponsored health plan. If a retiree defers enrollment in a PEBB retiree medical plan, enrollment must also be deferred for dental coverage. The retiree and eligible dependents may subsequently enroll in a PEBB retiree medical, or medical and dental, plan(s) if the retiree was continuously enrolled under the spouse's PEBB or school district-sponsored health coverage from the date the retiree was initially eligible for retiree coverage:

- (1) During any open enrollment period determined by the HCA; or
- (2) Within sixty days of the date the spouse ceases to be enrolled in a PEBB or school district-sponsored health plan as an eligible employee; or
- (3) Within sixty days of the date of the retiree's loss of eligibility as a dependent under the spouse's PEBB or school district-sponsored health plan.

[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,

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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 182-12-215 Continued PEBB medical/dental coverage under COBRA. Enrollees and eligible dependents who become ineligible for PEBB medical/dental coverage and who qualify for continued coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA), including any amendments hereinafter enacted, may continue their PEBB plan coverage by self-payment of plan premiums in accordance with COBRA statutes and regulations.

[Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-215, filed 3/29/96, effective 4/29/96. Statutory Authority: RCW 41.05.010 and 41.05.025. 91-11-010, § 182-12-215, filed 5/3/91, effective 6/3/91.]

WAC 182-12-220 Eligibility during appeal of dismissal. Employees awaiting hearing of a dismissal action before the personnel appeals board, higher education personnel board or court may continue their PEBB coverages by self-payment of premium on the same terms as an employee who is granted leave without pay. If the hearing board or court upholds the dismissal, coverages shall terminate at the end of the month in which the board or court's decision is made. If the hearing board or court sustains the employee in the appeal and directs reinstatement of employer paid coverages retroactively, the employer must forward to the HCA the full employer contribution for the period directed by the hearing board or court. PEBB will refund to the employee any premiums the employee paid that will be provided for by the reinstatement of the employer contribution provided the employee makes retroactive payment of any employee contribution amounts associated with the coverage. All optional life and long term disability insurance which was in force at the time of dismissal shall be reinstated retroactively, provided 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 obtain such optional coverage.

[Statutory Authority: RCW 41.05.160. 02-18-088 (Order 02-03), § 182-12-220, filed 9/3/02, effective 10/4/02. Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-220, filed 3/29/96, effective 4/29/96; 86-16-061 (Resolution No. 86-3), § 182-12-220, filed 8/5/86.]

WAC 182-12-230 Employer groups. This section applies to all employer groups participating in PEBB insurance programs.

(1) For purposes of this section, "employer group" means those employee organizations representing state civil service employees, blind vendors, K-12 school districts, educational service districts, county, municipality, and political subdivisions that meet the participation requirements of WAC 182-12-111 (2), (3) and (4) and that participate in PEBB insurance programs.

(2)(a) Each employer group shall determine an employee's eligibility for PEBB insurance coverage in accordance with the applicable sections of this chapter (chapter 182-12 WAC) and chapter 41.05 RCW.

(b) Each employer group applying for participation in PEBB insurance programs shall submit required documenta-

tion and meet all participation requirements set forth in the then-current PEBB Coverage K-12 and Political Subdivisions booklet(s).

(3)(a) Each employer group applying for participation in PEBB insurance programs shall sign an interlocal agreement with the health care authority.

(b) Each employer group already participating in PEBB insurance programs as of the effective date of this section shall sign an interlocal agreement with the health care authority no later than June 30, 2002. Failure to sign such an agreement by that date will result in termination of the employer group's participation in PEBB insurance programs effective as of the end of the month of the last full premium payment, and disenrollment of all employees of the employer group. Termination and disenrollment are subject to subsections (8) and (9) of this section.

(c) Each interlocal agreement shall be renewed no less frequently than once in every two-year period.

(4) At least twenty days prior to the premium due date, the health care authority shall cause each employer group to be sent a monthly billing statement. The statement of premium due will be based upon the enrollment information provided by the employer group.

(a) Changes in enrollment status shall be submitted to the health care authority prior to the twentieth day of the month during which the change occurs. Changes submitted after the twentieth day of each month may not be reflected on the billing statement until the following month.

(b) Changes submitted more than one month late shall be accompanied by a full explanation of the circumstances of the late notification.

(5) Beginning with the July 2002 premium (billed to employer groups no later than June 26, 2002, and due not later than July 20, 2002), an employer group shall remit the monthly premium as billed or as reconciled by it.

(a) If an employer group determines that the invoiced amount requires one or more changes, the employer group may adjust its remittance only if an insurance eligibility adjustment form detailing the adjustment accompanies the remittance. The proper form for reporting adjustments will be attached to the interlocal agreement as Exhibit A.

(b) Each employer group is solely responsible for the accuracy of the amount remitted and the completeness and accuracy of the insurance eligibility adjustment form.

(6) Each employer group shall remit the entire monthly premium due including the employee share, if any. The employer group is solely responsible for the collection of any employee share of the premium. The employer shall not withhold portions of the monthly premium due because it has failed to collect the entire employee share.

(7) Nonpayment of the full premium when due will subject the employer group to disenrollment and termination of each employee of the group.

(a) Prior to termination for nonpayment of premium, the health care authority shall cause a notice of overdue premium to be sent to the employer group, which notice will provide a one-month grace period for payment of all overdue premium.

(b) An employer group that does not remit the entirety of its overdue premium no later than the last day of the grace

period will be disenrolled effective the last day of the last month for which premium has been paid in full.

(c) Upon disenrollment, notification will be sent to both the employer group and each affected employee.

(d) Employer groups disenrolled due to nonpayment of premium shall have the right to a dispute resolution hearing in accordance with the terms of the interlocal agreement.

(e) Employees terminated due to the nonpayment of premium by the employer group are not eligible for continuation of group health plan coverage according to the terms of the Consolidated Omnibus Budget Reconciliation Act (COBRA). Terminated employees shall have conversion rights to an individual insurance policy as provided for by the employer group.

(f) Claims incurred by terminated employees of a disenrolled group after the effective date of disenrollment will not be covered.

(g) The employer group is solely responsible for refunding any employee share paid by the employee to the employer group and not remitted to the health care authority.

(8) A disenrolled employer group may apply for reinstatement in PEBB insurance programs under the following conditions:

(a) Reinstatement must be requested and all delinquent premium paid in full no later than ninety days after the date the premium was first due, as well as a reinstatement fee of one thousand dollars.

(b) Reinstatement requested more than ninety days after the effective date of disenrollment will be denied.

(c) Employer groups may be reinstated only once in any two-year period and will be subject to immediate disenrollment if, after the effective date of any such reinstatement, subsequent premiums become more than thirty days delinquent.

