

Washington State Health Care Authority

Basic PEBB Eligibility



PEBB Outreach & Training
April 2016

Agenda

- Schedule for the day
- Introductions
- PEBB eligibility and benefits
- How to fill out worksheets and enrollment forms
- Survey

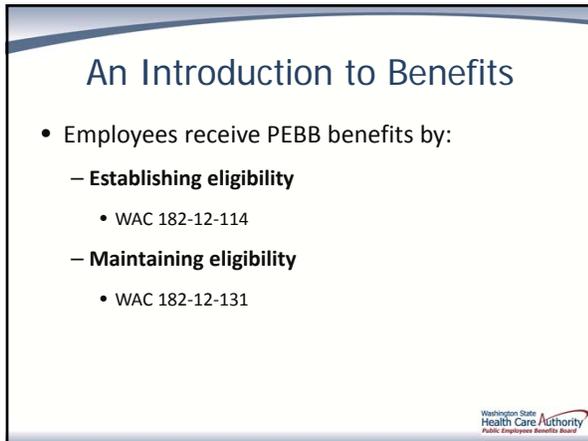
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Resources

- [PersPay website](#) (for employers)
 - Manuals
 - Worksheets
 - Quick Reference Guides
 - WAC and PEBB policy
 - Listserv and FUZE
 - Rates
- [PEBB website](#) (for employees)
- Class packet

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Establishing Eligibility
— WAC 182-12-114—

To establish eligibility, an hourly/salaried employee must work:

- a) An average of at least 80 hours per month,
- b) For at least 8 hours in each month, and
- c) For more than 6 consecutive months

See WAC 182-12-114(1)(a)



Establishing Eligibility
— WAC 182-12-114—

- An employee can become eligible upon:
 - **Employment:** An employee is eligible from the date of employment if the employing agency anticipates the employee will work according to WAC 182-12-114(1)(a).
 - **Revision of anticipated work schedule:** If an employing agency revises an employee's anticipated work hours such that they meet the eligibility criteria, the employee becomes eligible when the revision is made.



Establishing Eligibility
— WAC 182-12-114—

- An employee can become eligible upon:
 - **Work pattern change:** An employee who is determined to be ineligible, but later meets the eligibility criteria, becomes eligible the first of the month following the 6-month averaging period.
 - **Stacking of hours**
 - As long as work is within the same agency



When Coverage Begins — WAC 182-12-114—

- Coverage begins the first day of the month following the date an employee becomes eligible
- If employee becomes eligible on the first working day of the month, coverage begins on that date



Date of Eligibility & Effective Date

- **Date of eligibility = When employee becomes eligible**
 - If employee is eligible upon employment, this will be their first working day of the month
 - “Hire date” also means the date of eligibility—**not** the date the employee was offered the position
- **Effective date = When coverage begins**
 - When the employee *receives* benefits
- Date of eligibility and effective date are sometimes on the same day
 - Depends on when employee establishes eligibility

See 2016 First Working Day of the Month/Effective Date



Date of Eligibility & Effective Date Check-In

- Adam is eligible upon employment and starts work on June 15
 - What is Adam’s date of eligibility and when does coverage begin?
- Jeanne is eligible upon employment and starts work on August 1
 - What is Jeanne’s date of eligibility and when does coverage begin?
- Mary is eligible upon employment and starts work on January 4, 2016
 - What is Mary’s date of eligibility and when does coverage begin?



Maintaining Eligibility — WAC 182-12-131—

- Employee maintains eligibility by:
 - Being in pay status* 8 or more hours per month
 - Employee can physically work 8 hours
 - Employee can submit leave for 8 hours

*"Pay status" means all hours for which an employee receives pay.

See WAC 182-12-131



Losing Eligibility — WAC 182-12-131—

- If employee fails to maintain eligibility:
(by not being in pay status 8 or more hours per month)
 - Lose benefits
 - Effective the last day of the month the employee is eligible for the employer contribution
 - Employee must re-establish eligibility under WAC 182-12-114



Losing Eligibility Check-In

- Ron works 8 hours in June but only 3 hours in July—when does coverage end?
- Sandy works 8 hours on July 1 and no hours in August—when does coverage end?



