WSR 26-14-080
PERMANENT RULES
HEALTH CARE AUTHORITY
(Public Employees Benefits Board)
[Admin #2026.01—Filed June 29, 2026, 10:34 a.m., effective January 1, 2027]

Effective Date of Rule: January 1, 2027.

Purpose: The purpose of this proposal is to make technical amendments in multiple sections of chapters 182-08 and 182-12 WAC to support the public employees benefit board (PEBB) program:

Amended WAC 182-08-180 to clarify premium refund when the Centers for Medicare and Medicaid Services determines a subscriber is retroactively disenrolled from coverage, such as a PEBB program medicare advantage prescription drug plan, or a PEBB program medicare Part D plan.

Amended WAC 182-08-185 to add an exception regarding a subscriber who covers their spouse or state registered domestic partner who is eligible but elected not to enroll in school employees benefits board (SEBB) medical will not incur a premium surcharge.

Amended WAC 182-08-187 to clarify when an employer fails to timely notify an employee that they are eligible for PEBB benefits, the employee may elect to prospectively enroll in supplemental life insurance, supplemental accidental death and dismemberment insurance, and employee-paid long-term disability insurance, without requiring evidence of insurability.

Amended WAC 182-08-190 to clarify the entire employer contribution is due and payable to health care authority from the date PEBB benefits begin.

Amended WAC 182-08-191 to add a new subsection to include subscribers must provide their permanent residence address to determine that they reside in the health plan service area.

Amended WAC 182-08-198 to add the following special open enrollment events:

- A new special open enrollment event regarding a subscriber or subscriber's dependent becoming eligible and enrolling in a TRICARE plan or losing eligibility for a TRICARE plan.
- A new special open enrollment event regarding when the PEBB program determines that there has been a substantial increase in the employee's premiums when the employee transfers from one employing agency to another employing agency.

Amended WAC 182-08-199 to add a new special open enrollment event regarding when the PEBB program determines that there has been a substantial increase in the employee's premiums when the employee transfers from one employing agency to another employing agency.

Amended WAC 182-12-123 to clarify when an employee may not waive PEBB medical, PEBB dental, and PEBB vision to enroll in a SEBB participating employer group that only offers medical coverage.

Amended WAC 182-12-128 to clarify when an employee may not waive PEBB medical, PEBB dental, and PEBB vision to enroll in SEBB medical with SEBB participating employer group coverage that only offers medical coverage, and to clarify when PEBB medical will be waived when the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child.

Amended WAC 182-12-200 to make technical corrections when enrollment in PEBB retiree insurance coverage may be deferred when a sub-

scriber is enrolled as a dependent in a medical plan sponsored by PEBB or SEBB.

Amended WAC 182-12-232 to add a new subsection and explain what happens when a subscriber enrolled under this section or their dependent's PEBB medical plan enrollment is terminated as required by federal law.

Amended WAC 182-12-262 to include a note in subsection (3)(a)(i) regarding how the date the required form is received may determine the effective date of coverage before proof of the event is received, and to add a new special open enrollment event regarding when a subscriber or subscriber's dependent becomes eligible and enrolls in a TRICARE plan or loses eligibility for a TRICARE plan.

Citation of Rules Affected by this Order: Amending WAC 182-08-180, 182-08-185, 182-08-187, 182-08-190, 182-08-191, 182-08-198, 182-08-199, 182-12-123, 182-12-128, 182-12-200, 182-12-232, and 182-12-262.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.065, and 41.05.160.

Adopted under notice filed as WSR 26-10-029 on April 29, 2026.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 12, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 12, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 12, Repealed 0.

Date Adopted: June 29, 2026.

Wendy Barcus
Rules Coordinator

RDS-7128.1

AMENDATORY SECTION (Amending WSR 24-18-078, filed 8/29/24, effective 1/1/25)

WAC 182-08-180 Premium payments and premium refunds. Public employees benefits board (PEBB) insurance coverage premiums and applicable premium surcharges for all subscribers are due as described in this section, except when an employing agency is correcting its enrollment error as described in WAC 182-08-187 (4) or (5).

(1) **Premium payments.** PEBB insurance coverage premiums and applicable premium surcharges for all subscribers become due the first of the month in which PEBB insurance coverage is effective.

Premiums and applicable premium surcharges are due from the subscriber for the entire month of PEBB insurance coverage and will not

be prorated during any month, except as described in (e) of this subsection.

(a) For subscribers not eligible for the employer contribution that are electing to enroll in PEBB retiree insurance coverage as described in WAC 182-12-171 (1)(a), 182-12-180 (3)(a), 182-12-200 (3)(a) or (b), 182-12-205 (6) or (7), 182-12-211, and 182-12-265 (1), (2)(d), and (3); or electing to enroll in continuation coverage as described in WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, and 182-12-270; or a retired employee, a retired school employee, or a survivor electing to enroll in PEBB health plan coverage when their employer group ceases participation as described in WAC 182-12-232, the first premium payment and applicable premium surcharges are due to the health care authority (HCA) or the contracted vendor no later than 45 days after the election period ends as described within the Washington Administrative Code applicable to the subscriber. Premiums and applicable premium surcharges associated with continuing PEBB medical must be made to the HCA as well as premiums associated with continuing PEBB dental, PEBB vision, or long-term disability (LTD) insurance coverage. Any medicare Part D late enrollment penalty associated with the medicare advantage-prescription drug (MA-PD) plan or Uniform Medical Plan (UMP) Classic medicare plan must be made to the contracted vendor. Premiums associated with life insurance and accidental death and dismemberment (AD&D) insurance coverage must be made to the contracted vendor. Following the first premium payment, premiums and applicable premium surcharges must be paid as premiums become due.

Exceptions:

(1) A subscriber electing to enroll in PEBB retiree insurance coverage who elects to pay premiums by deducting from their Washington state department of retirement systems pension retirement benefit is not required to make the first premium payment and applicable premium surcharges to begin enrollment. If there is a delay in the deduction from the pension when the subscriber first enrolls, HCA will send an invoice to the subscriber for the first premium payment and applicable premium surcharges.

(2) A subscriber enrolled in continuation coverage as defined in WAC 182-08-015 or 182-30-020 who is electing to enroll in PEBB retiree insurance coverage, or a subscriber enrolled in continuation coverage as defined in WAC 182-08-015 who is electing to enroll in another type of continuation coverage is not required to make the first premium payment and applicable premium surcharges to begin the new enrollment.

(b) For employees who are eligible for the employer contribution, premiums and applicable premium surcharges are due to the employing agency or contracted vendor. If an employee elects supplemental coverage or employee-paid LTD insurance, or is enrolled in employee-paid LTD insurance as described in WAC 182-08-197 (1)(a) or (3)(a), or is enrolled in employee-paid LTD insurance as described in WAC 182-08-197 (1)(b), the employee is responsible for payment of premiums from the month that the supplemental coverage or employee-paid LTD insurance begins.

Exception:

An employee who is on a leave of absence and maintains eligibility for the employer contribution, will have their premiums waived for their employee-paid LTD insurance for the first 90 days. For this purpose, "leave of absence" is defined as a paid or unpaid temporary or indefinite administrative leave, involuntary leave, sick leave, or insurance continued under the federal Family and Medical Leave Act, or paid family and medical leave program as described in WAC 182-12-138.

(c) Unpaid or underpaid premiums or applicable premium surcharges for all subscribers must be paid, and are due from the employing agency, subscriber, or a subscriber's legal representative to the HCA or contacted vendor. For subscribers not eligible for the employer contribution, monthly premiums or applicable premium surcharges that remain unpaid for 30 days will be considered delinquent. A subscriber is allowed a grace period of 30 days from the date the monthly premiums or applicable premium surcharges become delinquent to pay the unpaid premium balance or applicable premium surcharges. If a subscriber's monthly premiums or applicable premium surcharges remain unpaid for 60 days from the original due date, the subscriber's PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premiums and any applicable premium surcharges were

paid. If it is determined by the HCA that payment of the unpaid balance in a lump sum would be considered a hardship, the HCA may develop a reasonable payment plan of up to 12 months in duration with the subscriber or the subscriber's legal representative upon request.

Exception: For a subscriber enrolled in a medicare advantage plan, a ((~~medicare advantage prescription drug~~)) MA-PD plan, or the ((~~Uniform Medical Plan~~)) UMP Classic medicare plan a notice will be sent to them notifying them that they are delinquent on their monthly premiums and that the enrollment will be terminated prospectively to the end of the month after the notice is sent.

(d) Monthly premiums or applicable premium surcharges due from a subscriber who is not eligible for the employer contribution will be considered unpaid if one of the following occurs:

(i) No payment of premiums or applicable premium surcharges are received by the HCA or contracted vendor and the monthly premiums or applicable premium surcharges remain unpaid for 30 days; or

(ii) Premium payments or applicable premium surcharges received by the HCA or contracted vendor are underpaid by an amount greater than an insignificant shortfall and the monthly premiums or applicable premium surcharges remain underpaid for 30 days past the date the monthly premiums or applicable premium surcharges were due.

(e) When an enrolled retiree dies on or after June 6, 2024, the premium payments for PEBB medical, PEBB dental, PEBB vision, and any applicable premium surcharges for the retiree will be waived by HCA for the month in which the death occurred. Subscribers enrolled as described in WAC 182-12-265 (2)(c) will be responsible for their continued payment of premiums and applicable premium surcharges as described in this section.

(2) **Premium refunds.** PEBB insurance coverage premiums and applicable premium surcharges will be refunded using the following methods:

(a) When a subscriber submits an enrollment change affecting subscriber or dependent eligibility, HCA may allow up to three months of accounting adjustments. HCA will refund to the individual or the employing agency any excess premiums and applicable premium surcharges paid during the 60-day adjustment period, except as indicated in WAC 182-12-148(5).

(b) When premiums and applicable premium surcharges are waived for a retiree who dies as described in subsection (1)(e) of this section, HCA will refund any excess premiums and applicable premium surcharges paid to the retiree's estate, to the department of retirement systems, or apply any excess premiums to the surviving dependent's account.