(9) Upon written petition by the employer group, disenrollment of an employer group or denial of reinstatement may be waived by the administrator upon a showing of good cause.

[Statutory Authority: RCW 41.05.160. 02-18-087 (Order 02-02), § 182-12-230, filed 9/3/02, effective 10/4/02. Statutory Authority: RCW 41.05.160, 41.05.021 (1)(h), 02-08-047 (Order 01-09), § 182-12-230, filed 3/29/02, effective 4/29/02.]

Chapter 182-13 WAC

STATE RESIDENT—MEDICARE SUPPLEMENT

WAC

182-13-010	Purpose.
182-13-020	Definitions.
182-13-030	Eligibility.
182-13-040	Application for Medicare supplement coverage.

WAC 182-13-010 Purpose. The purpose of this chapter is to establish criteria for state residents for participation in Medicare supplement coverage available through the HCA.

[Statutory Authority: RCW 41.05.197. 95-07-011, § 182-13-010, filed 3/3/95, effective 4/3/95.]

WAC 182-13-020 Definitions. Unless otherwise specified, the definitions contained in this section apply throughout this chapter.

(1) "HCA" means the Washington state health care authority.

(2) "Health plan," or "plan" means any individual or group: Policy, agreement, or other contract providing coverage for medical, surgical, hospital, or emergency care services, whether issued, or issued for delivery, in Washington or any other state. "Health Plan" or "plan" also includes self-insured coverage governed by the federal Employee Retirement Income Security Act, coverage through the Health Insurance Access Act as described in chapter 48.41 RCW, coverage through the Basic Health Plan as described in chapter 70.47 RCW, and coverage through the Medicaid program as described in Title 74 RCW. "Health plan" or "plan" does not mean or include: Hospital confinement indemnity coverage as described in WAC 284-50-345; disability income protection coverage as described in WAC 284-50-355; accident only coverage as described in WAC 284-50-360; specified disease and specified accident coverage as described in WAC 284-50-365; limited benefit health insurance coverage as described in WAC 284-50-370; long-term care benefits as described in chapter 48.84 RCW; or limited health care coverage such as dental only, vision only, or chiropractic only.

(3) "Lapse in coverage" means a period of time greater than ninety continuous days without coverage by a health plan.

(4) "Resident" means a person who demonstrates that he/she lives in the state of Washington at the time of application for, and issuance of coverage.

[Statutory Authority: RCW 41.05.197. 95-07-011, § 182-13-020, filed 3/3/95, effective 4/3/95.]

WAC 182-13-030 Eligibility. Residents are eligible to apply for Medicare supplement coverage arranged by the HCA when they are:

- (1) Eligible for Parts A and B of Medicare, and
- (2) Actually enrolled in both Parts A and B of Medicare not later than the effective date of Medicare supplement coverage.

[Statutory Authority: RCW 41.05.197. 95-07-011, § 182-13-030, filed 3/3/95, effective 4/3/95.]

WAC 182-13-040 Application for Medicare supplement coverage. Residents meeting eligibility requirements may apply for Medicare supplement coverage arranged by the HCA:

- (1) During the initial open enrollment period of January 1 through June 30, 1995, or
- (2) Within sixty days after becoming a resident, or
- (3) In the thirty day period before the resident becomes eligible for Medicare, or
- (4) Within sixty days of retirement, or
- (5) During any open enrollment period established by federal or state law, or
- (6) During any open enrollment period established by the HCA subsequent to the initial open enrollment period provided that the applicant is replacing a health plan with no lapse in coverage.

[Statutory Authority: RCW 41.05.197. 95-07-011, § 182-13-040, filed 3/3/95, effective 4/3/95.]

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Chapter 182-16 WAC PRACTICE AND PROCEDURE

WAC

182-16-010	Adoption of model rules of procedure.
182-16-020	Definitions.
182-16-030	Appeals from agency decisions—Applicability.
182-16-040	Appeals—Notice of appeal contents.
182-16-050	Appeals—Hearings.

WAC 182-16-010 Adoption of model rules of procedure. The model rules of procedure adopted by the chief administrative law judge pursuant to RCW 34.05.250, as now or hereafter amended, are hereby adopted for use by this agency. Those rules may be found in chapter 10-08 WAC. Other procedural rules adopted in this title are supplementary to the model rules of procedure. In the case of a conflict between the model rules of procedure and the procedural rules adopted in this title, the procedural rules adopted in this title shall govern.

[Statutory Authority: RCW 41.05.010 and 34.05.250. 91-14-025, § 182-16-010, filed 6/25/91, effective 7/26/91.]

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

- (1) "Administrator" shall mean the administrator of the health care authority;
- (2) "Agency" shall mean the health care authority;
- (3) "Agent" shall mean a person, association, or corporation acting on behalf of the health care authority pursuant to a contract between the health care authority and the person, association, or corporation.

[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 Appeals from agency decisions—Applicability. Any enrollee of the health care authority's administered insurance plans (the self-insured plans) aggrieved by a decision of the agency or its agent concerning any matter related to scope of coverage, denials of claims, determinations of eligibility, or cancellations or nonrenewals of coverage may obtain administrative review of such decision by filing a notice of appeal with the health care authority's appeals committee. Review of decisions made by HMOs or similar health care contractors will be pursuant to the grievance/arbitration provisions of those plans and are not subject to these rules. Except that decisions concerning eligibility determinations are reviewable only by the health care authority.

[Statutory Authority: RCW 41.05.160. 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 182-16-040 Appeals—Notice of appeal contents. Any person aggrieved by a decision of the health care authority may appeal that decision by filing a notice of appeal with the health care authority's appeals committee. The notice of appeal must contain:

- (1) The name and mailing address of the enrollee;
- (2) The name and mailing address of the appealing party;

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(3) The name and mailing address of the appealing party's representative, if any;

(4) A statement identifying the specific portion of the decision being appealed making it clear what it is that is believed to be unlawful or unjust;

(5) A clear and concise statement of facts in support of appealing party's position;

(6) Any and all information or documentation that the aggrieved person would like considered and feels substantiates why the claim or request for coverage should be covered (information or documentation submitted at a later date, unless specifically requested by the appeals committee, may not be considered in the appeal decision);

(7) A copy of the plan's response to the issue the appellant has raised;

(8) The type of relief sought;

(9) A statement that the appealing party has read the notice of appeal and believes the contents to be true, followed by his/her signature and the signature of his/her representative, if any;

(10) The appealing party shall file, personally or by mail, with the health care authority the original notice of appeal. The notice of appeal must be received by the health care authority within sixty days after the decision of the agency staff was mailed to the appealing party. The agency shall acknowledge receipt of the copies filed with the agency;

(11) Within thirty days after receipt of notice of appeal, the agency shall notify the appellant of any obvious errors or omissions, and request any additional information.

