



PROPOSED RULE MAKING

CR-102 (August 2017)
(Implements RCW 34.05.320)
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FILED

DATE: August 22, 2018
TIME: 11:34 AM

WSR 18-17-188

Agency: Health Care Authority (HCA) Public Employees Benefits Board (PEBB) Admin #2018-02

Original Notice

Supplemental Notice to WSR _____

Continuance of WSR _____

Preproposal Statement of Inquiry was filed as WSR 18-11-023 ; or

Expedited Rule Making--Proposed notice was filed as WSR _____ ; or

Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1).

Proposal is exempt under RCW _____.

Title of rule and other identifying information: (describe subject)

182-08-15 Definitions;

WAC 182-08-180 Premium payments and premium refunds;

182-08-185 What are the requirements regarding premium surcharges;

182-08-187 How do employing agencies and contracted vendors correct enrollment errors and is there a limit on retroactive enrollment;

182-08-196 What happens if my health plan becomes unavailable due to a change in contracted service area or eligibility for Medicare;

182-08-197 When must a newly eligible employee, or an employee who regains eligibility for the employer contribution, select public employees benefits board (PEBB) benefits and complete required forms;

182-08-198 When may a subscriber change health plans;

182-08-199 When may an employee enroll, or revoke an election and make a new election under the premium payment plan, medical flexible spending arrangement (FSA), or dependent care assistance program (DCAP);

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

182-08-235 Employer group and charter school application process;

182-08-240 How will the health care authority (HCA) decide to approve or deny a group application;

182-12-109 Definitions;

182-12-113 What are the obligations of a state agency in the application of employee eligibility;

182-12-114 How do employees establish eligibility for public employees benefits board (PEBB) benefits;

182-12-123 Is dual enrollment prohibited;

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?;

182-12-129 What happens when an employee moves from an eligible to an otherwise ineligible position or job due to a layoff;

182-12-131 How do eligible employees maintain the employer contribution toward public employees benefits board (PEBB) insurance coverage;

182-12-133 What options for continuation coverage are available to employees and their dependents during certain types of leave or when employment ends due to a layoff;

182-12-138 What options are available if an employee is approved for the federal Family and Medical Leave Act (FMLA);

182-12-141 If an employee reverts from an eligible position, what happens to their public employees benefits board (PEBB) insurance coverage;

182-12-142 What options for continuation coverage are available to faculty and seasonal employees who are between periods of eligibility;

182-12-146 When is an enrollee eligible to continue public employee's benefits board (PEBB) health plan coverage under Consolidated Omnibus Budget Reconciliation Act (COBRA);

182-12-148 What options for continuation coverage are available to employees during their appeal of dismissal;

182-12-171 When is a retiring employee eligible to enroll in public employees benefits board (PEBB) retiree insurance coverage;

182-12-180 When is an elected and full-time appointed official of the legislative and executive branch of state government, or their survivor eligible to continue enrollment in public employees benefits board (PEBB) retiree insurance coverage;

182-12-200 May a retiring employee or a retiree enrolled as a dependent in a health plan sponsored by public employees benefits board (PEBB), a Washington state school district, a Washington state educational service district, or a Washington state charter school defer PEBB health plan enrollment under PEBB retiree insurance coverage;

182-12-205 May a retiree or a survivor defer or voluntarily terminate public employees benefits board (PEBB) health plan enrollment under PEBB retiree insurance coverage;

182-12-207 When can a retiree or an eligible dependent's public employees benefits board (PEBB) insurance coverage be terminated by the health care authority (HCA);

182-12-208 What are the requirements regarding enrollment in dental under public employees benefits board (PEBB) retiree insurance coverage;

182-12-209 Who is eligible for retiree term life insurance;

182-12-211 May an employee who is determined to be retroactively eligible for disability retirement enroll in public employees benefits board (PEBB) retiree insurance coverage;

182-12-250 Public employees benefits board (PEBB) insurance coverage eligibility for survivors of emergency service personnel killed in the line of duty;

182-12-260 Who are eligible dependents;

182-12-262 When may subscribers enroll or remove eligible dependents;

182-12-263 National Medical Support Notice (NMSN);

182-12-265 What options for continuing health plan enrollment are available to a surviving spouse, state registered domestic partner, or child, if the employee or retiree dies;

182-12-270 What options for continuation coverage are available to dependents who cease to meet the eligibility criteria as described in WAC 182-12-260; and

182-12-300 Public employees benefits board (PEBB) wellness incentive program eligibility and procedural requirements.