Eligibility Scenario Walkthrough

Tony starts a new job at DOC on 5/1/2016. DOC anticipates he will work:

- a) 160 hours per month,
- b) For at least 8 hours in each month, and
- c) For 6 consecutive months

FOLLOW UP QUESTIONS

- Is Tony eligible upon employment?
- If so, what is Tony's date of eligibility and effective date?
- What rule supports your decision?



Eligibility Scenario Walkthrough —Continued—

On 8/15/2016, Tony's position is extended until 12/31/2016 (8 months total). He's anticipated to work the same number of hours per month until the end of his appointment.

FOLLOW UP QUESTIONS

- Is Tony eligible now?
- If so, what is Tony's date of eligibility and effective date?
- What rule supports your decision?



Eligibility Scenarios Group Work

Using your resources, work in groups (2–4 people per group) to solve the eligibility scenarios on the "Basic_Eligibility_Scenarios" document.



Washington State Health Care Authority

Employer Obligations



Employer Obligations

— WAC 182-12-113 & Policy 11-1—

- Employers are responsible for determining and notifying employees of eligibility
 - Mistakes are costly—to employer and employee
 - Appeals
 - Back premiums due
 - Error correction and recourse
 - Penalties
 - Employee's (or dependent's) health may be compromised

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Employer Obligations

— WAC 182-12-113 & Policy 11-1—

- Employers must notify employees of the following:
 - Determination of eligibility for benefits (regardless if eligible or ineligible)
 - Hours excluded when determining eligibility
 - Reference to WAC 182-12-114 and WAC 182-12-131
 - Appeal rights and reference to Chapter 182-16 WAC
- These notifications are located in the PEBB worksheets
 - Worksheets are required for state agencies and higher education institutions
 - Higher education institutions may use an approved alternate method of notification

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PEBB Appeals — WAC 182-16—

- Employees have the right to appeal a specific decision or denial regarding their benefits
 - Guidance available:
 - *Employee Enrollment Guide*
 - PEBB website (for employee)
 - PersPay website (for employer)
 - Contact:
 - Send message through FUZE



PEBB Worksheets

- Meets requirements of WAC 182-12-113 and Policy 11-1
 - Provides due dates for forms
 - Captures Affordable Care Act status code
 - If employee is not eligible upon employment, see the B-1 worksheet to track eligible hours
- Access through the [PersPay site](#)
 - Don't save worksheet to computer or fill out by hand





Enrollment Deadlines & Defaulting



Enrollment Deadlines

- Forms that must be received no later than **31 days** after the date of eligibility:
 - *Employee Enrollment/Change* form (includes the premium surcharge attestations)
 - *Long-Term Disability Enrollment/Change* form
 - *Medical FSA and DCAP Enrollment* form
 - Available to state and higher education institution employees only
 - Dependent verification (DV) documentation
- Forms that must be received no later than **60 days** after the date of eligibility:
 - *Life Insurance Enrollment/Change* form



Enrollment Deadlines

- 31-day (and 60-day) clock for submitting forms begins on employee's **date of eligibility**
- PEBB worksheets will auto-populate the due dates for required forms
- Do not allow employee additional time if they fail to timely submit forms



Defaulting

- If employee fails to timely submit forms and attest to the tobacco use premium surcharge, enroll employee as a single subscriber in:
 - Uniform Medical Plan (UMP)
 - Uniform Dental Plan (UDP)
 - Basic life
 - Basic LTD
 - » Employee will also pay \$25-per-month tobacco use premium surcharge

See WAC 182-08-197(1)(b)



Defaulting

- Employee will be defaulted as:
 - Single subscriber (no family members)
 - State or higher education employees may not enroll in a Medical Flexible Spending Arrangement (FSA) or Dependent Care Assistance Program (DCAP)
- If defaulted, employee may not make changes or add dependents until:
 - Annual open enrollment, or
 - Qualifying special open enrollment event occurs