(12) The appeals committee will render a written decision within sixty days of receipt of the appeal.

[Statutory Authority: RCW 41.05.160. 97-21-128, § 182-16-040, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.010 and 34.05.250. 91-14-025, § 182-16-040, filed 6/25/91, effective 7/26/91.]

WAC 182-16-050 Appeals—Hearings. (1) If the health care authority's appeals committee upholds the original denial, the enrollee may request a hearing by writing to the health care authority's appeals manager. The health care authority must receive the written request for a hearing within fifteen days of the date the appeals committee's decision was mailed to the appellant.

(2) The agency shall set the time and place of the hearing and give not less than seven days notice to all parties and persons who have filed written petitions to intervene.

(3) The administrator or his/her designee shall preside at all hearings resulting from the filings of appeals.

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

(5) Within ninety days of the hearing, the administrator or his/her designee shall render a decision which shall be the final decision of the agency. A copy of that decision accompanied by a written statement of the reasons for the decision shall be served on all parties and persons who have intervened.

[Statutory Authority: RCW 41.05.160. 97-21-128, § 182-16-050, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.010 and 34.05.250. 91-14-025, § 182-16-050, filed 6/25/91, effective 7/26/91.]

Chapter 182-20 WAC

STANDARDS FOR COMMUNITY HEALTH CLINICS

WAC

182-20-001	Purpose.
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WAC 182-20-001 Purpose. The purpose of this chapter is to establish procedures at the Washington state health care authority for determining eligibility and distribution of funds for medical, dental, and migrant services to community health clinics under section 214(3), chapter 19, Laws of 1989 1st ex. sess., including other state general fund appropriations for medical, dental, and migrant services in community health clinics since 1985.

[Statutory Authority: RCW 41.05.160. 01-04-080 (Order 00-06), § 182-20-001, filed 2/7/01, effective 3/10/01. Statutory Authority: RCW 43.70.040. 95-12-010, § 182-20-001, filed 5/26/95, effective 6/26/95.]

WAC 182-20-010 Definitions. For the purposes of these rules, the following words and phrases shall have these meanings unless the context clearly indicates otherwise.

(1) "Community health clinic" means a public or private nonprofit tax exempt corporation with the mission of providing primary health care to low income individuals at a charge based upon ability to pay.

(2) "Authority" means the Washington state health care authority.

(3) "Encounter" means a face-to-face contact between a patient and a health care provider exercising independent judgment, providing primary health care, and documenting the care in the individual's health record.

(4) "Health care provider" means any person having direct or supervisory responsibility for the delivery of health care including:

(a) Physicians under chapters 18.57 and 18.71 RCW;

(b) Dentists under chapter 18.32 RCW;

(c) Advanced registered nurse practitioner under chapter 18.79 RCW;

(d) Physician's assistant under chapters 18.71A and 18.57A RCW;

(e) Dental hygienist under chapter 18.29 RCW;

(f) Licensed midwife under chapter 18.50 RCW;

(g) Federal uniformed service personnel lawfully providing health care within Washington state.

(5) "Low-income individual" means a person with income at or below two hundred percent of federal poverty level. The poverty level has been established by Public Law 97-35 § 652 (codified at 42 USC 9847), § 673(2) (codified at 42 USC 9902 (2)) as amended; and the *Poverty Income Guideline* updated annually in the *Federal Register*.

(6) "Primary health care" means comprehensive care that includes a basic level of preventive and therapeutic medical and/or dental care, usually delivered in an outpatient setting,

and focused on improving and maintaining the individual's general health.

(7) "Relative value unit" means a standard measure of performance based upon time to complete a clinical procedure. The formula is one unit equals ten minutes. A table is available from the authority stating the actual values.

(8) "Administrator" means the administrator of the health care authority or the administrator's designee.

(9) "User" means an individual having one or more primary health care encounters and counted only once during a calendar year.

(10) "Contractor" means the community health clinic or other entity performing services funded by chapter 182-20 WAC, and shall include all employees of the contractor.

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

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

(1) Developing criteria for the selection of community health clinics to receive funding;

(2) Establishing statewide standards governing the granting of awards and assistance to community health clinics;

(3) Disbursing funds appropriated for community health clinics only to those clinics meeting the criteria in WAC 182-20-160;

(4) Distributing available state funds to community health clinics according to the following priority in the order listed:

(a) First, to community health clinics that are private, nonprofit corporations classified exempt under Internal Revenue Service Rule 501 (c)(3) and governed by a board of directors including representatives from the populations served;

(b) Second, to local health jurisdictions with an organized primary health clinic or division;

(c) Third, to private nonprofit or public hospitals with an organized primary health clinic or department.

(5) Reviewing records and conducting on-site visits of contractors or applicants as necessary to assure compliance with these rules; and

(6) Withholding funding from a contractor or applicant until such time as satisfactory evidence of corrective action is received and approved by the authority, if the authority determines:

(a) Noncompliance with applicable state law or rule; or

(b) Noncompliance with the contract; or

(c) Failure to provide such records and data required by the authority to establish compliance with section 214(3), chapter 19, Laws of 1989 1st ex. sess., this chapter, and the contract; or

(d) The contractor or applicant provided inaccurate information in the application.

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

(2003 Ed.)

WAC 182-20-130 Application for funds. (1) The authority shall, upon request, supply a prospective applicant with an application kit for a contract requesting information as follows:

(a) Include in the application a request for information as follows:

(i) The applicant's name, address, and telephone number;

(ii) A description of the primary health care provided;

(iii) A brief statement of intent to apply for funds;

(iv) The signature of the agency's authorized representative;

(v) Description of the nature and scope of services provided or planned;

(vi) Evidence of a current financial audit establishing financial accountability; and

(vii) A description of how the applicant meets eligibility requirements under WAC 182-20-160;

(b) Notify existing contractors at least ninety days in advance of the date a new contract application is due to the authority;

(c) Review completed application kits for evidence of compliance with this section;

(d) Develop procedures for:

(i) Awarding of funds for new contractors, special projects, and emergency needs of existing contractors; and

(ii) Notifying existing and prospective contractors of procedures and application process.

(2) The applicant shall:

(a) Complete the application on standard forms provided or approved by the authority; and

(b) Return the completed application kit to the authority by the specified due date.

[Statutory Authority: RCW 43.70.040. 95-12-010, § 182-20-130, filed 5/26/95, effective 6/26/95.]

