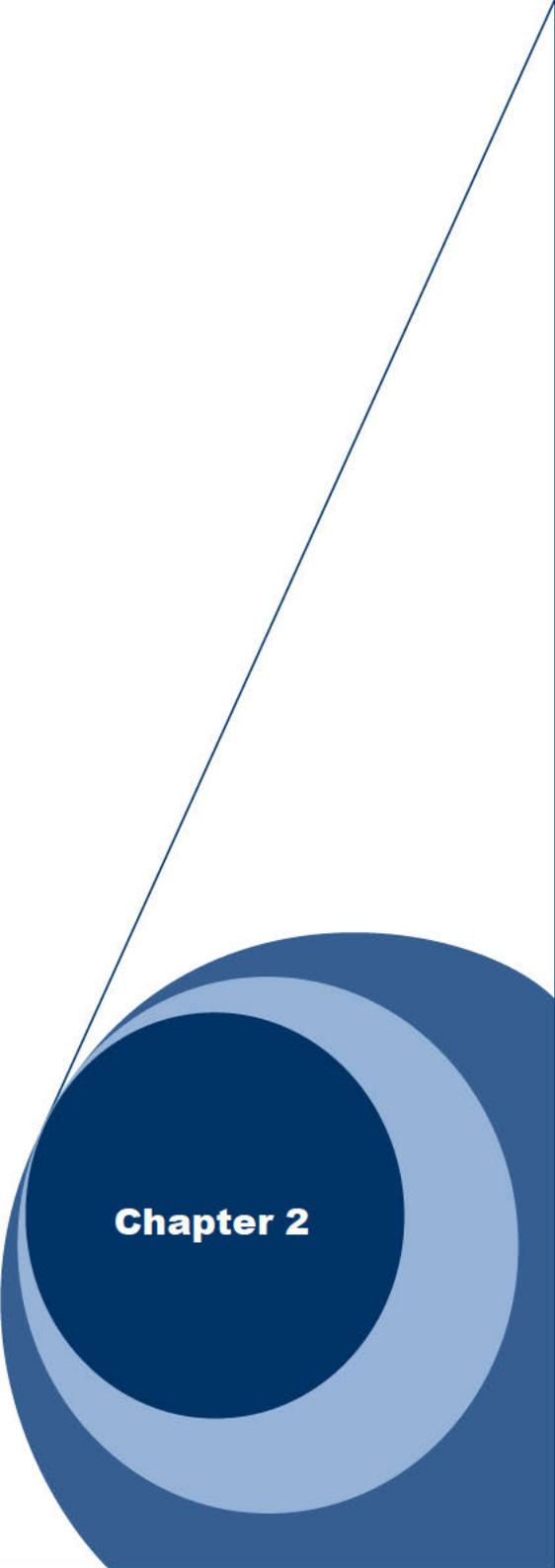


Medical and Dental



Chapter 2

Medical and Dental

Annual Open Enrollment	3
Special Open Enrollment	4
Erin Act	4
Enrolling a Newborn	4
Dual Enrollment	5
Employee Dual Enrollment.....	5
Important Elements of Employee Dual Enrollment	5
Dependent (Spouse/Children) Dual Enrollment.....	6
Important Elements of Dependent Dual Enrollment.....	6
Waiving Coverage and Employer-Based Group Medical Insurance	6
Removing Eligible Dependents	7
Returning from Waived Status	8
Sample Proof of Loss	9
Resources	9

Annual Open Enrollment

During November, which is PEBB's annual open enrollment period, employees can make changes to their coverage, such as:

- Change medical and dental plans
- Reinstate coverage without proof of loss (if they previously waived medical coverage)
- Waive medical coverage (if they have other employer-based group medical insurance)
- Add eligible dependents without proof of loss (Dependent verification documents are required for dependents not previously verified)
- Remove dependents
- Change premium payment plan (IRC Section 125) waiver status
- Change the IRC tax status of a dependent (Declaration of Tax Status form)
- Enroll or re-enroll in a Medical Flexible Spending Arrangement (FSA) or Dependent Care Assistance Program (DCAP) (for state and higher education employees only)
- Attest or re-attest to the spousal premium surcharge*, if applicable

*Employees may re-attest to the tobacco use premium surcharge at any time.

To make changes, employees must submit the proper form(s) to their agency's personnel, payroll, or benefits office by the last day of the open enrollment period (November 30).

Employees can also make the following changes through *My Account*:

- Change medical and dental plans
- Enroll in or waive medical for self
- Enroll or waive medical and dental for dependents (*Note: dependents not currently enrolled in either medical or dental may not be added through My Account; a paper form must be submitted*)
- Re-attest to the spousal premium surcharge*, if applicable

*Employees may re-attest to the tobacco use premium surcharge at any time.

All changes made to the employee's account are effective January 1 of the following year.

There is no annual open enrollment for life and long term disability (LTD) insurance. Changes can be made at any time during the year, although some changes require carrier approval.