(c) If a PEBB subscriber, dependent, or beneficiary submits a written appeal as described in WAC 182-16-2010, and provides clear and convincing evidence of extraordinary circumstances, such that the subscriber could not timely submit the necessary information to accomplish an allowable enrollment change within 60 days after the event that created a change of premiums, the PEBB director, the PEBB director's designee, or the PEBB appeals unit may:

(i) Approve a refund of premiums and applicable premium surcharges which does not exceed 12 months of premiums; and

(ii) Approve the enrollment change that was originally requested and which forms the basis for the refund.

(d) If a federal government entity determines that an enrollee is retroactively enrolled in coverage (for example, medicare) the subscriber or beneficiary may be eligible for a refund of premiums and applicable premium surcharges paid during the time they were enrolled under the federal program if approved by the PEBB director or the PEBB director's designee.

(e) If the Centers for Medicare and Medicaid Services determines that an enrollee is retroactively disenrolled from coverage (for example, a PEBB program MA-PD plan or a PEBB program medicare Part D plan), the subscriber or beneficiary may be eligible for a refund of premiums and applicable premium surcharges paid during the time they were disenrolled from the plan if approved by the PEBB director or the PEBB director's designee.

(f) HCA errors will be corrected by returning all excess premiums and applicable premium surcharges paid by the employing agency, subscriber, or beneficiary.

((~~(f)~~)) (g) Employing agency errors will be corrected by returning all excess premiums and applicable premium surcharges paid by the employee or beneficiary as described in WAC 182-08-187 (4) and (5).

AMENDATORY SECTION (Amending WSR 24-18-076, filed 8/29/24, effective 1/1/25)

WAC 182-08-185 What are the requirements regarding premium surcharges? (1) A subscriber's account will incur a premium surcharge in addition to the subscriber's monthly medical premium, when any enrollee, 13 years and older, engages in tobacco use.

(a) A subscriber must attest to whether any enrollee, 13 years and older, enrolled in their public employees benefits board (PEBB) medical engages in tobacco use. The subscriber must attest as described in (a)(i) through (vii) of this subsection:

(i) An employee who is newly eligible or regains eligibility for the employer contribution toward PEBB benefits must complete the required form to enroll in PEBB medical as described in WAC 182-08-197 (1) or (3). The employee must include their attestation on that form. The employee must submit the form to their employing agency. If the employee's attestation results in a premium surcharge, it will take effect the same date as PEBB medical begins.

(ii) If there is a change in the tobacco use status of any enrollee, 13 years and older on the subscriber's PEBB medical, the subscriber must update their attestation on the required form. An employee must submit the form to their employing agency. Any other subscriber must submit their form to the PEBB program. The attestation change will apply as follows:

• A change that results in a premium surcharge will begin the first day of the month following the status change. If that day is the first of the month, the change to the surcharge begins on that day.

• A change that results in removing the premium surcharge will begin the first day of the month following receipt of the attestation. If that day is the first of the month, the change to the surcharge begins on that day.

(iii) If a subscriber submits the required form to enroll a dependent, 13 years and older, in PEBB medical as described in WAC 182-12-262, the subscriber must attest for their dependent on the required form. An employee must submit the form to their employing agency. Any other subscriber must submit their form to the PEBB program. A change that results in a premium surcharge will take effect the same date as PEBB medical begins.

(iv) An enrollee, 13 years and older, who elects to continue medical coverage as described in WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, 182-12-270, or 182-12-232 must provide an at-

testation on the required form if they have not previously attested as described in (a) of this subsection. The enrollee must submit their form to the PEBB program. An attestation that results in a premium surcharge will take effect the same date as PEBB medical begins.

(v) An employee or retiree who enrolls in PEBB medical as described in WAC 182-12-171 (1)(a), 182-12-180 (3)(a), 182-12-200 (3)(a) or (b), 182-12-205 (6) or (7), or 182-12-211, must provide an attestation on the required form if they have not previously attested as described in (a) of this subsection. The employee or retiree must submit their form to the PEBB program. An attestation that results in a premium surcharge will take effect the same date as PEBB medical begins.

(vi) A surviving spouse, state registered domestic partner, or dependent child, 13 years and older, who enrolls in PEBB medical as described in WAC 182-12-180 (3)(a), 182-12-250(5) or 182-12-265, must provide an attestation on the required form to the PEBB program if they have not previously attested as described in (a) of this subsection. An attestation that results in a premium surcharge will take effect the same date as PEBB medical begins.

(vii) An employee who previously waived PEBB medical must complete the required form to enroll in PEBB medical as described in WAC 182-12-128(3). The employee must include their attestation on that form. An employee must submit the form to their employing agency. An attestation that results in a premium surcharge will take effect the same date as PEBB medical begins.

Exceptions:

(1) A subscriber enrolled in both medicare Parts A and B and in the medicare risk pool as described in RCW 41.05.080(3) is not required to provide an attestation and no premium surcharge will be imposed on the subscriber's account.

(2) An employee who waives PEBB medical as described in WAC 182-12-128 is not required to provide an attestation and no premium surcharge will be applied to their account as long as the employee remains in waived status.

(b) A subscriber's account will incur a premium surcharge when a subscriber fails to attest to the tobacco use status of all enrollees as described in (a) of this subsection.

(c) The PEBB program will provide a reasonable alternative for enrollees who use tobacco products. A subscriber can avoid the tobacco use premium surcharge if the subscriber attests on the required form that all enrollees who use tobacco products enrolled in or accessed one of the applicable reasonable alternatives offered below:

(i) An enrollee who is 18 years and older and uses tobacco products is currently enrolled in the free tobacco cessation program through their PEBB medical.

(ii) An enrollee who is 13 through 17 years old and uses tobacco products accessed the information and resources aimed at teens on the Washington state department of health's website at https://teen.smokefree.gov.

(iii) A subscriber may contact the PEBB program to accommodate a physician's recommendation that addresses an enrollee's use of tobacco products or for information on how to avoid the tobacco use premium surcharge.

(2) A subscriber will incur a premium surcharge in addition to the subscriber's monthly medical premium, if an enrolled spouse or state registered domestic partner has chosen not to enroll in another employer-based group medical where the spouse's or state registered domestic partner's share of the medical premium is less than 95 percent of the additional cost an employee would be required to pay to enroll a spouse or state registered domestic partner in the PEBB Uniform Medical Plan (UMP) Classic and the benefits have an actuarial value of at least 95 percent of the actuarial value of the PEBB UMP Classic's benefits.

(a) A subscriber who enrolled a spouse or state registered domestic partner under their PEBB medical may only attest during the following times:

(i) When a subscriber becomes eligible to enroll a spouse or state registered domestic partner in PEBB medical as described in WAC 182-12-262. The subscriber must complete the required form to enroll their spouse or state registered domestic partner, and include their attestation on that form. The employee must submit the form to their employing agency. Any other subscriber must submit the form to the PEBB program. If the subscriber's attestation results in a premium surcharge it will take effect the same date as PEBB medical begins;

(ii) During the annual open enrollment. A subscriber must attest if during the month prior to the annual open enrollment the subscriber was:

• Incurring the surcharge;

• Not incurring the surcharge because the spouse's or state registered domestic partner's share of the medical premium through their employer-based group medical was more than 95 percent of the additional cost an employee would be required to pay to enroll a spouse or state registered domestic partner in the PEBB UMP Classic; or

• Not incurring the surcharge because the actuarial value of benefits provided through the spouse's or state registered domestic partner's employer-based group medical was less than 95 percent of the actuarial value of the PEBB UMP Classic's benefits.

A subscriber must update their attestation on the required form. An employee must submit the form to their employing agency. Any other subscriber must submit the form to the PEBB program. The subscriber's attestation or any correction to a subscriber's attestation must be received no later than December 31st of the year in which the annual open enrollment occurs. If the subscriber's attestation results in a premium surcharge, being added or removed, the change to the surcharge will take effect January 1st of the following year; and

(iii) When there is a change in the spouse's or state registered domestic partner's employer-based group medical. A subscriber must provide evidence of the event and update their attestation on the required form. An employee must submit the form to their employing agency no later than 60 days after the spouse's or state registered domestic partner's employer-based group medical status changes. Any other subscriber must submit the form to the PEBB program no later than 60 days after the spouse's or state registered domestic partner's employer-based group medical status changes.

• A change that results in a premium surcharge will begin the first day of the month following the status change. If that day is the first day of the month, the change to the premium surcharge begins on that day.

• A change that results in removing the premium surcharge will begin the first day of the month following receipt of the attestation. If that day is the first day of the month, the change to the premium surcharge begins on that day.

Exceptions:

(1) A subscriber enrolled in both medicare Parts A and B and in the medicare risk pool as described in RCW 41.05.080(3) is not required to provide an attestation and no premium surcharge will be imposed on the subscriber's account.

(2) An employee who waives PEBB medical as described in WAC 182-12-128 is not required to provide an attestation and no premium surcharge will be applied to their account as long as the employee remains in waived status.

(3) An employee who covers their spouse or state registered domestic partner who has waived their own PEBB or school employees benefits board (SEBB) medical must attest as described in this subsection, but will not incur a premium surcharge if the employee provides an attestation that their spouse or state registered domestic partner is eligible for PEBB or SEBB medical.

(4) A subscriber who covers their spouse or state registered domestic partner who elected not to enroll in a TRICARE plan must attest as described in this subsection, but will not incur a premium surcharge if the subscriber provides an attestation that their spouse or state registered domestic partner is eligible for a TRICARE plan.

(b) A premium surcharge will be applied to a subscriber who does not attest as described in (a) of this subsection.

AMENDATORY SECTION (Amending WSR 25-14-081, filed 6/30/25, effective 1/1/26)

WAC 182-08-187 How do employing agencies and contracted vendors correct enrollment errors and is there a limit on retroactive enrollment? (1) An employing agency or contracted vendor that makes one or more of the following enrollment errors must correct the error as described in subsections (2) through (5) of this section.