WAC 182-20-160 Eligibility. Applicants shall:

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

(2) Receive other funds from at least one of the following sources:

(a) Section 329 of the Public Health Services Act;

(b) Section 330 of the Public Health Services Act;

(c) Community development block grant funds;

(d) Title V Urban Indian Health Service funds; or

(e) Other public or private funds providing the clinic demonstrates:

(i) Fifty-one percent of total clinic population are low income;

(ii) Fifty-one percent or greater of funds come from sources other than programs under WAC 182-20-160;

(3) Operate as a community health clinic providing primary health care for at least eighteen months prior to applying for funding;

(4) Provide primary health care services with:

(a) Twenty-four-hour coverage of the clinic including provision or arrangement for medical and/or dental services after clinic hours;

(b) Direct clinical services provided by one or more of the following:

(i) Physician licensed under chapters 18.57 and 18.71 RCW;

(ii) Physician's assistant licensed under chapters 18.71A and 18.57A RCW;

(iii) Advanced registered nurse practitioner under chapter 18.79 RCW;

(iv) Dentist under chapter 18.32 RCW;

(v) Dental hygienist under chapter 18.29 RCW;

(c) Provision or arrangement for services as follows:

(i) Preventive health services on-site or elsewhere including:

(A) Eye and ear examinations for children;

(B) Perinatal services;

(C) Well-child services; and

(D) Family planning services;

(ii) Diagnostic and treatment services of physicians and where feasible a physician's assistant and/or advanced registered nurse practitioner, on-site;

(iii) Services of a dental professional licensed under Title 18 RCW on-site or elsewhere;

(iv) Diagnostic laboratory and radiological services on-site or elsewhere;

(v) Emergency medical services on-site or elsewhere;

(vi) Arrangements for transportation services;

(vii) Preventive dental services on-site or elsewhere; and

(viii) Pharmaceutical services, as appropriate, on-site or elsewhere;

(5) Demonstrate eligibility to receive and receipt of reimbursement from:

(a) Public insurance programs; and

(b) Public assistant programs, where feasible and possible;

(6) Have established for at least eighteen months an operating sliding scale fee schedule for adjustment of charges, based upon the individual's ability to pay for low-income individuals;

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

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

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

WAC 182-20-200 Allocation of state funds. The authority shall allocate available funds to medical, dental and migrant contractors providing primary health care based on the following criteria:

(1) Medical.

(a) The authority may withhold appropriated funds as follows:

(i) As specified under law or up to ten percent to provide funding for new contractors, special projects, and emergency needs:

(A) With distribution of any remaining portion of this ten percent among contractors by the end of each funding year;

(B) Prorated according to the percentage of total medical contract funds distributed to each contractor;

(ii) Up to ten percent for administration.

(b) The remainder of the appropriated funds is referred to as the "medical base." The medical base means the total amount of money appropriated by the legislature for the medical program minus the amounts specified in (a)(i) and (ii) of this subsection. The medical base is distributed to medical contractors based upon the following formulas:

(i) Starting July 1, 1996, the medical base is distributed to medical contractors based upon the following formula:

(A) Forty percent of the medical base is distributed equally among all medical contractors;

(B) Thirty percent of the medical base is distributed by the ratio of the contractor's primary health care (PHC) medical sliding fee users divided by the total medical sliding fee users of all contractors as reported in the prior calendar year annual reports.

individual contractor's medical sliding fee users
_____ X 30% medical base

total of all contractors' medical sliding fee users

(C) Thirty percent of the medical base is distributed by the ratio of the contractor's primary health care (PHC) medical sliding fee encounters by the total number of medical sliding fee encounters reported by all contractors as reported in the prior calendar year annual reports.

individual contractor's medical sliding fee encounters
_____ X 30% medical base

total of all contractors' medical sliding fee encounters

(2) Dental.

(a) The authority may withhold appropriated funds as follows:

(i) As specified under law or up to ten percent of appropriated funds to provide funding for new contractors, special projects, and emergency needs:

(A) With distribution of any remaining portion of this ten percent among contractors by the end of each funding year;

(B) Prorated according to the percentage of total dental contract funds distributed to each contractor.

(ii) Up to ten percent for administration.

(b) The remainder of the funds is referred to as the dental base. The dental base means the total amounts appropriated by the legislature for dental programs minus the amounts specified in (a)(i) and (ii) of this subsection and as follows:

(i) Starting July 1, 1996, the dental base is distributed to dental contractors based upon the following formula:

(A) Forty percent of the dental base is distributed equally among all dental contractors;

(B) Thirty percent of the dental base is distributed by the ratio of the contractor's primary health care (PHC) dental sliding fee users divided by the total dental sliding fee users of all contractors as reported in the prior calendar year annual reports.

individual contractor's dental sliding fee users
_____ X 30% dental base

total of all contractors' dental sliding fee users

(C) Thirty percent of the dental base is distributed by the ratio of the contractor's primary health care (PHC) dental sliding fee relative value units (RVU) divided by the total number of dental sliding fee relative value units (RVU) reported by all contractors as reported in the prior calendar year annual reports.

individual contractor's dental sliding fee RVUs
 _____ X 30% dental base

total of all contractors' dental sliding fee RVUs

(3) Migrant.

(a) The authority may withhold appropriated funds as follows:

(i) As specified under law or up to ten percent to provide funding for new contractors, special projects, and emergency needs:

(A) With distribution of any remaining portion of this ten percent among contractors by the end of each funding year;

(B) Prorated according to the percentage of total migrant contract funds distributed to each contractor.

(ii) Up to ten percent for administration.

(b) The remainder of the appropriated funds is referred to as the "migrant base." The migrant base means the total amount of money appropriated by the legislature for the migrant program minus the amounts specified in (a)(i) and (ii) of this subsection. The migrant base is distributed to migrant contractors based upon the following formula:

The migrant base is distributed to migrant contractors based upon the following formula starting July 1, 1995: One hundred percent of the migrant base is distributed by the ratio of the contractor's primary health care (PHC) migrant users divided by the total migrant users of all contractors as reported in the prior calendar year annual reports.

individual contractor's migrant users
 _____ X 100% migrant base

total of all contractors' migrant users

[Statutory Authority: RCW 41.05.160. 01-04-080 (Order 00-06), § 182-20-200, filed 2/7/01, effective 3/10/01. Statutory Authority: RCW 43.70.040. 95-12-010, § 182-20-200, filed 5/26/95, effective 6/26/95.]

WAC 182-20-250 Allocation of state noncitizen immigrant funds. The authority will allocate available funds to existing CHS contracted nonprofit community clinic contractors as of July 1, 2002, based on the following criteria:

(1) The initial time period covered for noncitizen immigrant funding is October 1, 2002, through June 30, 2003.

(2) The funding available will be targeted to noncitizen immigrants who are below one hundred percent of the federal poverty level.

(3) Awards will be by contract amendments.