Dependent Verification



Required Forms & Dependent Verification

- Dependents must be verified before being enrolled in coverage
 - Dependent verification (DV) is needed for:
 - Spouse/registered domestic partner
 - Children up to age 26
 - Certification is needed for:
 - Extended dependents
 - Disabled children (age 26 or older)

See *Dependent Verification*



Required Forms & Dependent Verification

- **BEST PRACTICE:** Have employee submit DV with *Employee Enrollment/Change* form
 - Employer is responsible for contacting employee if employee does not submit DV with enrollment forms
 - Once valid DV documents are approved, dependent is enrolled in coverage
 - **If employee fails to submit timely DV, dependents will not be enrolled in coverage**
 - The employee must wait until annual open enrollment or a qualifying special open enrollment event to occur





What Have We Learned So Far?

A-1 & B-1 Worksheets



Special Open Enrollment

Special Open Enrollment

- Event that occurs outside of annual open enrollment that allows employee to make changes to their coverage
 - Change must be consistent with event that triggered special open enrollment (SOE)
 - [Policy 45-2, Addendum 45-2A](#) (what changes are permitted according to each SOE event)
 - *Employee Enrollment Guide*



Special Open Enrollment Scenarios

- Margot has a baby
- Steve gets married
- Kathy's spouse loses his job
- Burt receives a promotion and moves to a new position
- Greg becomes Medicare-eligible

See [Policy 45-2, Addendum 45-2A](#)





Premium Surcharges



See premium surcharge guidance in [Eligibility Manual](#)

Tobacco Use Premium Surcharge

- Monthly \$25-per account surcharge if employee or any dependent (age 13 or older) enrolled in PEBB medical uses a tobacco product
- Included in the *Employee Enrollment/Change* form
- Surcharge is in addition to premium
- Employee can re-attest at any time
 - **If change results in surcharge:**
 - Effective the first day of the month following the status change*
 - **If change results in removal of surcharge:**
 - Effective the first day of the month following receipt of the attestation*

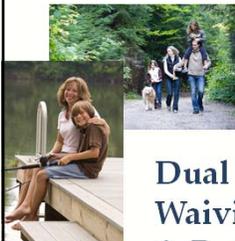
*If that day is the first of the month, the change to the surcharge begins on that day.



Spousal Premium Surcharge

- Monthly \$50 surcharge if employee covers spouse/partner in PEBB medical who has chosen to not enroll in medical coverage comparable to UMP Classic through their employer
- Surcharge is in addition to premium
- Included in the *Employee Enrollment/Change* form
- Employee can only re-attest during specific times of the year
 1. When employee is eligible to enroll a spouse or partner in PEBB medical
 2. During annual open enrollment
 3. When there is a change in the spouse or partner's employer-based group medical insurance





Dual Enrollment, Waiving Coverage, & Returning from Waive

Dual Enrollment

- Prohibited by WAC 182-12-123
 - Sami enrolls in benefits after starting at HCA, and when her employer enrolls her in PAY1, they discover she's already enrolled on her father's coverage
- Employee **can waive medical, but may not waive dental, basic life, or basic LTD** (for full benefits package employees)
 - Sami can waive her medical insurance and remain on her father's coverage, but she cannot waive her own dental, basic life, or basic LTD



Process for Dual Enrollment

- Send a message to Outreach and Training through FUZE or conduct a dependent search in PAY1 to determine what employer is currently covering employee
- Contact your employee
 - Employee determines if they want own coverage or wish to remain on other subscriber's medical
- Contact other subscriber's employer
 - Coordinate benefits



Waiving Medical Coverage

- Employee can waive medical coverage if:
 - Enrolled in other **employer-based** group medical insurance
 - As a subscriber or dependent (e.g., Boeing)
 - An employee may not waive for retiree coverage (except TRICARE) or Health Benefit Exchange coverage
 - Enrolled in TRICARE
 - Enrolled in Medicare
- If employee waives medical, their dependents cannot enroll in medical