(a) Failure to timely notify an employee of their eligibility for public employee benefits board (PEBB) benefits and the employer contribution as described in WAC 182-12-113(2);

(b) Failure to enroll the employee and their dependents in PEBB benefits as elected by the employee, if the elections were timely;

(c) Failure to enroll an employee and their dependents in PEBB benefits as described in WAC 182-08-197 (1)(b) or (3)(c);

(d) Failure to accurately reflect an employee's premium surcharge attestation on the employee's account;

(e) Enrolling an employee or their dependent in PEBB insurance coverage when they are not eligible as described in WAC 182-12-114 or 182-12-260 and it is clear there was no fraud or intentional misrepresentation by the employee involved; or

(f) Providing incorrect information regarding PEBB benefits to the employee that they relied upon.

(2) The employing agency or the applicable contracted vendor must enroll the employee and the employee's dependents, as elected, or terminate enrollment in PEBB benefits as described in subsection (3) of this section, reconcile premium payments and applicable premium surcharges as described in subsection (4) of this section, and provide recourse as described in subsection (5) of this section.

(3) **Enrollment or termination.**

(a) PEBB medical, dental, and vision enrollment is effective the first day of the month following the date the enrollment error is identified, unless the authority determines additional recourse is warranted, as described in subsection (5) of this section. If the enrollment error is identified on the first day of the month, the enrollment correction is effective that day;

Exception: When an employee who is called to active duty in the uniformed services under Uniformed Services Employment and Reemployment Rights Act (USERRA) loses eligibility for the employer contribution toward PEBB benefits, they regain eligibility for the employer contribution toward PEBB benefits the day they return from active duty. Employer-paid PEBB benefits will begin the first day of the month in which they return from active duty.

(b) Basic life, supplemental life insurance, basic accidental death and dismemberment (AD&D), supplemental AD&D, employer-paid long-term disability (LTD) insurance, and employee-paid LTD insurance will begin for a newly eligible employee as described in WAC 182-12-114 and for an employee regaining eligibility as described in WAC 182-08-197(3). An employee who regains eligibility may need to submit evidence of insurability for supplemental life insurance or employee-paid LTD insurance as required in WAC 182-08-197(3).

Exception: When an employing agency fails to timely notify an employee that they are eligible for PEBB benefits, the employee may elect to prospectively enroll, without requiring evidence of insurability, in supplemental life insurance, supplemental AD&D insurance, and employee-paid LTD insurance effective the first day of the month following the date the enrollment error is identified, unless the authority determines additional recourse is warranted, as described in subsection (5) of this section. If the enrollment error is identified on the first day of the month, the enrollment correction is effective that day.

(c) If the employee is eligible and elects (or elected) to enroll in the flexible spending arrangement (FSA), limited purpose FSA, or dependent care assistance program (DCAP), enrollment is limited to 60 days prior to the date enrollment is processed, but not earlier than the current plan year. If an employee was not enrolled in a FSA, limited purpose FSA, or DCAP as elected, the employee may either participate at the amount originally elected with a corresponding increase in contributions for the balance of the plan year, or participate at a reduced amount for the plan year by maintaining the per-pay period contribution in effect;

(d) If the employee or their dependent was not eligible but still enrolled as described in subsection (1)(e) of this section, the employee's or their dependent's PEBB benefits will be terminated prospectively effective as of the last day of the month.

(4) **Premium payments.**

(a) The employing agency must remit to the authority the employer contribution and the employee contribution for health plan premiums, applicable premium surcharges, basic life, basic AD&D, and employer-paid LTD starting the date PEBB benefits begins as described in subsections (3) and (5)(a)(i) of this section. If a state agency failed to notify a newly eligible employee of their eligibility for PEBB benefits, the state agency may only collect the employee contribution for health plan premiums and applicable premium surcharges for coverage for the months after the employee was notified.

(b) When an employing agency fails to correctly enroll the amount of employee-paid LTD insurance elected by the employee, premiums will be corrected as follows:

(i) When additional premiums are due to the authority, the employee is responsible for premiums for the most recent 24 months of coverage. The employing agency is responsible for additional months of premiums.

(ii) When a premium refund is due to the employee, the LTD insurance contracted vendor is responsible for premium refunds for the most recent 24 months of coverage. The employing agency is responsible for additional months of premium refund.

(c) When an employing agency mistakenly enrolls an employee or their dependent as described in subsection (1)(e) of this section, premiums and any applicable premium surcharges will be refunded by the employing agency to the employee without rescinding the insurance coverage.

(5) **Recourse.**

(a) An employee who establishes eligibility will have benefits begin as described in WAC 182-12-114. An employee who regains eligibility for the employer contribution toward PEBB benefits will have benefits begin as described in WAC 182-08-197(3). Dependent eligibility is described in WAC 182-12-260, and dependent enrollment is described in WAC 182-12-262. When retroactive correction of an enrollment error is limited as described in subsection (3)(a), (b), and (c) of this section, the employing agency must work with the employee, and receive approval from the authority, to implement retroactive PEBB benefits within the following parameters:

(i) Retroactive enrollment in a PEBB insurance coverage;

(ii) Reimbursement of claims paid;

(iii) Reimbursement of amounts paid by the employee or dependent for medical, dental, and vision premiums;

(iv) Reimbursement of amounts paid by the employee for the premium surcharges;

(v) Other legal remedy received or offered; or

(vi) Other recourse, upon approval by the authority.

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

AMENDATORY SECTION (Amending WSR 21-13-103, filed 6/18/21, effective 1/1/22)

WAC 182-08-190 The employer contribution is set by the health care authority (HCA) and paid to the HCA for all eligible employees. State agencies and employer groups that participate in the public employees benefits board (PEBB) program under contract with the health care authority (HCA) must pay the employer contributions to the HCA for PEBB benefits for all eligible employees and their enrolled dependents.

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

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

(3) Each employee of a state agency eligible under WAC 182-12-131 or each eligible employee of a state agency on leave under the federal Family and Medical Leave Act (FMLA) or the paid family and medical leave program is eligible for the employer contribution as described in WAC 182-12-138.

(4) Employees of employer groups eligible under criteria stipulated under contract with the HCA are eligible for the employer contribution.

(5) The entire employer contribution is due and payable to the HCA from the date the employee is eligible for PEBB benefits to begin, even if enrollment is waived as described in WAC 182-12-128.

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

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

AMENDATORY SECTION (Amending WSR 24-18-076, filed 8/29/24, effective 1/1/25)

WAC 182-08-191 Subscriber address requirements. (1) All employees must provide their employing agency with their correct address and update their address if it changes. All other subscribers must provide the public employees benefits board (PEBB) program with their correct address and updates to their address if it changes.

(2) All subscribers enrolling in a medicare supplement plan, a medicare advantage plan, a medicare advantage-prescription drug plan, or the Uniform Medical Plan Classic medicare plan, must provide their permanent residence address to the PEBB program to determine that they reside in the health plan service area.

(3) In the event of an appeal, appellants must update their address as required in WAC 182-16-055.

AMENDATORY SECTION (Amending WSR 25-14-081, filed 6/30/25, effective 1/1/26)

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

(1) **During the annual open enrollment:** A subscriber may change health plans during the public employees benefits board (PEBB) annual open enrollment period. A subscriber must submit the required enrollment forms to change their health plan. An employee submits the enrollment forms to their employing agency. Any other subscriber submits the enrollment forms to the PEBB program. The required enrollment forms must be received no later than the last day of the annual open enrollment. Enrollment in the new health plan will begin January 1st of the following year.

(2) **During a special open enrollment:** A subscriber may revoke their health plan election and make a new election outside of the annual open enrollment if a special open enrollment event occurs. A special open enrollment event must be an event other than an employee gaining initial eligibility for PEBB benefits as described in WAC 182-12-114 or regaining eligibility for PEBB benefits as described in WAC 182-08-197. The change in enrollment must be allowable under Internal Revenue Code and Treasury regulations, and correspond to and be consistent with the event that creates the special open enrollment for the subscriber, the subscriber's dependent, or both.

A subscriber may not change their health plan during a special open enrollment if their state registered domestic partner or state registered domestic partner's child is not a tax dependent. A subscriber may change their health plan as described in subsection (1) of this section.

To disenroll from a medicare advantage (MA) plan, medicare advantage-prescription drug (MA-PD) plan, or the Uniform Medical Plan (UMP) Classic medicare plan, the change in enrollment must be allowable under 42 C.F.R. Secs. 422.62(b) and 423.38(c). To make a health plan change, a subscriber must submit the required enrollment forms (and a completed disenrollment form, if required). The forms must be received no later than 60 days after the event occurs, except as described in (i) and (j) of this subsection. An employee submits the enrollment forms to their employing agency. Any other subscriber submits the enrollment forms to the PEBB program. In addition to the required forms, a subscriber must provide evidence of the event that created the special open enrollment. New health plan coverage will begin the first day of the month following the later of the event date or the date the form is received. If that day is the first of the month, the change in enrollment begins on that day except for a MA plan, a MA-PD plan, or the UMP Classic medicare plan which will begin the first day of the month following the date the form is received.

Exception: When a subscriber or their dependent is enrolled in a MA plan, a MA-PD plan, or the UMP Classic medicare plan, they may disenroll during a special enrollment period as allowed under 42 C.F.R. Secs. 422.62(b) and 423.38(c). The new medical plan coverage will begin the first day of the month following the date the plan disenrollment form is received.

If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, health plan coverage will begin the month in which the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption occurs. If the special open enrollment is due to the enrollment of an extended dependent or a dependent with a disability, the change in health plan coverage will begin the first day of the month following the later of the event date or eligibility certification. Any one of the following events may create a special open enrollment:

(a) Subscriber acquires a new dependent due to:

(i) Marriage or registering a state registered domestic partnership;

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

(iii) A child becoming eligible as an extended dependent through legal custody or legal guardianship;

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

(c) Subscriber has a change in employment status that affects the subscriber's eligibility for their employer contribution toward their employer-based group health plan;

(d) The subscriber's dependent has a change in their own employment status that affects their eligibility or their dependent's eligibility for the employer contribution under their employer-based group health plan;

Note: As used in (d) of this subsection, "employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 26 C.F.R. 54.9801-6.