(4) Starting October 1, 2002, the noncitizen immigrant funds will be distributed in three allocations to contractors based upon the following formula:

(a) For the first allocation on October 1, 2002:

(i) Five percent of all available funds will be shared equally among participating contractors.

(ii) Thirty-five percent of all available funds will be distributed based on a ratio derived from payments made by Medical Assistance Administration (MAA) for the period July 1, 2001, through December 31, 2001, specific to the non-citizen immigrant population, to CHS contractors (subset of MAA list of top fifty dental providers and clinics). Each clinic ratio will then be multiplied against the thirty-five percent of the total money available.

(b) For the second allocation to be awarded on or about February 15, 2003:

Thirty percent of all available funds (referred to as the second allocation base) will be distributed based on the following formula:

(i) Twenty percent will be distributed based on the ratio of the contractor's primary health care (PHC) noncitizen immigrant dental sliding fee users divided by the total noncitizen immigrant dental sliding fee users of all contractors as reported between October 1, 2002, and December 31, 2002.

individual contractor's dental noncitizen immigrant sliding fee users
 _____ X 20% second allocation base

total of all contractor's dental noncitizen immigrant sliding fee users

(ii) Eighty percent will be distributed based on the ratio of the contractor's primary health care (PHC) noncitizen immigrant dental sliding fee relative value units (RVUs), as defined in WAC 182-20-010(7), divided by the total noncitizen immigrant dental sliding fee RVUs of all contractors as reported between October 1, 2002, and December 31, 2002.

individual contractor's dental noncitizen immigrant sliding fee RVUs
 _____ X 80% second allocation base

total of all contractor's dental noncitizen immigrant sliding fee RVUs

(iii) Interpreter services not available from any other source, and paid for by the contractor, will be reportable and will be counted as each ten minutes of interpreter time equals one RVU.

(c) For the third allocation to be awarded on or about May 15, 2003:

Thirty percent of all available funds (referred to as the third allocation base) will be distributed based on the following formula:

(i) Twenty percent will be distributed based on the ratio of the contractor's primary health care (PHC) noncitizen immigrant dental sliding fee users divided by the total noncitizen immigrant dental sliding fee users of all contractors as reported between January 1, 2003, and March 31, 2003.

individual contractor's dental noncitizen immigrant sliding fee users
 _____ X 20% second allocation base

total of all contractor's dental noncitizen immigrant sliding fee users

(ii) Eighty percent will be distributed based on the ratio of the contractor's primary health care (PHC) noncitizen immigrant dental sliding fee RVUs divided by the total non-citizen immigrant dental sliding fee RVUs of all contractors as reported between January 1, 2003, and March 31, 2003.

individual contractor's dental noncitizen immigrant sliding fee RVUs
_____ X 80% second allocation base

total of all contractor's dental noncitizen immigrant sliding fee RVUs

(iii) Interpreter services not available from any other source, and paid for by the contractor, will be reportable and will be counted as each ten minutes of interpreter time equals one RVU.

[Statutory Authority: RCW 41.05.220. 02-18-089 (Order 02-04), § 182-20-250, filed 9/3/02, effective 10/1/02.]

WAC 182-20-300 Dispute resolution procedures. The authority shall define dispute resolution procedures in the contract which shall be the exclusive remedy and shall be binding and final to all parties.

[Statutory Authority: RCW 43.70.040. 95-12-010, § 182-20-300, filed 5/26/95, effective 6/26/95.]

WAC 182-20-320 Audit review. Contractors shall:

- (1) Maintain books, records, documents, and other materials relevant to the provision of goods or services adequate to document the scope and nature of the goods or services provided;
- (2) Make the materials in subsection (1) of this section available at all reasonable times with prior notice for inspection by the authority;
- (3) Retain these materials for at least three years after the initial contract with the authority;
- (4) Provide access to the facilities at all reasonable times with prior notice for on-site inspection by the authority; and
- (5) Submit annual reports consistent with the instructions of the authority.

[Statutory Authority: RCW 43.70.040. 95-12-010, § 182-20-320, filed 5/26/95, effective 6/26/95.]

WAC 182-20-400 Limitations on awards. Specific to the medical, dental, and migrant base as referenced in WAC 182-20-200 (1)(b), (2)(b), and (3)(b):

Starting July 1, 1997:

- (1) Any approved contractor shall initially receive no more than one hundred twenty-five percent of that contractor's previous year's initial allotment.
- (2) Any approved contractor shall initially receive no less than seventy-five percent of that contractor's previous year's initial allotment. In the event that funding is inadequate to provide seventy-five percent, criteria shall be established to equitably allocate the available funds.
- (3) Funds in excess of the initial allocation shall be distributed in a supplemental allotment pursuant to WAC 182-20-200.

[Title 182 WAC—p. 20]

[Statutory Authority: RCW 41.05.160. 01-04-080 (Order 00-06), § 182-20-400, filed 2/7/01, effective 3/10/01. Statutory Authority: RCW 43.70.040. 95-12-010, § 182-20-400, filed 5/26/95, effective 6/26/95.]

Chapter 182-25 WAC

WASHINGTON BASIC HEALTH PLAN

WAC

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182-25-040	Enrollment in the plan.
182-25-050	Employer groups.
182-25-060	Home care agencies.
182-25-070	Financial sponsors.
182-25-080	Premiums and co-payments.
182-25-085	Enrollees' failure to report correct income.
182-25-090	Disenrollment from BHP.
182-25-100	Where to find instructions for filing an appeal.
182-25-105	How to appeal health care authority (HCA) decisions.
182-25-110	How to appeal a managed health care system (MHCS) decision.

WAC 182-25-001 Authority. The administrator's authority to promulgate and adopt rules is contained in RCW 70.47.050.

[Statutory Authority: RCW 70.47.050. 96-15-024, § 182-25-001, filed 7/9/96, effective 8/9/96.]

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

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

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

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

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

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

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

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

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

(9) "Dependent" means:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Income includes:

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

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

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

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

(v) Work study or training stipends;

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

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

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

(i) Capital gains;

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

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

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

(v) Income earned by dependent children;

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

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

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

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

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

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

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

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

(22) "Managed health care system" (or "MHCS") means:

(a) Any health care organization (including health care providers, insurers, health care service contractors, health maintenance organizations, or any combination thereof) which has entered into a contract with the HCA to provide basic health care services; or

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

(23) "Maternity benefits through medical assistance," also known as S-Medical, means the coordinated program between BHP and DSHS for eligible pregnant women. This

program includes all Medicaid benefits, including maternity coverage. Eligible members must be at or below one hundred eighty-five percent of the federal poverty level. Eligibility for this program is determined by DSHS, based on Medicaid eligibility criteria.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(35) "Schedule of benefits" means the basic health care services adopted and from time to time amended by the administrator, which an enrollee shall be entitled to receive from a managed health care system in exchange for payment

of premium and applicable co-payments, as described in the member handbook.