Hearing location(s):

Date:	Time:	Location: (be specific)	Comment:
September 25, 2018	10:00 AM	Health Care Authority Cherry Street Plaza Building Sue Crystal Conf Rm 106A & B 626 – 8 th Avenue Olympia, WA 98504	Metered public parking is available street side around building. A map is available at: https://www.hca.wa.gov/assets/program/Driving-parking-checkin-instructions.pdf or directions can be obtained by calling: (360) 725-1000

Date of intended adoption: Not sooner than September 26, 2018 (Note: This is **NOT** the **effective** date)

Submit written comments to:

Name: HCA Rules Coordinator
 Address: PO Box 45504, Olympia, WA 98504-5504
 Email: arc@hca.wa.gov
 Fax: 360-586-9727
 Other:
 By (date) September 25, 2018

Assistance for persons with disabilities:

Contact Amber Lougheed
 Phone: 360-725-1349
 Fax: 360-586-9727
 TTY: Telecommunication Relay Services (TRS): 711
 Email: amber.lougheed@hca.wa.gov
 Other:
 By (date) September 21, 2018

Purpose of the proposal and its anticipated effects, including any changes in existing rules:

- 1. Implement Public Employees Benefits (PEB) Board policy resolutions:**
 - Amend WAC 182-08-187 which governs the process an employing agency would use to correct an eligibility or enrollment error.
 - Authorize a retiree who is no longer eligible to remain enrolled in a PEBB health plan to remain enrolled in retiree term life insurance coverage.
 - Authorize retirees and survivors to defer enrollment in a PEBB health plan if they are enrolled in the Civilian Health and Medical Program of the Department of Veteran's Affairs (CHAMPVA) coverage.
- 2. Making technical amendments to:**
 - Change references to the PEBB Appeals Committee to instead refer to the PEBB Appeals Unit and changing cross-references to rules in Chapter 182-16 WAC.
 - Clarify that it is the PEBB Program that sends and receives the COBRA election form, reviews COBRA eligibility, and receives COBRA payments.

- Clarify in WAC 182-12-146 that enrollees that do not fit the definition of qualified beneficiary under COBRA qualify for continuation of PEBB coverage as authorized by RCW 26.60.015 and the PEB Board through their policy resolution on May 23, 2000.
- Revise several definitions in WAC 182-08-015 and 182-12-109.
- Make child eligibility consistent within state statutes.
- Correct numbering errors in WAC 182-08-187.
- Clarify in WAC 182-08-197 that an employee's forms must be received by their employing state agency or the applicable contracted vendor no later than 31 days after the employee becomes eligible for PEBB benefits.
- Revise WAC 182-08-198 to address when coverage begins for a member who enrolls in a Medicare Advantage plan.
- Clarify where enrollment forms should be submitted in WAC 182-08-198.
- Revise WAC 182-08-199 to clarify procedures during open enrollment and special open enrollment for FSA and DCAP and amending multiple rules to better align with Salary Reduction Plan document language. Clarify each employer's responsibility for payment of the employer contribution when an employee transfers from one employing agency to another in WAC 182-08-200.
- Revise WAC 182-08-240 to improve readability.
- Amend procedural requirements in WAC 182-12-171 to add if a retiree employee elects to enroll a dependent in PEBB insurance coverage, the dependent must be enrolled in the same PEBB medical and PEBB dental plan as the retiring employee with a narrow exception.
- Update WAC 182-12-123 to refer to the appropriate WAC reference to enroll in PEBB retiree insurance coverage after deferring.
- Include more detail in WAC 182-12-205 regarding who is eligible and to reference the appropriate WAC for requirements to defer a PEBB retiree health plan.
- Add additional language to WAC 182-12-262 to make clear that a subscriber has to satisfy the enrollment requirements in WAC 182-12-262(4) in order to enroll eligible dependents.
- Clarify the enforcement of the National Medical Support Notice (NMSN) when a terminated employee elects self-only COBRA in WAC 182-12-263.
- Clarify the 45-day rule related to premium payments and premium refunds by cross-referencing WAC 182-12-146 with WAC 182-08-180, clarify if WAC 182-08-180 is applicable to all or just employees eligible for the employer contribution.
- Clarify rules related to elected officials in WAC 182-12-180.
- Add additional language so it is clear that the surcharges are in addition to the monthly premium and cross-referenced additional rules within the WAC 182-08-185 that apply.
- Clarify WAC 182-08-185 that a premium surcharge will be applied when a spouse or state-registered domestic partner is enrolled in medical coverage.
- Clarify that the dependent of a retiree must be enrolled in the same medical and dental plan with narrow exceptions in Chapter 182-12 WAC.
- Amend a cross-reference to the definition of separated employee in WAC 182-12-171.
- Remove NMSN from the special open enrollment event rules in Chapters 182-08 and 182-12 WAC because it is addressed in a separate rule.
- Clarify that the subscriber must maintain continuous enrollment in one of the types of coverage allowed and clarify timelines for deferral upon retirement and post retirement in WAC 182-12-200 and 182-12-205.
- Clarify COBRA and the deferral process for surviving dependents in WAC 182-12-265 and 182-12-180.