Returning from Waive Status

- Employees can reinstate their medical coverage during:
 - Annual open enrollment
 - Does not require proof of other employer-based group medical insurance
 - Special open enrollment
 - Requires proof of the qualifying special open enrollment event





PEBB Medical



Medical Coverage

- Employee may only enroll in a plan available in their area
 - Group Health and Kaiser only available in certain counties
 - UMP available anywhere in Washington and worldwide
- Dependents aren't required to see same provider as employee, but must be within same plan
 - Employee and spouse/partner can see different providers
- Medical benefit comparison tool available on the PEBB website for employees who need help deciding which plan to choose



PEBB Medical Plans

- Managed-Care Plan
 - Group Health and Kaiser Permanente
- Preferred-Provider Organization (PPO)
 - Uniform Medical Plan (administered by Regence Blue Shield)
- Select Network PPO
 - UMP Plus (administered by Regence Blue Shield) and SoundChoice (Group Health)
- Consumer-Directed Health Plan (CDHP)
 - Group Health, Kaiser Permanente, and Uniform Medical Plan



Managed-Care Plan

- Requires employee to select a primary care provider (PCP) within its own network
 - May not pay benefits if employee sees a non-contracted provider
 - Will refer employee to contracted specialists of their choosing



Preferred-Provider Organization

- Allows employee to self-refer to provider of employee's choice
 - Employee can see any provider who is a preferred provider or takes Regence insurance
 - Employee will pay less out-of-pocket if provider is "preferred" or "in-network"



Select Network PPO

- Allows employee to self-refer to provider of employee's choice
 - Employee will pay **less** out-of-pocket if provider participates within the network
 - Employee will pay **more** out-of-pocket if provider does not participate in the network
 - Even if provider is a preferred provider or takes Regence or Group Health insurance



Consumer-Directed Health Plan

- High deductible plan with a Health Savings Account (HSA)
 - An HSA is a tax-free health savings account used to pay for IRS-qualified out-of-pocket medical expenses
 - Not a “use it or lose it” benefit
- Employer contributes:
 - \$700.08 year/\$58.34 month for subscriber (+ \$125 for SmartHealth wellness incentive, if earned the prior year)
 - \$1400.04 year/\$116.76 month for subscriber and enrolled dependent(s) (+ \$125 for SmartHealth wellness incentive, if earned the prior year)
 - Employer contribution is deposited monthly
 - Employee contribution is optional
 - Employee should consider *employer* contribution and wellness incentive when calculating maximum allowable contribution