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

(i) If the subscriber has a change in residence and the subscriber's current medical plan is no longer available, the subscriber must select a new medical plan as described in WAC 182-08-196(3);

(ii) If the subscriber or the subscriber's dependent has a change in residence and the subscriber's current dental plan does not have available providers within 50 miles of the subscriber or the subscriber's dependent's new residence, the subscriber may select a new dental plan;

(f) A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state registered domestic partner is not an eligible dependent);

(g) Subscriber or a subscriber's dependent enrolls in coverage under medicaid or a state children's health insurance program (CHIP), or the subscriber or a subscriber's dependent loses eligibility for coverage under medicaid or CHIP;

(h) Subscriber or a subscriber's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from medicaid or CHIP;

(i) Subscriber or a subscriber's dependent enrolls in coverage under medicare, or the subscriber or a subscriber's dependent loses

eligibility for coverage under medicare, or enrolls in or terminates enrollment in a MA-PD or a Part D plan. If the subscriber's current medical plan becomes unavailable due to the subscriber's or a subscriber's dependent's enrollment in medicare, the subscriber must select a new medical plan as described in WAC 182-08-196(2);

(i) A subscriber enrolled in PEBB retiree insurance coverage, a retired employee, a retired school employee, or a survivor enrolled in PEBB health plan coverage after their employer group ceased participation, or an eligible subscriber enrolled in Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage has six months from the date of their or their dependent's enrollment in medicare Part B to enroll in a PEBB medicare supplement plan for which they or their dependent is eligible. The forms must be received by the PEBB program no later than six months after the enrollment in medicare Part B for either the subscriber or the subscriber's dependent;

(ii) A subscriber enrolled in PEBB retiree insurance coverage, a retired employee, a retired school employee, or a survivor enrolled in PEBB health plan coverage after their employer group ceased participation, or an eligible subscriber enrolled in COBRA coverage has seven months to enroll in a MA plan, MA-PD plan, or the UMP Classic medicare plan that begins three months before they or their dependent first enrolled in both medicare Part A and Part B and ends three months after the month of medicare eligibility. A subscriber may also enroll themselves or their dependent in a MA plan, MA-PD plan, or the UMP Classic medicare plan before their last day of the medicare Part B initial enrollment period. The forms must be received by the PEBB program no later than the last day of the month prior to the month the subscriber or the subscriber's dependent enrolls in the MA plan, MA-PD plan, or the UMP Classic medicare plan;

(j) Subscriber or a subscriber's dependent gains, loses, or has a change in low-income subsidy (LIS) eligibility as described in 42 C.F.R. § 423.38 (c)(9). They may enroll in a MA plan, MA-PD plan, medicare supplement plan, or the UMP Classic medicare plan if eligible, within three months after a gain, loss, or change to LIS eligibility, or notification of such a change, whichever is later. The forms must be received by the PEBB program no later than three months after they gain, lose, or have a change in LIS eligibility, or notification of such a change, whichever is later;

(k) Subscriber or a subscriber's dependent's current medical plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA). The authority may require evidence that the subscriber or subscriber's dependent is no longer eligible for an HSA;

(l) Subscriber or a subscriber's dependent experiences a disruption of care for active and ongoing treatment, that could function as a reduction in benefits for the subscriber or the subscriber's dependent. A subscriber may not change their health plan election if the subscriber's or dependent's physician stops participation with the subscriber's health plan unless the PEBB program determines that a continuity of care issue exists. The PEBB program will consider but not limit its consideration to the following:

(i) Active cancer treatment such as chemotherapy or radiation therapy;

(ii) Treatment following a recent organ transplant;

(iii) A scheduled surgery;

(iv) Recent major surgery still within the postoperative period; or

(v) Treatment for a high-risk pregnancy;

(m) Subscriber or a subscriber's dependent becomes eligible and enrolls in a TRICARE plan or loses eligibility for a TRICARE plan;

(n) The PEBB program determines that there has been a substantial decrease in the providers available under a PEBB medical plan;

(o) The PEBB program determines that there has been a substantial increase in the employee's premiums when the employee transfers from one employing agency to another employing agency.

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

AMENDATORY SECTION (Amending WSR 24-18-083, filed 8/29/24, effective 1/1/25)

WAC 182-08-199 When may an employee enroll, or revoke an election and make a new election under the premium payment plan, flexible spending arrangement (FSA), limited purpose FSA, or dependent care assistance program (DCAP)? An employee who is eligible to participate in the salary reduction plan as described in WAC 182-12-116 may enroll, or revoke their election and make a new election under the premium payment plan, flexible spending arrangement (FSA), limited purpose FSA, or dependent care assistance program (DCAP) at the following times:

(1) When newly eligible under WAC 182-12-114 and enrolling as described in WAC 182-08-197(1).

(2) **During annual open enrollment:** An eligible employee may elect to enroll in or opt out of participation under the premium payment plan during the annual open enrollment by submitting the required form to their employing agency. An eligible employee may elect to enroll or reenroll in the FSA, limited purpose FSA, DCAP, or both an FSA and DCAP during the annual open enrollment by submitting the required forms to their employing agency or applicable contracted vendor as instructed. All required forms must be received no later than the last day of the annual open enrollment. The enrollment or new election becomes effective January 1st of the following year.

(a) Employees cannot enroll in a FSA and a limited purpose FSA in the same year.

(b) Employees enrolled in a consumer directed health plan (CDHP) with a health savings account (HSA) cannot also enroll in a FSA in the same plan year. Employees who elect enrollment in the CDHP with a HSA and a FSA will only be enrolled in a CDHP with a HSA.

(c) Employees who enroll in a CDHP with a HSA during the annual open enrollment and have a carryover amount from a FSA, will be enrolled in a limited purpose FSA and the carryover amount will be deposited into the limited purpose FSA.

(d) Employees who are not enrolled in a CDHP with a HSA and elect both a FSA and a limited purpose FSA will be enrolled in the FSA.

(3) **During a special open enrollment:** An employee who is eligible to participate in the salary reduction plan may enroll or revoke their election and make a new election under the premium payment plan, FSA, limited purpose FSA, or DCAP outside of the annual open enrollment if a special open enrollment event occurs. The enrollment or change in election must be allowable under Internal Revenue Code (IRC) and

Treasury regulations, and correspond to and be consistent with the event that creates the special open enrollment. To make a change or enroll, the employee must submit the required form to their employing agency. The employing agency must receive the required form and evidence of the event that created the special open enrollment no later than 60 days after the event occurs.

For purposes of this section, an eligible dependent includes any person who qualifies as a dependent of the employee for tax purposes under IRC 26 U.S.C. Sec. 152 without regard to the income limitations of that section. It does not include a state registered domestic partner unless the state registered domestic partner otherwise qualifies as a dependent for tax purposes under IRC 26 U.S.C. Sec. 152.

(a) **Premium payment plan.** An employee may enroll or revoke their election and elect to opt out of the premium payment plan when any of the following special open enrollment events occur, if the requested change corresponds to and is consistent with the event. The enrollment or election to opt out will be effective the first day of the month following the later of the event date or the date the required form is received. If that day is the first of the month, the enrollment or change in election begins on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, the enrollment or change in election will begin the first of the month in which the event occurs.

(i) Employee acquires a new dependent due to:

• Marriage;

• Registering a state registered domestic partnership when the dependent is a tax dependent of the employee;

• Birth, adoption, or when the employee has assumed a legal obligation for total or partial support in anticipation of adoption; or

• A child becoming eligible as an extended dependent through legal custody or legal guardianship.

(ii) Employee's dependent no longer meets public employee benefits board (PEBB) eligibility criteria because:

• Employee has a change in marital status;

• Employee's domestic partnership with a state registered domestic partner who is a tax dependent is dissolved or terminated;

• An eligible dependent child turns age 26 or otherwise does not meet dependent child eligibility criteria;

• An eligible dependent ceases to be eligible as an extended dependent or as a dependent with a disability; or

• An eligible dependent dies.

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

(iv) Employee has a change in employment status that affects the employee's eligibility for their employer contribution toward their employer-based group health plan;

(v) The employee's dependent has a change in their own employment status that affects their eligibility or their dependent's eligibility for the employer contribution under their employer-based group health plan;

Note: As used in (a)(v) of this subsection, "employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 26 C.F.R. 54.9801-6.

(vi) Employee or an employee's dependent has a change in enrollment under an employer-based group health plan during its annual open enrollment that does not align with the PEBB annual open enrollment;

(vii) Employee or an employee's dependent has a change in residence that affects health plan availability. If the employee has a change in residence and the employee's current medical plan is no longer available, the employee must select a new medical plan as described in WAC 182-08-196(3);

(viii) Employee's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States and that change in residence resulted in the dependent losing their health insurance;

(ix) A court order requires the employee or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state registered domestic partner is not an eligible dependent);

(x) Employee or an employee's dependent enrolls in coverage under medicaid or a state children's health insurance program (CHIP), or the subscriber or a subscriber's dependent loses eligibility for coverage under medicaid or CHIP;

(xi) Employee or an employee's dependent becomes eligible for state premium assistance subsidy for PEBB medical plan coverage from medicaid or CHIP;

(xii) Employee or an employee's dependent enrolls in coverage under medicare or the employee or an employee's dependent loses eligibility for coverage under medicare;

(xiii) Employee or an employee's dependent's current medical plan becomes unavailable because the employee or enrolled dependent is no longer eligible for a health savings account (HSA). The health care authority (HCA) requires evidence that the employee or employee's dependent is no longer eligible for an HSA;

(xiv) Employee or an employee's dependent experiences a disruption of care for active and ongoing treatment, that could function as a reduction in benefits for the employee or the employee's dependent. The employee may not change their health plan election if the employee's or dependent's physician stops participation with the employee's health plan unless the PEBB program determines that a continuity of care issue exists. The PEBB program will consider but not limit its consideration to the following:

- Active cancer treatment such as chemotherapy or radiation therapy;
- Treatment following a recent organ transplant;
- A scheduled surgery;
- Recent major surgery still within the postoperative period; or
- Treatment for a high-risk pregnancy.