3. Amending rule to improve administration of the PEBB Program:

- Revise the employer group application process to authorize alternative requirements for employer groups that are not able to provide historical claims data and cost information as required in WAC 182-08-235.
- Clarify in Chapter 182-08 WAC that an employee must provide evidence of the special open enrollment event in addition to the required form in order to make an enrollment change during a special open enrollment.
- Add an exception to WAC 182-12-205 regarding when PEBB insurance coverage will end for a member who enrolls in a Medicare Advantage plan. Clarifying that once a retiree voluntarily terminates the coverage, the retiree cannot reenroll in PEBB benefits unless the retiree becomes newly eligible.
- Change the reasonable alternative for enrollees who use tobacco products to require enrollees eighteen or older to attest to having enrolled in a cessation program and to require enrollees thirteen through seventeen to have accessed the required website information.
- Revise WAC 182-12-262 to convey anti-rescission limitations in the PEBB Program's discretion.

- Revise WAC 182-12-300 to include the requirement for subscribers who complete the well-being assessment and earn the \$25 gift card to claim the gift card within the same calendar year.

Reasons supporting proposal: See purpose.

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Statute being implemented: ESSB 6241 and EHB 2242

Is rule necessary because of a:

- Federal Law? Yes No
 Federal Court Decision? Yes No
 State Court Decision? Yes No

If yes, CITATION: 42 U.S.C. Secs. 300bb-1 through 300bb-8; 38 U.S.C. Secs. 4301 through 4335; 26 U.S.C. Sec. 125, 26 U.S.C. Sec. 129 or other sections of the Internal Revenue Code; and 42 U.S.C. § 1395w-114

Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters:

Name of proponent: (person or organization) Health Care Authority Private
 Public
 Governmental

Name of agency personnel responsible for:

	Name	Office Location	Phone
Drafting:	Stella Ng	626 8 th Avenue SE, Olympia, Washington	360-725-0852
Implementation:	Barbara Scott	626 8 th Avenue SE, Olympia, Washington	360-725-0830
Enforcement:	Scott Palafox	626 8 th Avenue SE, Olympia, Washington	360-725-1858

Is a school district fiscal impact statement required under RCW 28A.305.135? Yes No

If yes, insert statement here:

The public may obtain a copy of the school district fiscal impact statement by contacting:

- Name:
- Address:
- Phone:
- Fax:
- TTY:
- Email:
- Other:

Is a cost-benefit analysis required under RCW 34.05.328?

- Yes: A preliminary cost-benefit analysis may be obtained by contacting:
 - Name:
 - Address:
 - Phone:
 - Fax:

TTY:

Email:

Other:

No: Please explain: RCW 34.05.328 does not apply to Health Care Authority rules unless requested by the Joint Administrative Rules Review Committee or applied voluntarily.