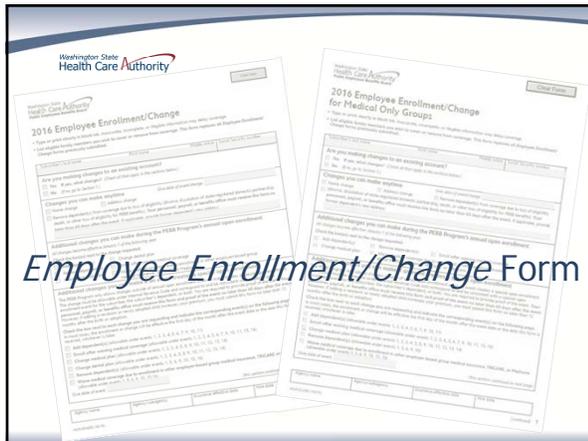
Smart[]Health

smarthealth.hca.wa.gov

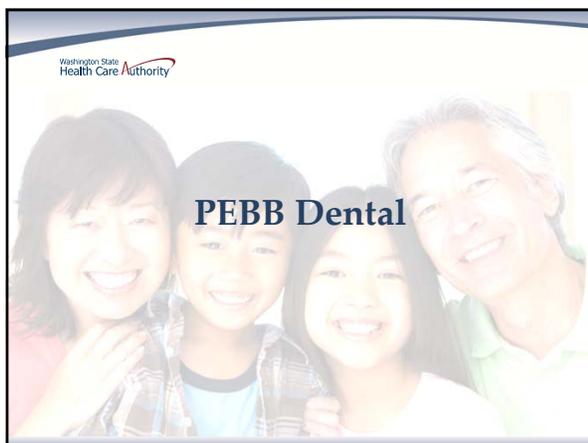
SmartHealth Wellness Program

- Program designed to help improve employees' health and well-being
 - Earn points for completing the well-being assessment and health challenges
 - 2,000 points = wellness incentive:
 - \$125 reduction in 2017 PEBB medical plan deductible, or
 - One-time deposit of \$125 in 2017 HSA





Employee Enrollment/Change Form



PEBB Dental

PEBB Dental

- **Employees may not waive dental**
 - No cost to employee for state and higher ed employees
 - No cost to add dependents for state and higher ed employees
- Dependents do not have to enroll in dental

See Dental Benefits Comparison in *Employee Enrollment Guide*



Types of Dental Plans

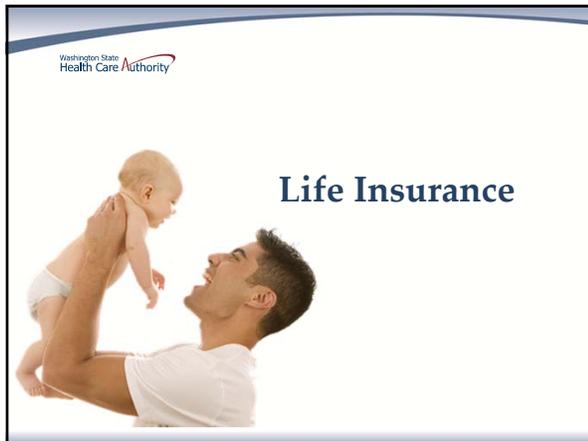
- **Uniform Dental Plan**
 - Administered by Delta Dental of Washington
 - Preferred Provider Organization
- **DeltaCare**
 - Administered by Delta Dental of Washington
 - Managed Care Plan
- **Willamette Dental**
 - Managed Care Plan

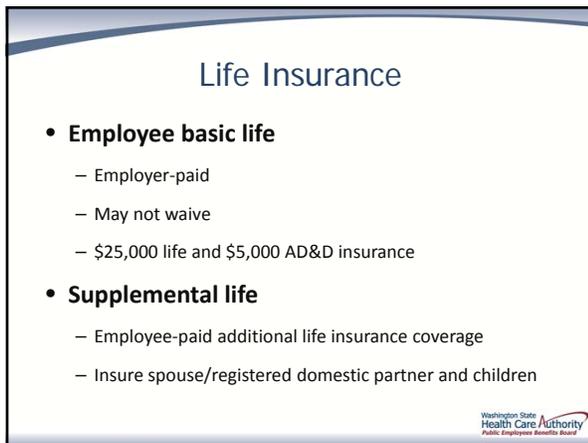


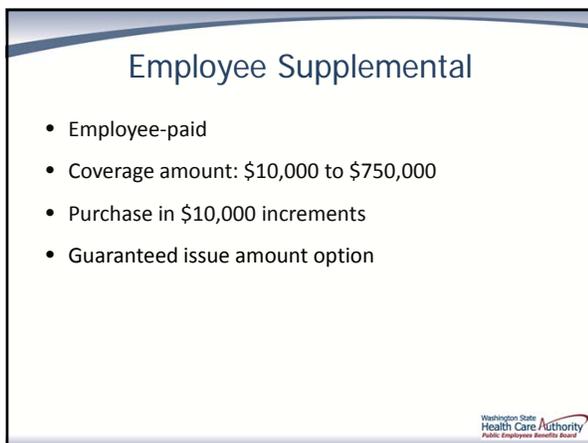
Dental Plan Selection

- **DeltaCare and UDP are both administered by Delta Dental of Washington**
 - Networks are very different
 - Employee should call plan to verify which network their dentist participates in
 - Do not call dentist office to verify