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

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

(38) "Subsidized enrollee" or "reduced premium enrollee" means an individual who enrolls in BHP, either as the subscriber or an eligible dependent, whose current gross family income does not exceed twice the federal poverty level as adjusted for family size and determined annually by the federal Department of Health and Human Services, and who receives a premium subsidy from the HCA. To the extent that state funds are specifically appropriated for this purpose, with a corresponding federal match, "subsidized enrollee" also means an individual who enrolls in BHP, either as the subscriber or an eligible dependent, whose current gross family income is more than two hundred percent, but less than two hundred fifty-one percent, of the federal poverty level as adjusted for family size and determined annually by the federal Department of Health and Human Services, and who receives a premium subsidy from the HCA.

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

[Statutory Authority: RCW 70.47.050, 70.47.020 (4) and (5), 70.47.060 (9) and (10), 74.08A.100 and 2002 c 371, 02-24-051 (Order 02-06), § 182-25-010, filed 12/3/02, effective 1/1/03. Statutory Authority: RCW 70.47.050, 01-09-001 (Order 00-08), § 182-25-010, filed 4/4/01, effective 5/5/01. Statutory Authority: RCW 70.47.050 and 70.47.020 as revised by E2SSB 6067, 01-01-134 (Order 00-04), § 182-25-010, filed 12/20/00, effective 1/20/01. Statutory Authority: RCW 70.47.050, 70.47.060 and 70.47.100, 99-24-005 (Order 99-06), § 182-25-010, filed 11/18/99, effective 12/19/99. Statutory Authority: RCW 70.47.050, 70.47.060(9) and SHB 2556, 98-15-018, § 182-25-010, filed 7/6/98, effective 8/6/98. Statutory Authority: RCW 70.47.050, 98-07-002, § 182-25-010, filed 3/5/98, effective 4/5/98; 97-15-003, § 182-25-010, filed 7/3/97, effective 8/3/97; 96-15-024, § 182-25-010, filed 7/9/96, effective 8/9/96.]

WAC 182-25-020 BHP benefits. (1) The administrator shall design and from time to time may revise BHP benefits, according to the requirements of chapter 70.47 RCW, as amended. These benefits will include physician services, prescription drugs and medications, and inpatient and outpatient hospital services, limited mental health care services, limited chemical dependency services, limited organ transplant services, and all services necessary for prenatal, postnatal and well-child care, and will emphasize proven preventive and primary care services. The Medicaid scope of benefits may be provided by BHP as the BHP plus program through coordination with DSHS for children under the age of nineteen, who are found to be Medicaid eligible. BHP benefits may include co-payments, waiting periods, limitations and exclusions which the administrator determines are appropriate and

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consistent with the goals and objectives of the plan. BHP benefits will be subject to a nine-month waiting period for preexisting conditions. Exceptions (for example, maternity, prescription drugs, services for a newborn or newly adopted child) are outlined in the schedule of benefits. Credit toward the waiting period will be given for any continuous period of time for which an enrollee was covered under similar health coverage if that coverage was in effect at any time during the three-month period immediately preceding the date of reservation or application for coverage under BHP. Similar coverage includes BHP; all DSHS programs administered by the medical assistance administration which have the Medicaid scope of benefits; the DSHS program for the medically indigent; Indian health services; most coverages offered by health carriers; and most self-insured health plans. A list of BHP benefits, including co-payments, waiting periods, limitations and exclusions, will be provided to the subscriber.

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

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

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

[Statutory Authority: RCW 70.47.050 and 70.47.090, 02-19-053 (Order 01-08), § 182-25-020, filed 9/12/02, effective 10/13/02. Statutory Authority: RCW 70.47.050 and 70.47.060, 00-23-037, § 182-25-020, filed 11/9/00, effective 1/1/01. Statutory Authority: RCW 70.47.050, 98-07-002, § 182-25-020, filed 3/5/98, effective 4/5/98; 97-15-003, § 182-25-020, filed 7/3/97, effective 8/3/97; 96-15-024, § 182-25-020, filed 7/9/96, effective 8/9/96.]

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

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

(b) Institutionalized at the time of enrollment.

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

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fined to an institution at the time of enrollment, who is subsequently confined to an institution, will not be disenrolled, provided he or she remains otherwise eligible and continues to make all premium payments when due.

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

(4) For subsidized enrollment in BHP, an individual must meet the eligibility criteria in subsection (1) of this section and the definition of "subsidized enrollee" in WAC 182-25-010(38), and must pay, or have paid on his or her behalf, the monthly BHP premium.

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

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

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

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

(ii) Children eligible for BHP Plus;

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

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

(v) Eligible individual home care providers;

(vi) Licensed foster care workers;

(vii) Limited enrollment of new employer groups; and

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

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

[Statutory Authority: RCW 70.47.050 and 70.47.020 as revised by E2SSB 6067. 01-01-134 (Order 00-04), § 182-25-030, filed 12/20/00, effective 1/20/01. Statutory Authority: RCW 70.47.050, 70.47.060 and 70.47.100. 99-24-005 (Order 99-06), § 182-25-030, filed 11/18/99, effective 12/19/99. Statutory Authority: RCW 70.47.050 and 70.47.060. 99-16-022 (Order 99-02), § 182-25-030, filed 7/26/99, effective 8/26/99. Statutory Authority: RCW 70.47.050. 98-07-002, § 182-25-030, filed 3/5/98, effective 4/5/98; 97-15-003, § 182-25-030, filed 7/3/97, effective 8/3/97; 96-15-024, § 182-25-030, filed 7/9/96, effective 8/9/96.]

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

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

(b) The enrollee is otherwise eligible for BHP;

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

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

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

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

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

(2) Each applicant shall list all eligible dependents to be enrolled and supply other information and documentation as

required by BHP and, where applicable, DSHS medical assistance.

(a) Documentation, showing the amount and sources of the applicant's gross family income is required. Documentation will include a copy of the applicant's most recently filed federal income tax form, and/or other documentation that shows year-to-date income, or income for the most recent thirty days or complete calendar month as of the date of application. Applicants who were not required to file a federal income tax return may be required to provide verification of nonfiling status. An average of documented income received over a period of several months may be required for purposes of eligibility determination.

(b) Documentation of Washington state residence, displaying the applicant's name and address is required, for example, a copy of a current utility bill or rent receipt. Other documentation may be accepted if the applicant does not have a physical residence, for example, a signed statement from a person or other entity who is providing temporary shelter.