(xv) Employee or employee's dependent becomes eligible and enrolls in a TRICARE plan, or loses eligibility for a TRICARE plan;

(xvi) The PEBB program determines that there has been a substantial decrease in the providers available under a PEBB medical plan;

(xvii) The PEBB program determines that there has been a substantial increase in the employee's premiums when the employee transfers from one employing agency to another employing agency.

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

(b) **FSA and limited purpose FSA.** An employee may enroll or revoke their election and make a new election under the FSA or limited purpose FSA when any one of the following special open enrollment events occur, if the requested change corresponds to and is consistent with the event. The enrollment or new election will be effective the first day of the month following the later of the event date or the date the required form and evidence of the event that created the special open enrollment is received by the employing agency. If that day is the first of the month, the enrollment or change in election begins on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, the enrollment or change in election will begin the first of the month in which the event occurs.

(i) Employee acquires a new dependent due to:

• Marriage;

• Registering a state registered domestic partnership if the domestic partner qualifies as a tax dependent of the employee;

• Birth, adoption, or when the employee has assumed a legal obligation for total or partial support in anticipation of adoption; or

• A child becoming eligible as an extended dependent through legal custody or legal guardianship.

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

• Employee has a change in marital status;

• Employee's domestic partnership with a state registered domestic partner who qualifies as a tax dependent is dissolved or terminated;

• An eligible dependent child turns age 26 or otherwise does not meet dependent child eligibility criteria;

• An eligible dependent ceases to be eligible as an extended dependent or as a dependent with a disability; or

• An eligible dependent dies.

(iii) Employee or an employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the HIPAA;

(iv) Employee or an employee's dependent has a change in employment status that affects the employee's or a dependent's eligibility for the FSA or limited purpose FSA;

(v) A court order requires the employee or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state registered domestic partner is not an eligible dependent);

(vi) Employee or an employee's dependent enrolls in coverage under medicaid or a state children's health insurance program (CHIP), or the employee or an employee's dependent loses eligibility for coverage under medicaid or CHIP;

(vii) Employee or an employee's dependent enrolls in coverage under medicare.

(c) **DCAP.** An employee may enroll or revoke their election and make a new election under the DCAP when any one of the following special open enrollment events occur, if the requested change corresponds to and is consistent with the event. The enrollment or new election will be effective the first day of the month following the later of the event date or the date the required form and evidence of the event that created the special open enrollment is received by the employing agency. If that day is the first of the month, the enrollment or change in election begins on that day. If the special open enrollment

is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, the enrollment or change in election will begin the first of the month in which the event occurs.

(i) Employee acquires a new dependent due to:

• Marriage;

• Registering a state registered domestic partnership if the domestic partner qualifies as a tax dependent of the employee;

• Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or

• A child becoming eligible as an extended dependent through legal custody or legal guardianship.

(ii) Employee or an employee's dependent has a change in employment status that affects the employee's or a dependent's eligibility for DCAP;

(iii) Employee or an employee's dependent has a change in enrollment under an employer-based DCAP during its annual open enrollment that does not align with the PEBB annual open enrollment;

(iv) Employee changes dependent care provider; the change to the DCAP election amount can reflect the cost of the new provider;

(v) Employee or the employee's spouse experiences a change in the number of qualifying individuals as defined in IRC 26 U.S.C. Sec. 21 (b)(1);

(vi) Employee's dependent care provider imposes a change in the cost of dependent care; employee may make a change in the DCAP election amount to reflect the new cost if the dependent care provider is not a qualifying relative of the employee as defined in IRC 26 U.S.C. Sec. 152.

RDS-7130.1

AMENDATORY SECTION (Amending WSR 24-18-083, filed 8/29/24, effective 1/1/25)

WAC 182-12-123 Is dual enrollment in public employees benefits board (PEBB) and school employees benefits board (SEBB) prohibited? Public employees benefits board (PEBB) medical, dental, and vision coverage is limited to a single enrollment per individual as described in subsections (1) through (5) of this section. Effective January 1, 2022, individuals are limited to a single enrollment in medical, dental, and vision plans in either the PEBB program or school employees benefits board (SEBB) program as described in subsection (6) of this section.

(1) An individual who has more than one source of eligibility for enrollment in PEBB medical, PEBB dental, and PEBB vision coverage (called "dual eligibility") is limited to one enrollment.

(2) An eligible employee may waive PEBB medical and enroll as a dependent under the PEBB medical plan of their spouse, state registered domestic partner, or parent as described in WAC 182-12-128.

(3) A dependent enrolled in PEBB medical, PEBB dental, or PEBB vision who becomes eligible for PEBB benefits as an employee must elect to enroll in PEBB benefits as described in WAC 182-08-197 (1) or

(3). This includes making an election to enroll in or waive enrollment in PEBB medical as described in WAC 182-12-128.

(a) If the employee does not waive enrollment in PEBB medical, the employee is not eligible to remain enrolled in their spouse's, state registered domestic partner's, or parent's PEBB medical as a dependent. If the employee's spouse, state registered domestic partner, or parent does not take action to remove the employee (who is enrolled as a dependent) from their subscriber account, the PEBB program will automatically disenroll the employee's enrollment as a dependent the last day of the month before the employee's enrollment in PEBB benefits begins as described in WAC 182-12-114.

Exception: An enrolled dependent who becomes newly eligible for PEBB benefits as an employee may be dual-enrolled in PEBB medical, dental, and vision for one month. This exception is only allowed for the first month the dependent is enrolled as an employee, and only if the dependent becomes enrolled as an employee on the first working day of a month that is not the first day of the month.

(b) If the employee elects to waive their enrollment in PEBB medical, the employee will remain enrolled in PEBB medical under their spouse's, state registered domestic partner's, or parent's PEBB medical as a dependent.

(4) A child who is eligible for PEBB medical, PEBB dental, and PEBB vision under two subscribers may be enrolled under both subscribers but is limited to a single enrollment in PEBB medical, a single enrollment in PEBB dental, and a single enrollment in PEBB vision.

(5) When an employee is eligible for the employer contribution toward PEBB benefits due to employment in more than one PEBB-participating employing agency the following provisions apply:

(a) The employee must choose to enroll under only one employing agency.

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

(b) If the employee loses eligibility under the employing agency, they must notify their other employing agency no later than 60 days from the date PEBB benefits end through the employing agency described in (a) of this subsection to transfer coverage.

(c) The employee's elections remain the same when an employee transfers their enrollment under one employing agency to another employing agency without a break in PEBB benefits for one month or more, as described in (b) of this subsection.

(6) An individual who has more than one source of eligibility for enrollment in the PEBB and SEBB programs is limited to a single enrollment in medical, dental, and vision plans in either the PEBB or SEBB program. An employee must elect to enroll in PEBB benefits as described in WAC 182-08-197, waive enrollment as described in WAC 182-12-128, or remove eligible dependents as described in WAC 182-12-262. An employee may not waive PEBB medical, PEBB dental, and PEBB vision to enroll in SEBB medical with a SEBB participating employer group that offers only medical coverage. If the employee takes no action to resolve the dual enrollment, the PEBB program or the SEBB program will automatically enroll or automatically disenroll the individual as described in (c) through (g) of this subsection.

(a) An eligible employee may waive enrollment in PEBB medical to enroll in SEBB medical only if they are enrolled in SEBB dental and SEBB vision as described in WAC 182-12-128. An employee who waives enrollment in PEBB medical to enroll in SEBB medical also waives enrollment in PEBB dental and PEBB vision.

(b) A school employee in the SEBB program who waives SEBB medical, SEBB dental, and SEBB vision for PEBB medical must be enrolled in PEBB dental and PEBB vision. If the school employee is not already en-

rolled in PEBB dental and PEBB vision the PEBB program will automatically enroll the school employee in the associated subscriber's PEBB dental and PEBB vision.

(c) If the employee is enrolled only in PEBB dental and PEBB vision, and is also enrolled in SEBB medical, and no action is taken to resolve their dual enrollment, the employee will remain in SEBB medical. The PEBB program will automatically disenroll the employee from PEBB dental and PEBB vision in which they are enrolled. If the employee is not already enrolled in SEBB dental or SEBB vision, the SEBB program will automatically enroll them in both as described in WAC 182-31-070 (6)(g). The employee's enrollment in PEBB program life insurance, accidental death and dismemberment (AD&D) insurance, and long-term disability (LTD) insurance will remain.

(d) If the employee is enrolled in PEBB medical and is also a school employee in the SEBB program and enrolled in SEBB medical, and the employee has been enrolled in SEBB medical longer than they have been enrolled in PEBB medical, and no action is taken by the employee to resolve their dual enrollment, they will remain in SEBB medical. The PEBB program will automatically disenroll the employee from PEBB medical, PEBB dental, and PEBB vision. The employee's enrollment in PEBB program life insurance, AD&D insurance, and LTD insurance will remain. If the employee is not enrolled in any medical under either the PEBB or SEBB program but is enrolled in PEBB dental, PEBB vision, SEBB dental, and SEBB vision, the employee will remain in SEBB benefits. The PEBB program will automatically disenroll the employee from PEBB dental and PEBB vision.

(e) If the employee's dependent is enrolled in any PEBB medical, PEBB dental, or PEBB vision plan, and the dependent is also a school employee in the SEBB program and enrolled in SEBB medical, and no action is taken by either the employee or the dependent to resolve the dependent's dual enrollment, the employee's dependent will remain in SEBB medical. The PEBB program will automatically disenroll the employee's dependent from PEBB medical, PEBB dental, and PEBB vision in which they are enrolled.

(f) If the employee's dependent is enrolled in both PEBB medical and SEBB medical as a dependent and has been enrolled in SEBB medical longer than they have been enrolled in PEBB medical, and no action is taken to resolve the dual enrollment, the employee's dependent will remain in SEBB medical. The PEBB program will automatically disenroll the employee's dependent from PEBB medical, PEBB dental, and PEBB vision if they are enrolled. If the employee's dependent who is eligible as a dependent in both the PEBB and SEBB programs is not enrolled in any medical but is enrolled in both a PEBB and SEBB dental plan, PEBB and SEBB vision plan, or any combination of these coverages as a dependent, the dependent will remain in SEBB benefits. The PEBB program will automatically disenroll the employee's dependent from PEBB benefits.