The employee must submit a *Life Insurance Enrollment/Change* form or *LTD Enrollment/Change* form to their agency's personnel, payroll, or benefits office and an *Evidence of Insurability* form to the carrier, if applicable.

For guidance on annual open enrollment, refer to WAC 182-08-198, WAC 182-08-199, WAC 182-12-128, and WAC 182-12-262.

Special Open Enrollment

A life-changing event may allow an employee to enroll in, waive, or change coverage outside of annual open enrollment. This is called a special open enrollment event. WAC and federal regulations determine when employees can make changes to their medical and dental coverage—including the employee, their spouse or registered domestic partner, and dependents.

The following WACs describe special open enrollment:

- 182-08-198: When may a subscriber change health plans?
- 182-08-199: When may an employee enroll in or change his or her election under the premium payment plan, medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP)?
- 182-12-128: Can an employee waive or enroll in public employees benefits board (PEBB) medical?
- 182-12-262: When may subscribers enroll or remove eligible dependents?

Changes must be allowable, correspond to, and be consistent with the event that creates the special open enrollment for the employee, dependent(s), or both.

To make a change, the employee must complete and submit the appropriate form(s) and proof of the qualifying event, no later than 60 days after the date of the qualifying event, to their agency's personnel, payroll, or benefits office. Refer to Policy 45-2, Addendum 45-2A for special open enrollment events and allowable changes permitted for each event. If you have questions, contact PEBB through [FUZE](#).

Changes are effective the first of the month following the receipt of the form.

Erin Act ([RCW 48.43.115\(3\)\(f\)](#))

When the mother's medical plan has maternity benefits, a newborn child will receive 21 days of coverage under the plan automatically, regardless if the child is ultimately enrolled in the mother's plan or not.

Enrolling a Newborn

If an employee wishes to enroll a newborn, the employee should notify their agency's personnel, payroll, or benefits office by submitting an *Employee Enrollment/Change* form as soon as possible to ensure timely payment of claims.

If adding the child increases the premium (this is the first child enrolled on the account), the employee must submit an enrollment form and dependent verification documentation no later than 12 months after the date of birth. The employee is responsible for paying back premiums to the employer. For example, if the child is born October 1 but is not added until June 1, the employee must pay back premiums for nine months (October through June).

If the employee wishes to change plans or add their spouse or registered domestic partner in addition to adding the newborn, the enrollment form and dependent verification documentation must be submitted to their agency's personnel, payroll, or benefits office no later than **60 days** after the date of birth.

Note: The Erin Act addresses newborn coverage in the first 21 days of life. The special open enrollment rules for enrolling the dependent in coverage also applies to a child whom the employee has adopted or assumed legal obligation for total or partial support in anticipation of adoption.

Dual Enrollment

Dual enrollment in PEBB coverage is not permitted for a subscriber or a dependent. Refer to WAC 182-12-123 and Policy 45-2, Addendum 45-2A for more details.

When a subscriber or dependent is added to PAY1, the system will search for existing enrollment, referencing the social security number entered. If the subscriber or dependent is already enrolled in PEBB medical or dental coverage, enrollment of coverage will not be allowed. The following message displays in PAY1: "PEBB dual enrollment not allowed—contact subscriber for resolution."

Employee Dual Enrollment

(Dependent enrolled on a PEBB account who becomes eligible for benefits as an employee.)

Important Elements of Employee Dual Enrollment

- Defer to the new employee to determine desired enrollment.
- The eligible employee must enroll in dental (if employer participates in PEBB dental), but may choose to:
 - Enroll in medical, or
 - Waive medical and remain enrolled in medical as a dependent on the other account.
- If the employee does not submit forms within 31 days of becoming eligible for benefits, the employee is defaulted to Uniform Medical Plan Classic and Uniform Dental Plan (WAC 182-12-197).

- Both employers and HCA must coordinate to prevent a gap in coverage for the new employee when the employee switches coverage to their new employer.

To view the process for correcting employee dual enrollment issues in PAY1, see the [PAY1 System Manual](#).

Dependent (Spouse/Children) Dual Enrollment

(Employee requesting enrollment for a dependent already enrolled on another PEBB account as a dependent or agency receives a court order or Medical Support Notice.)

Important Elements of Dependent Dual Enrollment

- Defer to the new employee to determine desired enrollment. There must also be coordination with the other PEBB subscriber.
 - The subscriber where the dependent is currently enrolled must submit an enrollment form to their employer to remove the dependent from their account within 60 days of the special open enrollment qualifying event (Change in Employment Status; see Policy 45-2, Addendum 45-2A).
 - The dependent may be enrolled in medical only, dental only or both medical and dental.
- The removal date must coincide with the dependent's effective date. Both employees must coordinate to prevent a gap in coverage for the dependent when he/she switches coverage to the new employee's account.
- **Do not term a dependent if they are currently enrolled on an account due to a court or Support NMSN order.** Refer the employee back to the Support Enforcement office.