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

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

(3) Each member may be enrolled in only one BHP account. Each family applying for enrollment must designate a MHCS from which the applicant and all enrolled dependents will receive covered services. All applicants from the same family who are covered under the same account must receive covered services from the same MHCS (with the exception of cases in which a subscriber who is paying for BHP coverage for his/her dependent who lives in a different service area). No applicant will be enrolled for whom designation of a MHCS has not been made as part of the application for enrollment. Procedures for the selection of MHCS are set forth in the BHP member handbook. Generally, enrollees may change from one MHCS to another only during open enrollment or if they are able to show good cause for the transfer, for example, when enrollees move to an area served by a different MHCS or where they would be billed a higher premium for their current MHCS.

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

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

(a) Individual policy commission: Subject to availability of funds, and as a pilot program, BHP will pay a one-time fee to any currently licensed insurance broker or agent who sells

BHP to an eligible individual applicant if that applicant has not been a BHP member within the previous five years.

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

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

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

(e) BHP will not pay renewal commissions.

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

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

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

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

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

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

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

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

(b) Marriage or assuming custody or dependency of a child or adult dependent (other than newborn or newly adopted children), provided BHP receives the new family

member's application within thirty days of the change in family status; or

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

(10) Subscribers must notify BHP of any changes that could affect their eligibility or subsidy or their dependents' eligibility or subsidy:

(a) Within thirty days of the end of the first month of receiving an increased income; or

(b) Within thirty days of a change other than an income change (for example, a change in family size or address).

(11) BHP will verify the continuing eligibility of enrollees through the recertification process at least once every twelve months. Upon request of BHP, enrollees must submit evidence satisfactory to BHP, proving their continued eligibility for enrollment and for the premium subsidy they are receiving.

(a) BHP will verify income through comparison with other state and federal agency records or other third-party sources.

(b) If the enrollee's income on record with other agencies or third-party source differs from the income the enrollee has reported to BHP, or if questions arise concerning the documentation submitted, BHP will require updated documentation from the enrollee to prove continued eligibility for the subsidy they are receiving. At that time, BHP may also require updated documentation of residence to complete the recertification process.

(c) Enrollees who have been enrolled in BHP six months or more and have not provided updated income documentation for at least six months will be required to submit new income documentation if their wage or salary income cannot be compared to an independent source for verification.

(12) In addition to verification of income, enrollees must annually submit documentation satisfactory to BHP of the following:

(a) Washington state residence;

(b) Full-time student status for dependent students age nineteen through twenty-two; and

(c) Medicare ineligibility for enrollees age sixty-five or over.

(13) For good cause such as, but not limited to, when information received indicates a change in income or a source of income the enrollee has not reported, BHP may require enrollees to provide verification required in subsections (11) and (12) of this section more frequently, regardless of the length of time since their last recertification.

(14) Enrollees who fail to comply with a recertification request will be disenrolled, according to the provisions of WAC 182-25-090 (2)(f).

(15) If, as a result of recertification, BHP determines that an enrollee has not reported income or income changes accurately, the enrollee will be subject to the provisions of WAC 182-25-085.

[Statutory Authority: RCW 70.47.050, 70.47.060(9), and 2002 c 371 § 212(5). 02-19-054 (Order 01-07), § 182-25-040, filed 9/12/02, effective

10/13/02. Statutory Authority: RCW 70.47.050, 70.47.060 and 70.47.100. 99-24-005 (Order 99-06), § 182-25-040, filed 11/18/99, effective 12/19/99. Statutory Authority: RCW 70.47.050 and 70.47.060. 99-16-022 (Order 99-02), § 182-25-040, filed 7/26/99, effective 8/26/99. Statutory Authority: RCW 70.47.050. 98-07-002, § 182-25-040, filed 3/5/98, effective 4/5/98; 97-15-003, § 182-25-040, filed 7/3/97, effective 8/3/97; 96-15-024, § 182-25-040, filed 7/9/96, effective 8/9/96.]

WAC 182-25-050 Employer groups. (1) BHP will accept applications for group enrollment in BHP from business owners, their spouses and eligible dependents, and on behalf of their eligible full-time and/or part-time employees, their spouses and eligible dependents.

(2) With the exception of home care agencies (see WAC 182-25-060(2)), the employer must enroll at least seventy-five percent of all eligible employees within a classification of employees in the basic health plan, and the employer must not offer other health care coverage to the same classification of employees. For purposes of this section, a "classification of employees" will be defined as a subgroup of employees (for example, part-time employees, full-time employees or bargaining units). Employees who demonstrate in the application process that they have health care coverage from other sources, such as their spouse or a federal program, shall be excluded from the minimum participation calculation.

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

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

(5) The employer will pay all or a designated portion of the premium, as determined by the administrator, on behalf of the enrollee. It is the employer's responsibility to collect the employee's portion of the premium and remit the entire payment to BHP and to notify BHP of any changes in the employee's account.

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

(7) Employees enrolling in BHP must meet all BHP eligibility requirements as outlined in WAC 182-25-030.

[Statutory Authority: RCW 70.47.050. 96-15-024, § 182-25-050, filed 7/9/96, effective 8/9/96.]

WAC 182-25-060 Home care agencies. BHP will accept applications from home care agencies under contract with the department of social and health services (DSHS) for group enrollment in BHP, with premiums paid by the home care agency or DSHS or a designee, under the provisions for employer groups, WAC 182-25-050, with the following exceptions or additions:

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

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

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

(4) Home care agencies are not subject to WAC 182-25-050(5).

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

[Statutory Authority: RCW 70.47.050, 96-15-024, § 182-25-060, filed 7/9/96, effective 8/9/96.]

WAC 182-25-070 Financial sponsors. (1) A third party may, with the approval of the administrator, become a financial sponsor to BHP enrollees. Financial sponsors may not be a state agency or a managed health care system.

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

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

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

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

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

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

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

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

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

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

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

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

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(3) The financial sponsor will establish eligibility for participation in that particular financial sponsor group; however, sponsored enrollees must meet all BHP eligibility requirements as outlined in WAC 182-25-030.

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

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

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

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

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

[Statutory Authority: RCW 70.47.050, 98-07-002, § 182-25-070, filed 3/5/98, effective 4/5/98; 96-15-024, § 182-25-070, filed 7/9/96, effective 8/9/96.]

WAC 182-25-080 Premiums and co-payments. (1) Subscribers or their employer or financial sponsor shall be responsible for paying the full monthly premium to BHP, on behalf of the subscriber and all enrolled dependents, according to the most current premium schedule. A third party may, with the approval of the administrator, become a financial sponsor and pay all or a designated portion of the premium on behalf of a subscriber and dependents, if any.