Exception: If there is a National Medical Support Notice (NMSN) or a court order in place, enrollment will be in accordance with the NMSN or order.

(g) If the employee's dependent, who is also a school employee in the SEBB program who the SEBB program automatically disenrolled from SEBB dental and SEBB vision, the PEBB program will automatically enroll the employee's dependent in PEBB dental and PEBB vision, if they are not already enrolled.

(h) If the employee who is eligible for the employer contribution toward PEBB benefits was enrolled as a dependent in SEBB medical, SEBB dental, and SEBB vision and is removed by the SEBB subscriber, the em-

ployee will be required to return from waived enrollment as described in WAC 182-12-128 (3)(b).

(i) If the PEBB program automatically disenrolls an individual from PEBB medical, PEBB dental, or PEBB vision to resolve their dual enrollment as described in (d), (e), or (f) of this subsection, but later determines that the employee did take action to resolve their dual enrollment within the required timelines, the PEBB program will reinstate coverage retroactive to the first of the month in which the individual was disenrolled.

(7) A retiree who defers enrollment in PEBB retiree insurance coverage as described in WAC 182-12-200 by enrolling as an eligible dependent in a ((~~health~~)) medical plan sponsored by PEBB or SEBB and who loses the employer contribution for such coverage must enroll in PEBB retiree insurance coverage as described in WAC 182-12-200 or defer enrollment as described in WAC 182-12-205.

AMENDATORY SECTION (Amending WSR 25-14-084, filed 6/30/25, effective 1/1/26)

WAC 182-12-128 When may an employee waive enrollment in public employees benefits board (PEBB) medical and when may they enroll in PEBB medical after having waived enrollment? An employee may waive enrollment in public employees benefits board (PEBB) medical if they are enrolled in other employer-based group medical, a TRICARE plan, or medicare Part A and Part B as described in subsection (1)(a) through (c) of this section. They may not waive enrollment in PEBB medical if they are enrolled in PEBB retiree insurance coverage, and their PEBB retiree insurance coverage will be automatically deferred as described in WAC 182-12-205 (11)(a) or will be auto disenrolled as described in WAC 182-12-262 (2)(d). An employee who waives enrollment in PEBB medical must enroll in PEBB dental, PEBB vision, basic life insurance, basic accidental death and dismemberment insurance, and employer-paid long-term disability (LTD) insurance (unless the employing agency does not participate in these PEBB insurance coverages). For an employing agency that participates in LTD insurance, an employee will also be enrolled in employee-paid LTD insurance automatically unless the employee declines their employee-paid LTD insurance as described in WAC 182-08-197.

Exception: An employee may waive their enrollment in PEBB medical to enroll in school employees benefits board (SEBB) medical only if they are enrolled in SEBB dental and SEBB vision. An employee who waives enrollment in PEBB medical to enroll in SEBB medical also waives enrollment in PEBB dental and PEBB vision. An employee may not waive PEBB medical, PEBB dental, and PEBB vision to enroll in SEBB medical with a SEBB participating employer group that offers only medical coverage.

(1) To waive enrollment in PEBB medical, the employee must submit the required form to their employing agency at one of the following times:

(a) **When the employee becomes eligible:** An employee may waive PEBB medical when they become eligible for PEBB benefits. The employee must indicate their election to waive enrollment in PEBB medical on the required form and submit the form to their employing agency. The employing agency must receive the form no later than 31 days after the date the employee becomes eligible for PEBB benefits (see WAC 182-08-197). PEBB medical will be waived as of the date the employee becomes eligible for PEBB benefits.

(b) **During the annual open enrollment:** An employee may waive PEBB medical during the annual open enrollment. The required form must be

received by the employee's employing agency before the end of the annual open enrollment. PEBB medical will be waived beginning January 1st of the following year.

(c) **During a special open enrollment:** An employee may waive PEBB medical during a special open enrollment only if they are enrolled in other employer-based group medical, a TRICARE plan, or medicare Part A and Part B as described in subsection (4) of this section. A special open enrollment event must be an event other than an employee gaining initial eligibility or regaining eligibility for PEBB benefits.

The employee must submit the required form to their employing agency. The employing agency must receive the form no later than 60 days after the event that creates the special open enrollment. In addition to the required form, the employee must provide evidence of the event that creates the special open enrollment to the employing agency.

PEBB medical will be waived the last day of the month following the later of the event date or the date the required form is received. If that day is the first of the month, PEBB medical will be waived the last day of the previous month. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, PEBB medical will be waived the last day of the ((~~previous~~)) month prior to the month in which the birth, adoption, or assuming legal obligation occurred.

(2) If an employee waives PEBB medical, the employee may not enroll dependents in PEBB medical.

(3) Once PEBB medical is waived, the employee is only allowed to enroll in PEBB medical at the following times:

(a) During the annual open enrollment. The required form must be received by the employee's employing agency before the end of the annual open enrollment. PEBB medical will begin January 1st of the following year.

(b) During a special open enrollment. A special open enrollment allows an employee to revoke their election and make a new election outside of the annual open enrollment. A special open enrollment may be created when one of the events described in subsection (4) of this section occurs.

The employee must submit the required form to their employing agency. The employing agency must receive the form no later than 60 days after the event that creates the special open enrollment. In addition to the required form, the employee must provide evidence of the event that creates the special open enrollment to the employing agency.

PEBB medical will begin the first day of the month following the later of the event date or the date the required form is received. If that day is the first of the month, coverage is effective on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, PEBB medical for the employee will begin on the first day of the month in which the event occurs. PEBB medical for the newly born child, newly adopted child, spouse, or state registered domestic partner will begin as described in WAC 182-12-262 (3)(a)(iv).

If an employee who is eligible for the employer contribution toward PEBB benefits was enrolled as a dependent in SEBB medical, SEBB dental, and SEBB vision and is removed by the SEBB subscriber, the health care authority will notify the employee of their removal from

the SEBB subscriber's account and that they have experienced a special enrollment event. The employee will be required to return from waived enrollment and elect PEBB medical, PEBB dental, and PEBB vision. If the employee's employing agency does not receive the employee's required forms indicating their medical, dental, and vision elections within 60 days of the employee losing SEBB medical, SEBB dental, and SEBB vision, they will be defaulted into employee-only PEBB medical, PEBB dental, and PEBB vision as described in WAC 182-08-197 (1)(b)(i) through (iii).

(4) **Special open enrollment:** Any one of the events in (a) through (k) of this subsection may create a special open enrollment that allows the employee to enroll in PEBB medical after having waived enrollment. The change in enrollment must be allowable under the Internal Revenue Code (IRC) and Treasury regulations, and correspond to and be consistent with the event that creates the special open enrollment for the employee, the employee's dependent, or both.

(a) Employee acquires a new dependent due to:

(i) Marriage or registering a state registered domestic partnership;

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

(iii) A child becoming eligible as an extended dependent through legal custody or legal guardianship.

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

(c) Employee has a change in employment status that affects the employee's eligibility for their employer contribution toward their employer-based group medical;

(d) The employee's dependent has a change in their own employment status that affects their eligibility or their dependent's eligibility for the employer contribution under their employer-based group medical;

Note: As used in (d) of this subsection, "employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 26 C.F.R. 54.9801-6.

(e) Employee or an employee's dependent has a change in enrollment under an employer-based group medical plan during its annual open enrollment that does not align with the PEBB program's annual open enrollment;

(f) Employee's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States and that change in residence resulted in the dependent losing their health insurance;

(g) A court order requires the employee or any other individual to provide a health plan for an eligible dependent of the employee (a former spouse or former state registered domestic partner is not an eligible dependent);

(h) Employee or an employee's dependent enrolls in coverage under medicaid or a state children's health insurance program (CHIP), or the employee or an employee's dependent loses eligibility for coverage under medicaid or CHIP;

Note: An employee may only return from having waived PEBB medical for the events described in (h) of this subsection. An employee may not waive their PEBB medical for the events described in (h) of this subsection.

(i) Employee or an employee's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from medicaid or CHIP;

(j) Employee or employee's dependent becomes eligible and enrolls in a TRICARE plan, or loses eligibility for a TRICARE plan;

(k) Employee becomes eligible and enrolls in medicare, or loses eligibility for medicare.

AMENDATORY SECTION (Amending WSR 24-18-083, filed 8/29/24, effective 1/1/25)

WAC 182-12-200 May a retiring employee, a retiring school employee, or a retiree enrolled as a dependent in a health plan sponsored by public employees benefits board (PEBB) or school employees benefits board (SEBB) defer enrollment under PEBB retiree insurance coverage? (1) A retiring employee or a retiring school employee may defer enrollment in public employees benefits board (PEBB) retiree insurance coverage at retirement if they meet substantive eligibility requirements as described in WAC 182-12-171(2) or as described in WAC 182-12-180(1). An enrolled retiree may defer enrollment after enrolling in PEBB retiree insurance coverage. Enrollment in PEBB retiree insurance coverage may be deferred when they are enrolled as a dependent in a ((~~health~~)) medical plan sponsored by PEBB or school employees benefits board (SEBB), including such coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or continuation coverage.

(2) A retiring employee, a retiring school employee, or a retiree who defers enrollment in PEBB retiree insurance coverage defers enrollment in PEBB medical, PEBB dental, and PEBB vision. A retiree must be enrolled in PEBB medical to enroll in PEBB dental except for a nonmedicare retiree must enroll in PEBB medical to be able to enroll in PEBB dental, in PEBB vision, or in both PEBB dental and PEBB vision. When a retiree ((~~who~~)) defers enrollment ((~~also defers~~)), enrollment for all eligible dependents will be terminated. A retiree may only defer enrollment in PEBB retiree term life insurance as described in WAC 182-12-209 (3)(b).