Spouse and Dependent Basic

- Employee-paid
- Premium is \$0.60 per month, regardless of number of dependents
- \$2,500 for spouse/partner and each child



Spouse Supplemental

- Employee-paid
- Must first enroll spouse/partner in spouse basic
- Coverage amount: Cannot exceed 1/2 of employee supplemental amount
 - If employee has \$500,000 total coverage, spouse coverage can be up to what amount?
- Purchase in \$5,000 increments
- Guaranteed issue amount option



Supplemental AD&D

- Employee-paid
- Coverage amount: \$25,000 to \$250,000
- Purchase coverage in \$25,000 increments
- Never requires approval
- Include your spouse/partner and children



Guaranteed Issue Amount

Newly eligible employees can elect a pre-defined amount of coverage without submitting evidence of insurability for carrier approval

- **Employee supplemental**
 - Up to \$250,000 if under the age of 60
 - Up to \$100,000 if over the age of 60
- **Spouse supplemental**
 - Up to \$50,000
- Must be within 60 days of gaining eligibility, or
- If adding spouse/partner due to marriage, spouse supplemental must be within 60 days of marriage/partnership date



Evidence of Insurability

- Employees must submit an *Evidence of Insurability (EOI)* form for carrier approval if they:
 - Submitted *Life Enrollment/Change* form more than 60 days after the initial date of eligibility or date of marriage/partnership
 - Requested more than the guaranteed issue amount for employee and spouse supplemental
- For current employees making a change to coverage that requires EOI, only *EOI* form is sent to carrier



Premiums

- Life insurance premium is based on:
 - Employee's age
 - Tobacco use*
- AD&D cost is based on:
 - Requested amount
 - Inclusion of family members

*If a current employee has a change in tobacco use status (tobacco-free for 2 months or more), they can submit an [Amendment to Original Application](#) and receive the non-tobacco user rate



Calculating Life Premium

- See 2016 Life LTD Rates
- Example:
 - Employee wants to purchase *guaranteed issue amount* for employee and spouse supplemental coverage:
 - Employee is 35 years old and a non-smoker
 - Spouse is 48 years old and uses tobacco
 - \$250K + \$50K = \$300K total supplemental
 - Calculation: 300 x \$0.049 (smoker rate* for ages 35-39**)=\$14.70/mo.

*Smoker rate is applied to premium if either employee or spouse uses tobacco
**Only the age of employee is applied to premium



Calculating AD&D Premium

- See 2016 Life LTD Rates
- Examples:
 - Employee wants to purchase supplemental AD&D
 - \$250K for employee only: \$3.00/mo.
 - \$250K for employee + dependent: \$4.75/mo.



Life Final Action Notice (FAN)

- A FAN will be issued by ReliaStar when:
 - Employee requests more than guaranteed issue amount
 - Employee elects to increase or apply for supplemental coverage after initial date of eligibility
 - FAN will indicate if request for coverage is approved, denied, or closed



Life Waiver of Premium

- The following (combined) circumstances may allow an employee to waive their life insurance premiums:
 - Employee becomes totally disabled
 - Disabled for at least 6 months
 - Employee is under the age of 60
- A waiver can be requested for each part of life insurance employee is currently enrolled in, except Supplemental AD&D



Accelerated Benefit Claim

- Payable to an employee with a terminal condition and a life expectancy of no more than 24 months
 - Benefit is equal to 50% of the amount of employee basic and supplemental or \$100,000, whichever is less
 - Must have at least \$10,000 in life insurance coverage to qualify





Long-Term Disability (LTD)

Basic Long-Term Disability

- Employer-paid
- Cannot waive
- Benefit begins after 90 days of continuous disability or after the period of accumulated leave
- Minimum of \$50/maximum of \$240 per month
 - Amount received is based on earnings before the disability and deductible income earned once disabled