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

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

(4) Full payment for premiums due must be received by BHP by the date specified on the premium statement. If BHP does not receive full payment of a premium by the date specified on the premium statement, BHP shall issue a notice of delinquency to the subscriber, at the subscriber's last address on file with BHP or, in the case of group or financial sponsor coverage, to the employer or financial sponsor. If full pay-

ment is not received by the date specified in the delinquency notice, the subscriber and enrolled family members will be suspended from coverage for one month. If payment is not received by the due date on the notice of suspension, the subscriber and enrolled family members will be disenrolled effective the date of the initial suspension. If an enrollee's coverage is suspended more than two times in a twelve-month period, the enrollee will be disenrolled for nonpayment under the provisions of WAC 182-25-090(2). Partial payment of premiums due, payment which for any reason cannot be applied to the correct BHP enrollee's account, or payment by check which is not signed, cannot be processed, or is returned due to nonsufficient funds will be regarded as nonpayment.

(5) Enrollees shall be responsible for paying any required co-payment directly to the provider of a covered service at the time of service or directly to the MHCS. Repeated failure to pay co-payments in full on a timely basis may result in disenrollment, as provided in WAC 182-25-090(2).

[Statutory Authority: RCW 70.47.050 and 70.47.090. 02-19-053 (Order 01-08), § 182-25-080, filed 9/12/02, effective 10/13/02. Statutory Authority: RCW 70.47.050. 98-07-002, § 182-25-080, filed 3/5/98, effective 4/5/98; 96-15-024, § 182-25-080, filed 7/9/96, effective 8/9/96.]

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

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

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

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

(3) When a decision under subsection (1)(a) of this section is final, BHP may establish a payment schedule and, for enrollees who remain enrolled in BHP, will collect the amount owed through future premium statements. Enrollees who disenroll prior to paying the full amount of the subsidy overpayment may continue the payment plan previously approved by BHP or may be billed for the entire amount due. BHP may charge interest for the amount past due, at the rate specified under RCW 43.17.240 and rules promulgated thereunder. The payment schedule will be for a period of no more than six months, unless BHP approves an alternative payment schedule requested by the enrollee. When a payment schedule is established, BHP will send the enrollee advance written notice of the schedule and the total amount due. The total amount due each month will include the regular monthly premium plus charges for subsidy overpayment. If an enrollee does not pay the amount due, including charges for subsidy overpayment, the enrollee and all family members enrolled on the account will be disenrolled for nonpayment under WAC 182-25-090 (2)(b).

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

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

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

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

[Statutory Authority: RCW 70.47.050, 70.47.060(9), and 2002 c 371 § 212(5). 02-19-054 (Order 01-07), § 182-25-085, filed 9/12/02, effective 10/13/02. Statutory Authority: RCW 70.47.050, 70.47.060 and 70.47.090. 99-12-033 (Order 99-01), § 182-25-085, filed 5/26/99, effective 6/26/99.]

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

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

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

(b) Nonpayment of premium under the provisions of subsection (6) of this section;

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

(d) 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;

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

(f) 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;

(g) Abuse or intentional misconduct;

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

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

(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 (i) 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) Under the provisions of this subsection, BHP will suspend or disenroll enrollees and groups who do not pay their premiums when due, including amounts owed for subsidy overpayment, if any. Partial payment or payment by check which cannot be processed or is returned due to non-sufficient funds will be regarded as nonpayment.

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

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

(i) The effective date of the suspension;

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

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

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

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

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

(i) The effective date of the disenrollment; and

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

(7)(a) Enrollees who voluntarily disenroll or are disenrolled from BHP may not reenroll for a period of twelve months from the date their coverage ended 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.

(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, 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.]

WAC 182-25-100 Where to find instructions for filing an appeal. (1) WAC 182-25-105 and 182-25-110 cover appeals submitted by or on behalf of **basic health plan** enrollees or applicants. To appeal a decision regarding a child enrolled in **BHP plus** or a woman receiving **maternity**

benefits through medical assistance, subscribers must contact the Washington state department of social and health services (DSHS) to request a fair hearing under chapters 388-08 and 388-526 WAC.

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

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

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

WAC 182-25-105 How to appeal health care authority (HCA) decisions. (1) Health care authority decisions regarding the following may be appealed under this section:

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

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

- (a) The name, mailing address, and BHP account number of the subscriber or applicant;
- (b) The name and address of the enrollee or applicant affected by the decision, if that person is not the subscriber on the account;
- (c) A copy of the HCA notice of the decision that is being appealed or, if the notice is not available, a statement of the decision being appealed;
- (d) A statement explaining why the appealing party believes the decision was incorrect, outlining the facts surrounding the decision and including supporting documentation; and

(e) If the appealing party is not an enrollee or the subscriber on the account, a signed agreement from the enrollee, authorizing the appealing party to act on his/her behalf.

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

(4) **Initial HCA decisions:** The HCA will conduct appeals according to RCW 34.05.485. The HCA appeals committee or a single presiding officer designated by the HCA will review and decide the appeal. The appealing party may request an opportunity to be present in person or by telephone to explain his or her view. If the appealing party does not request an opportunity to be present to explain, the HCA appeals committee or presiding officer will review and decide the appeal based on the information and documentation submitted.

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

- (a) The appeal is received within ten business days of the effective date of the loss of coverage; and
- (b) The enrollee has clearly stated in the letter of appeal or has otherwise notified the HCA that he or she has an urgent medical need.

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

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

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

- (i) Be received within thirty days of the date of the initial HCA decision.
- (ii) Include a summary of the initial HCA decision being appealed and state why the appealing party believes the decision was incorrect; and

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

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

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

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

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

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

(b) The enrollee:

(i) Remains otherwise eligible;

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

and

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

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

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

[Statutory Authority: RCW 70.47.050. 01-23-095 (Order 00-01), § 182-25-105, filed 11/21/01, effective 1/1/02; 99-07-078, § 182-25-105, filed 3/18/99, effective 4/18/99; 98-07-002, § 182-25-105, filed 3/5/98, effective 4/5/98; 96-15-024, § 182-25-105, filed 7/9/96, effective 8/9/96.]

WAC 182-25-110 How to appeal a managed health care system (MHCS) decision. (1) Enrollees who are appealing a MHCS decision, including decisions related to coverage disputes; denial of claims; benefits interpretation; or resolution of complaints must follow their MHCS's complaint/appeals process.

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

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

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

(b) Investigating and resolving MHCS contractual issues; and

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

[Statutory Authority: RCW 70.47.050. 01-23-095 (Order 00-01), § 182-25-110, filed 11/21/01, effective 1/1/02; 99-07-078, § 182-25-110, filed 3/18/99, effective 4/18/99; 96-15-024, § 182-25-110, filed 7/9/96, effective 8/9/96.]