(3) A retiring employee, a retiring school employee, or a retiree who defers enrollment as described in this section may later enroll themselves and their dependents in a PEBB health plan by submitting the required forms as described below and evidence of continuous enrollment in a ((~~health~~)) medical plan sponsored by PEBB or SEBB. Evidence of continuous enrollment in a ((~~health~~)) medical plan sponsored by a Washington state educational service district may be required if a retiring employee, a retiring school employee, or a retiree deferred enrollment under this section prior to January 1, 2024. A gap of 31 days or less is allowed between the date PEBB retiree insurance coverage is deferred and the start date of enrollment in a ((~~health~~)) medical plan sponsored by PEBB, a Washington state educational service district, or SEBB, and between each period of enrollment in qualifying coverages as described in WAC 182-12-205 (3)(a) through (e) during the deferral period:

(a) During the PEBB annual open enrollment period. The required form must be received by the PEBB program no later than the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or

(b) When enrollment in a ((~~health~~)) medical plan sponsored by PEBB, or SEBB ends, or such coverage under COBRA or continuation coverage ends. The required forms to enroll must be received by the PEBB program no later than 60 days after coverage ends. PEBB health plan coverage begins the first day of the month following the date the other coverage ends. To continue in a deferred status, the retiree must defer enrollment as described in WAC 182-12-205.

Note: Enrollment in the PEBB program's medicare advantage (MA) plan, medicare advantage-prescription drug (MA-PD) plan, or the Uniform Medical Plan (UMP) Classic medicare plan may not be retroactive.

(1) If a subscriber elects to enroll in a MA plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in a plan with the same contracted vendor during the gap month(s) prior to when the MA coverage begins.

(2) If a subscriber elects to enroll in a MA-PD plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in transitional coverage as designated by the director or designee during the gap month(s) prior to when the MA-PD coverage begins.

(3) If a subscriber elects to enroll in the UMP Classic medicare plan, and the required forms are received by the PEBB program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in transitional UMP coverage during the gap month(s) prior to when the UMP Classic medicare plan begins.

(c) If a retiree elects to enroll a dependent in PEBB health plan coverage as described in this subsection, the dependent must be enrolled in the same PEBB medical or PEBB dental plan as the retiree.

Exceptions: (1) If a retiree selects a medicare supplement plan, a MA-PD plan, or the UMP Classic medicare plan, nonmedicare enrollees will be enrolled in the UMP Classic. If a retiree selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees.

(2) If a retiree selects a medicare supplement plan, MA-PD plan, or any other medicare plan, they may elect a PEBB vision plan available for any nonmedicare enrollees.

(d) A nonmedicare retiree must enroll in PEBB medical to be able to enroll in PEBB dental, in PEBB vision, or in both PEBB dental and PEBB vision. Any nonmedicare dependents they elect to enroll must be enrolled in the same PEBB medical, PEBB dental, and PEBB vision plan.

AMENDATORY SECTION (Amending WSR 24-18-081, filed 8/29/24, effective 1/1/25)

WAC 182-12-232 What options for continuing health plan enrollment are available to a retiree of an employer group that ended participation in public employees benefits board (PEBB) or school employees benefits board (SEBB) insurance coverage? (1) A retired employee, a retired school employee, or an eligible survivor of an employee, school employee, or retiree of an employer group as defined in WAC 182-12-109 who loses eligibility for public employees benefits board (PEBB) retiree insurance coverage due to the employer group ending participation in PEBB or school employees benefits board (SEBB) insurance coverage may continue enrollment in PEBB health plan coverage by self-paying the premium and applicable premium surcharges set by the health care authority (HCA). A retired employee, a retired school employee, or a survivor enrolled under this section is not eligible for any subsidy provided under RCW 41.05.085.

(2) A retired employee, a retired school employee, or a survivor as described in subsection (1) of this section may enroll in PEBB medical, dental, or vision.

(a) The required forms must be received by the PEBB program no later than 60 days after the employer group's date of termination. The effective date of enrollment in PEBB health plan coverage will be the first day of the month following the day eligibility for PEBB retiree insurance coverage ended.

Note: Enrollment in the PEBB program's medicare advantage (MA) plan, medicare advantage prescription-drug (MA-PD) plan, or the Uniform Medical Plan (UMP) Classic medicare plan may not be retroactive.

(1) If a subscriber elects to enroll in a MA plan, and the required forms are received by the PEBB program after the date the PEBB health plan coverage is to begin, the subscriber and their enrolled dependents will be enrolled in a plan with the same contracted vendor during the gap month(s) prior to when the MA coverage begins.

(2) If a subscriber elects to enroll in a MA-PD plan, and the required forms are received by the PEBB program after the date the PEBB health plan coverage is to begin, the subscriber and their enrolled dependents will be enrolled in transitional coverage as designated by the director or designee during the gap month(s) prior to when the MA-PD coverage begins.

(3) If a subscriber elects to enroll in the UMP Classic medicare plan, and the required forms are received by the PEBB program after the date the PEBB health plan coverage is to begin, the subscriber and their enrolled dependents will be enrolled in transitional UMP coverage during the gap month(s) prior to when the UMP Classic medicare plan begins.

(b) The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends as described in (a) of this subsection. Following the first premium payment, premiums and applicable premium surcharges must be paid as described in WAC 182-08-180 (1)(c).

Note: An employer group as defined in WAC 182-12-109 that enters into a contractual agreement with the HCA on or after May 4, 2023, and whose contractual agreement is subsequently terminated, shall make a one-time payment to the HCA for each of the employer group's retired or disabled employees who continue participation under this section as described in RCW 41.05.083.

(c) If a retired employee, a retired school employee, or a survivor elects to enroll a dependent in PEBB health plan coverage, the dependent must be enrolled in the same PEBB medical and PEBB dental plan as the retired employee, retired school employee, or survivor.

Exceptions: (1) If a retired employee, a retired school employee, or a survivor selects a medicare supplement plan, a MA-PD plan, or the UMP Classic medicare plan, nonmedicare enrollees will be enrolled in the UMP classic. If a retired employee, a retired school employee, or a survivor selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees.

(2) If a retired employee, a retired school employee, or a survivor selects a medicare supplement plan, MA-PD plan, or any other medicare plan, they may elect a PEBB vision plan available for any nonmedicare enrollees.

(3) A subscriber enrolled under this section may continue PEBB health plan coverage until they request to terminate enrollment as described in subsection (4) of this section, or premiums and applicable premium surcharges are no longer paid as described in WAC 182-08-180 (1)(c). If PEBB health plan coverage is terminated for these reasons, the subscriber and their enrolled dependents will not be eligible to reenroll under this section.

(4) A subscriber enrolled under this section who requests to voluntarily terminate their PEBB health plan coverage must do so in writing. PEBB health plan coverage will end on the last day of the month in which the PEBB program receives the termination request or on the last day of the month specified in the subscriber's termination request, whichever is later. If the termination request is received on the first day of the month, PEBB health plan coverage will end on the last day of the previous month.

Exception: When a subscriber or their dependent is enrolled in a MA plan, a MA-PD plan, or the UMP Classic medicare plan, the enrollment in PEBB health plan coverage will terminate on the last day of the month when the plan disenrollment form is received.

(5) A subscriber enrolled under this section or their dependent may have their PEBB medical plan enrollment terminated as required by federal law as described in WAC 182-08-196(5). If PEBB medical plan enrollment is terminated for this reason, any enrollment in PEBB dental plan coverage may continue. If all health plan coverage is terminated, the subscriber or their dependent will not be eligible to reenroll under this section.

AMENDATORY SECTION (Amending WSR 25-14-084, filed 6/30/25, effective 1/1/26)

WAC 182-12-262 When may subscribers enroll or remove eligible dependents? (1) **Enrolling dependents in public employees benefits board (PEBB) health plan coverage, supplemental dependent life insur-**

ance, and accidental death and dismemberment (AD&D) insurance. A dependent must be enrolled in the same health plan coverage as the subscriber unless otherwise described in the Washington Administrative Code applicable to the subscriber. The subscriber must be enrolled in health plan coverage to enroll their dependent in health plan coverage except as provided in WAC 182-12-205 (3)(c). A dependent with more than one source of eligibility for enrollment in the PEBB and school employees benefits board (SEBB) programs is limited to a single enrollment in medical, dental, and vision plans in either the PEBB or SEBB program. Subscribers must satisfy the enrollment requirements as described in subsection (4) of this section and may enroll eligible dependents at the following times:

(a) **When the subscriber becomes eligible** and enrolls in PEBB benefits. If eligibility is verified the dependent's effective date will be as follows:

(i) PEBB health plan coverage will be the same as the subscriber's effective date;

(ii) Supplemental dependent life insurance or AD&D insurance, if elected, will be effective the first day of the month following the date the contracted vendor receives the required form or approves the enrollment. A newly born child must be at least 14 days old before supplemental dependent life insurance or AD&D insurance coverage is effective.

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

(c) **During special open enrollment.** Subscribers may enroll dependents during a special open enrollment as described in subsection (3) of this section;

(d) **When a National Medical Support Notice (NMSN)** requires a subscriber to cover a dependent child in health plan coverage as described in WAC 182-12-263; or

(e) **Any time during the calendar year for supplemental dependent life insurance or AD&D insurance** by submitting the required form to the contracted vendor for approval. Evidence of insurability may be required for supplemental dependent life insurance but will not be required for supplemental AD&D insurance. Supplemental dependent life insurance or AD&D insurance will be effective the first day of the month following the date the contracted vendor receives the required form or approves the enrollment. A newly born child must be at least 14 days old before supplemental dependent life insurance or AD&D insurance coverage is effective.