Optional Long-Term Disability

- Optional coverage combines with basic to increase monthly benefit payment
- Choose your benefit waiting period
 - Consider your sick leave accrual
 - Maximum benefit period determined by the age you become disabled
- Retirement Supplement included
 - Based on your retirement plan and contains a pre-existing condition provision



Optional Long-Term Disability

- Monthly premiums are based on:
 - Waiting period selected
 - Monthly salary
 - Retirement plan
- Pays 60% of your monthly salary
 - Maximum of \$10,000 per month
 - Minimum of \$100 per month (\$50 basic + \$50 optional)
- Payments may be offset by other income
 - See *Long-Term Disability* booklet for deductible income



Optional Long-Term Disability

- Change waiting period at any time
 - Carrier approval and evidence of insurability is required when decreasing waiting period
- *LTD Enrollment/Change* form due no later than **31 days** after initial date of eligibility



LTD Premium Waiver

- If disabled, an employee's payment of premiums is waived while:
 - LTD benefits are payable; and
 - The employee is completing the Benefit Waiting Period, provided the employee is not in pay status.



LTD Final Action Notice (FAN)

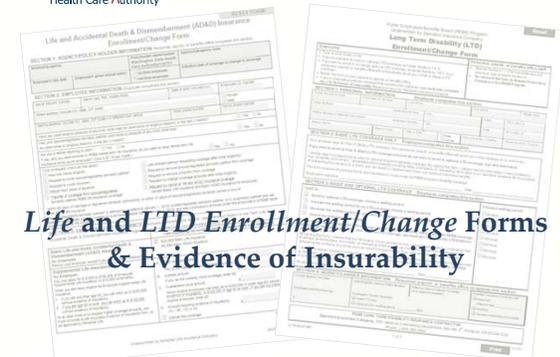
- A FAN will be issued by Standard when:
 - Employee requests optional LTD after initial period of eligibility
 - Employee chooses to decrease waiting period
 - FAN will indicate if request for coverage is approved, denied, or closed



Calculating LTD Premium

- See *2016 Life LTD Rates*
- Example:
 - Employee wants to purchase optional coverage:
 - 90-day waiting period
 - Earns \$5,000/month
 - Participates in PERS retirement plan
 - Calculation: $\$5,000 \times 0.51\% (0.0051) = \$25.50/\text{mo.}$





Life and LTD Enrollment/Change Forms & Evidence of Insurability

Forms Reminders

- Make sure to:
 - Stamp a “date received” on all forms
 - Receive accurate social security number for employee and all dependents
 - Employee may be charged a \$50 fine by the IRS for each inaccurate SSN on their account
 - Receive accurate phone number(s) for employee
 - If current employee is making changes to life or LTD coverage that requires evidence of insurability, only the *Evidence of Insurability* form is submitted to carrier



Forms Reminders

- Complete the bottom of page 1 of the *Employee Enrollment/Change* form
 - Lists agency name, agency/sub agency number, effective date, and hire date (date of eligibility)
- Complete section 1 of the *Life Insurance Enrollment/Change* form
- Complete Section 4 of the *LTD Enrollment/Change* form





Medical Flexible Spending Arrangement & Dependent Care Assistance Program



Medical FSA/DCAP

- Available to employees of:
 - State agencies
 - Higher education institutions
- Administered by Navia Benefits
- A "use it or lose it" benefit
 - Unused balances are forfeited to the plan administrator (HCA)
- Employees must re-enroll every year during open enrollment to keep benefit
- List of eligible expenses and other tools at: www.pebb.naviabenefits.com



Medical FSA

- Pre-tax dollars may be applied to:
 - Out-of-pocket healthcare expenses
- Minimum contribution is \$240
- Up to a maximum of \$2,500 per year



Dependent Care Assistance Program

- Pre-tax dollars can be applied to:
 - Childcare expenses
 - Elder care expenses
- May save employee more money than credits on annual tax return
 - Employees should consult a tax advisor
- Family maximum of \$5,000 per year



Thank you for your input!