Waiving Coverage and Employer-Based Group Medical Insurance

Eligible employees may waive medical coverage if they have other employer-based group medical insurance, TRICARE, or Medicare. Enrollment in dental, basic life, and basic LTD is required for all state agencies and higher education institutions. Employer-based group medical insurance is defined as insurance offered by a spouse or registered domestic partner's employer that the spouse or partner is eligible for as an employee. This includes COBRA insurance offered by the employer.

Employer-based group medical insurance does not include:

- Health Benefit Exchange coverage
- Retiree medical coverage offered by the spouse or registered domestic partner's employer that the spouse or partner is eligible for as a retiree (except TRICARE)

Note: An employee can waive their PEBB medical if eligible for Medicaid (known as Apple Health in Washington State).

If an employee waives medical, medical coverage is automatically waived for all dependents. The employee can enroll in medical and enroll their dependents in medical, dental, or both. To waive medical, employees must submit an *Employee Enrollment/Change* form to their agency's personnel, payroll, or benefits office.

Employees may waive coverage:

- **When they become eligible for PEBB benefits.** The enrollment form must be submitted no later than 31 days after they become eligible. Medical will be waived as of the date the employee becomes eligible for PEBB benefits.
- **During annual open enrollment.** The enrollment form must be submitted before the end of annual open enrollment (November 30). Medical will be waived beginning January 1 of the following year.
- **During a special open enrollment.** The enrollment form must be submitted no later than 60 days after the qualifying event that triggered the special open enrollment. Refer to Policy 45-2, Addendum 45-2A for the effective date.

Refer to WAC 182-12-128 for more details.

Removing Eligible Dependents

To remove a dependent from medical or dental coverage, the employee must submit an *Employee Enrollment/Change* form to their agency's personnel, payroll, or benefits office.

Employees may choose to remove their dependent(s):

- **When employee becomes eligible for PEBB benefits.** The enrollment form must be submitted no later than 31 days after the employee becomes eligible.
- **During annual open enrollment.** The enrollment form must be submitted before the end of the annual open enrollment (November 30). The dependent will be removed beginning January 1st of the following year.
- **During a special open enrollment.** The enrollment form must be submitted no later than 60 days after the qualifying event that triggered the special open enrollment. Refer to Policy 45-2, Addendum 45-2A for the effective date.

Refer to WAC 182-12-128 for more details.

Returning from Waived Status

Employees who previously waived medical coverage may enroll themselves and eligible dependents in PEBB coverage during annual open enrollment without providing “proof of loss.” The effective date of coverage is January 1 of the following year.

If an employee or their dependent experiences a qualifying event that triggers a special open enrollment, the employee can re-enroll after waiving medical coverage or add their dependent to PEBB coverage. See Policy 45-2, Addendum 45-2A for a list of allowable changes. The appropriate form(s) and proof of the event must be submitted no later than 60 days after the event that triggered the special open enrollment.

Refer to WAC 182-12-128 for more details.

Outside of annual open enrollment, reinstatements are keyed by PEBB. Submit the *Employee Enrollment/Change* form and proof of loss through [FUZE](#). See Policy 45-2, Addendum 45-2A for a list of valid proof of loss documents.

Send the *Employee Enrollment/Change* form, proof of loss, and acceptable dependent verification documentation, if adding a dependent who has not been previously verified, to HCA - PEBB Outreach and Training, Mail Stop 42684, through FUZE, or by fax to 360-725-0771. If the employee’s past coverage was through PEBB, proof of loss is not required.

If approved, PEBB will key the employee’s enrollment in the PAY1 insurance system. If information submitted is incomplete, PEBB will request resolution from the employer.

If the employee fails to timely provide the necessary documentation to their agency’s personnel, payroll, or benefits office, the employee will be defaulted to UMP, UDP, basic life, and basic LTD as a single subscriber (no dependents) and will incur the tobacco use premium surcharge.

Sample Proof of Loss

H.C.A.	CERTIFICATE OF CREDITABLE COVERAGE May 22, 2008				
John Doe [REDACTED]	[REDACTED]				
<p>IMPORTANT: This certificate provides evidence of your prior health coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll. This certificate may need to be provided if medical advice, diagnosis, care, or treatment was recommended or received for the condition within the six-month period prior to your enrollment in the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to buy, for yourself or your family, an insurance policy that does not exclude coverage for medical conditions that are present before you enroll. The individual(s) listed below have had PEBB medical insurance coverage for the following periods of time:</p>					
NAME	SOCIAL SECURITY	BIRTHDATE	RELATIONSHIP	BEGIN DATE	END DATE
John Doe	[REDACTED]	10-11-1955	Subscriber	05-01-2003	05-30-2008
Jane Doe	999-99-0001	09-13-1950	Spouse	05-01-2003	05-30-2008
<p>Please review this document for accuracy. If you have questions, please call the Health Care Authority at [REDACTED] or toll-free at 1-800-200-1004.</p>					
HCA 50-609 (5/97)					

Resources

- [Policy 45-2, Addendum 45-2A](#)
- [Chapter 182-08 WAC](#)
- [Chapter 182-12 WAC](#)
- [FUZE](#)
- [PersPay website](#) (for agencies only)