(2) **Removing dependents from a subscriber's PEBB health plan coverage or supplemental dependent life insurance or AD&D insurance.**

(a) **A dependent's eligibility for enrollment in PEBB health plan coverage or supplemental dependent life insurance or AD&D insurance ends the last day of the month the dependent** meets the eligibility criteria as described in WAC 182-12-250 or 182-12-260. Subscribers must provide notice when a dependent is no longer eligible due to divorce, annulment, dissolution, or qualifying event of a dependent ceasing to be eligible as a dependent child, as described in WAC 182-12-260(3). For supplemental dependent life insurance or AD&D insurance, subscribers must notify the contracted vendor on the required form, in writing, or by telephone when a dependent is no longer eligible. Contact information for the contracted vendor may be found at hca.wa.gov/employees-contact-plan. For PEBB health plan coverage, the notice must be received within 60 days of the last day of the month the dependent loses eligibility. Employees must notify their employing

agency when a dependent is no longer eligible for PEBB health plan coverage, except as required under WAC 182-12-260 (3)(g)(ii). All other subscribers must notify the PEBB program. Consequences for not submitting notice within the required 60 days include, but are not limited to:

(i) The dependent may lose eligibility to continue PEBB medical, dental, or vision under one of the continuation coverage options described in WAC 182-12-270;

(ii) The subscriber may be billed for claims paid by the health plan for services that were rendered after the dependent lost eligibility as described in WAC 182-12-270;

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

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

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

(i) During the annual open enrollment. The dependent will be removed from PEBB health plan coverage the last day of December;

(ii) During a special open enrollment as described in subsections (3) and (4)(f) of this section;

(iii) When a NMSN requires a spouse, former spouse, or other individual to provide health plan coverage for a dependent who is already enrolled in PEBB coverage, and that health plan coverage is in fact provided as described in WAC 182-12-263(2); or

(iv) Any time during the calendar year from supplemental dependent life insurance or AD&D insurance by submitting a request to the contracted vendor on the required form, in writing, or by telephone. Contact information for the contracted vendor may be found at hca.wa.gov/employees-contact-plan.

(c) **Retirees (see WAC 182-12-171, 182-12-180, or 182-12-211), survivors (see WAC 182-12-180, 182-12-250, or 182-12-265), PEBB continuation coverage enrollees (see WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, or 182-12-148), and retired employees, retired school employees, or survivors continuing PEBB health plan coverage after their employer group ceased participation (see WAC 182-12-232) may remove dependents** from their PEBB health plan coverage outside of the annual open enrollment or a special open enrollment by providing written notice to the PEBB program. The dependent will be removed from the subscriber's PEBB health plan coverage prospectively. PEBB health plan coverage will end on the last day of the month in which the written notice is received by the PEBB program or on the last day of the month specified in the subscriber's written notice, whichever is later. If the written notice is received on the first day of the month, PEBB health plan coverage will end on the last day of the previous month. PEBB continuation coverage enrollees may remove dependents from supplemental dependent life insurance or AD&D insurance any time during the calendar year by submitting a request to the contracted vendor on the required form, in writing, or by telephone. Contact information for the contracted vendor may be found at hca.wa.gov/employees-contact-plan.

(d) When a retiree or a survivor's dependent becomes eligible for the employer contribution toward PEBB or SEBB benefits, the subscriber's dependent will be auto disenrolled from PEBB retiree insurance coverage.

(3) **Special open enrollment.**

(a) Subscribers may enroll or remove their eligible dependents outside of the annual open enrollment if a special open enrollment event occurs. The change in enrollment must be allowable under the Internal Revenue Code and Treasury Regulations, and correspond to and be consistent with the event that creates the special open enrollment for the subscriber, the subscriber's dependents, or both. To disenroll from a medicare advantage (MA) plan, a medicare advantage-prescription drug (MA-PD) plan, or the Uniform Medical Plan (UMP) Classic medicare plan, the change in enrollment must be allowable under 42 C.F.R. Secs. 422.62(b) and 423.38(c).

(i) PEBB health plan coverage will begin the first of the month following the later of the event date or the date the required form is received. If that day is the first of the month, the change in enrollment begins on that day except for a MA plan, a MA-PD plan, or the UMP Classic medicare plan, which will begin the first day of the month following the date the form is received.

Note: As used in (a)(i) of this subsection, "the date the required form is received" may determine the effective date of coverage before proof of the event is received.

(ii) PEBB health plan coverage for an extended dependent or a dependent with a disability will begin the first day of the month following the later of the event date or eligibility certification.

(iii) The dependent will be removed from the subscriber's PEBB health plan coverage the last day of the month following the later of the event date or the date the required form and proof of the event is received. If that day is the first of the month, the change in enrollment will be made the last day of the previous month.

(iv) If the special open enrollment is due to the birth or adoption of a child, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of a child, PEBB health plan coverage will begin or end as follows:

• For the newly born child, PEBB health plan coverage will begin the date of birth;

• For a newly adopted child, PEBB health plan coverage will begin on the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier;

• For a spouse or state registered domestic partner of a subscriber, PEBB health plan coverage will begin the first day of the month in which the event occurs. The spouse or state registered domestic partner will be removed from PEBB health plan coverage the last day of the month in which the event occurred.

(v) Supplemental dependent life insurance or AD&D insurance will begin the first day of the month following the date the contracted vendor receives the required form or approves the enrollment. A newly born child must be at least 14 days old before supplemental dependent life insurance or AD&D insurance coverage is effective.

(b) The events described in this subsection (3)(b)(i) of this section create a special open enrollment to enroll eligible dependents in supplemental dependent life insurance or AD&D insurance. Any one of the following events may create a special open enrollment to enroll or remove eligible dependents from PEBB health plan coverage:

(i) Subscriber acquires a new dependent due to:

• Marriage or registering a state registered domestic partnership;

• Birth, adoption, or when a subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or

• A child becoming eligible as an extended dependent through legal custody or legal guardianship.

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

(iii) Subscriber has a change in employment status that affects the subscriber's eligibility for their employer contribution toward their employer-based group health plan;

(iv) The subscriber's dependent has a change in their own employment status that affects their eligibility or their dependent's eligibility for the employer contribution under their employer-based group health plan;

Note: As used in (iv) of this subsection, "employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 54.9801-6.

(v) Subscriber or a subscriber's dependent has a change in enrollment under an employer-based group health plan during its annual open enrollment that does not align with the PEBB program's annual open enrollment;

(vi) Subscriber's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States and that change in residence resulted in the dependent losing their health insurance;

(vii) A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state registered domestic partner is not an eligible dependent);

(viii) Subscriber or a subscriber's dependent enrolls in coverage under medicaid or a state children's health insurance program (CHIP), or the subscriber or a subscriber's dependent loses eligibility for coverage under medicaid or CHIP;

(ix) Subscriber or a subscriber's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from medicaid or CHIP;

(x) Subscriber's dependent enrolls in medicare, or loses eligibility for medicare;

(xi) Subscriber or a subscriber's dependent enrolled in a MA plan, MA-PD plan, medicare supplement plan, or the UMP Classic medicare plan who gains, loses, or has a change to their low-income subsidy eligibility as described in 42 C.F.R. § 423.38 (c)(9)<u>;</u>

<u>(xii) Subscriber or a subscriber's dependent becomes eligible and enrolls in a TRICARE plan or loses eligibility for a TRICARE plan</u>.

(4) **Enrollment requirements. A subscriber must submit the required forms within the time frames described in this subsection.** For PEBB health plan coverage, an employee must submit the required forms to their employing agency, any other subscriber must submit the required forms to the PEBB program. In addition to the required forms indicating dependent enrollment, the subscriber must provide the required documents as evidence of the dependent's eligibility; or as evidence of the event that created the special open enrollment. All required forms and documents must be received within the required time frames. An employee enrolling a dependent in supplemental dependent life insurance or AD&D insurance must submit the required form to the contracted vendor for approval within the required time frames.

Note: When enrolling a state registered domestic partner or a state registered domestic partner's child, a subscriber must certify that the state registered domestic partner or state registered domestic partner's child is a tax dependent on the required form; otherwise, the PEBB program will assume the state registered domestic partner or state registered domestic partner's child is not a tax dependent.

(a) If a subscriber wants to enroll their eligible dependents in PEBB health plan coverage when the subscriber becomes eligible to en-

roll in PEBB benefits, the subscriber must include the dependent's enrollment information on the required forms and submit them within the required time frame described in WAC 182-08-197, 182-12-171, 182-12-180, 182-12-211, 182-12-232, or 182-12-250. If an employee enrolls a dependent in supplemental dependent life insurance or AD&D insurance, the required form must be submitted within the required time frame described in WAC 182-08-197.

(b) If a subscriber wants to enroll eligible dependents in PEBB health plan coverage during the PEBB annual open enrollment period, the required forms must be received no later than the last day of the annual open enrollment.

(c) If a subscriber wants to enroll newly eligible dependents, the required forms must be received no later than 60 days after the dependent becomes eligible. An employee enrolling a dependent in supplemental dependent life insurance or AD&D insurance must submit the required form to the contracted vendor for approval. An employee may enroll a dependent in supplemental dependent life insurance up to the guaranteed issue coverage amount without evidence of insurability if the required form is submitted to the contracted vendor as required. Evidence of insurability will be required for supplemental dependent life insurance over the guaranteed issue coverage amount. Evidence of insurability is not required for supplemental AD&D insurance.

(d) If a subscriber wants to enroll a newborn or child whom the subscriber has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption in PEBB health plan coverage, the subscriber should notify the PEBB program by submitting the required forms as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the required forms must be received no later than 60 days after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption. An employee enrolling a dependent in supplemental dependent life insurance or AD&D insurance must submit the required form to the contracted vendor for approval no later than 60 days after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption. A newly born child must be at least 14 days old before supplemental dependent life insurance or AD&D insurance coverage can become effective.

(e) If the subscriber wants to enroll a child age 26 or older as a child with a disability in PEBB health plan coverage, the required forms must be received no later than 60 days after the child reaches age 26 or within the relevant time frame described in (a), (b), and (f) of this subsection. To recertify an enrolled child with a disability, the required forms must be received by the PEBB program or the contracted vendor by the child's scheduled PEBB health plan coverage termination date.

(f) If the subscriber wants to change a dependent's enrollment status in PEBB health plan coverage during a special open enrollment, the required forms must be received no later than 60 days after the event that creates the special open enrollment.

Exception: If the subscriber wants to change a dependent's enrollment or disenrollment in a MA plan, a MA-PD plan, or the UMP Classic medicare plan, the required forms must be received during a special enrollment period as allowed under 42 C.F.R. Secs. 422.62(b) and 423.38(c).

(g) An employee may enroll a dependent in supplemental dependent life insurance or AD&D insurance at any time during the calendar year by submitting the required form to the contracted vendor for approval. Evidence of insurability may be required for supplemental dependent

life insurance but will not be required for supplemental AD&D insurance.