Regulatory Fairness Act Cost Considerations for a Small Business Economic Impact Statement:

This rule proposal, or portions of the proposal, **may be exempt** from requirements of the Regulatory Fairness Act (see chapter 19.85 RCW). Please check the box for any applicable exemption(s):

This rule proposal, or portions of the proposal, is exempt under RCW 19.85.061 because this rule making is being adopted solely to conform and/or comply with federal statute or regulations. Please cite the specific federal statute or regulation this rule is being adopted to conform or comply with, and describe the consequences to the state if the rule is not adopted.

Citation and description:

This rule proposal, or portions of the proposal, is exempt because the agency has completed the pilot rule process defined by RCW 34.05.313 before filing the notice of this proposed rule.

This rule proposal, or portions of the proposal, is exempt under the provisions of RCW 15.65.570(2) because it was adopted by a referendum.

This rule proposal, or portions of the proposal, is exempt under RCW 19.85.025(3). Check all that apply:

RCW 34.05.310 (4)(b)
(Internal government operations)

RCW 34.05.310 (4)(e)
(Dictated by statute)

RCW 34.05.310 (4)(c)
(Incorporation by reference)

RCW 34.05.310 (4)(f)
(Set or adjust fees)

RCW 34.05.310 (4)(d)
(Correct or clarify language)

RCW 34.05.310 (4)(g)
((i) Relating to agency hearings; or (ii) process requirements for applying to an agency for a license or permit)

This rule proposal, or portions of the proposal, is exempt under RCW ____.

Explanation of exemptions, if necessary: .

COMPLETE THIS SECTION ONLY IF NO EXEMPTION APPLIES

If the proposed rule is **not exempt**, does it impose more-than-minor costs (as defined by RCW 19.85.020(2)) on businesses?

No Briefly summarize the agency's analysis showing how costs were calculated. The proposed rules do not impose any cost on small businesses.

Yes Calculations show the rule proposal likely imposes more-than-minor cost to businesses, and a small business economic impact statement is required. Insert statement here:

The public may obtain a copy of the small business economic impact statement or the detailed cost calculations by contacting:

Name:

Address:

Phone:

Fax:

TTY:

Email:

Other:

Date: August 22, 2018

Name: Wendy Barcus

Title: HCA Rules Coordinator

Signature:



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

"Affordable Care Act" means the federal Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, P.L. 111-152, or federal regulations or guidance issued under the Affordable Care Act.

"Annual open enrollment" means an annual event set aside for a period of time when subscribers may make changes to their health plan enrollment and salary reduction elections for the following plan year. During the annual open enrollment, subscribers may transfer from one health plan to another, enroll or remove dependents from coverage, or enroll in or waive enrollment in PEBB medical. Employees eligible to participate in the salary reduction plan may enroll in or change their election under the dependent care assistance program (DCAP)((7)) and the medical flexible spending arrangement (FSA)((7-09)). They may also enroll in or opt out of the premium payment plan.

"Authority" or "HCA" means the Washington state health care authority.

"Board" means the public employees benefits board established under provisions of RCW 41.05.055.

"Calendar days" or "days" means all days including Saturdays and Sundays.

"Consolidated Omnibus Budget Reconciliation Act" or "COBRA" means continuation coverage as administered under 42 U.S.C. Secs. 300bb-1 through 300bb-8.

"Continuation coverage" means the temporary continuation of ((PEBB)) health plan coverage available to enrollees after a qualifying event occurs as administered under ((Title XXII of the Public Health Service (PHS) Act)) the Consolidated Omnibus Budget Reconciliation Act (COBRA), 42 U.S.C. Secs. 300bb-1 through 300bb-8, the Uniformed Services Employment and Reemployment Rights Act (USERRA), 38 U.S.C. Secs. 4301 through 4335, or PEBB insurance coverage extended by the public employees benefits board under WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, and 182-12-270.

"Contracted vendor" means any person, persons, or entity under contract or agreement with the HCA to provide goods or services for the provision or administration of PEBB benefits. The term "contracted vendor" includes subcontractors of the HCA and subcontractors of any person, persons, or entity under contract or agreement with the HCA that provide goods or services for the provision or administration of PEBB benefits.

"Creditable coverage" means coverage that meets the definition of "creditable coverage" under RCW 48.66.020 (13)(a) and includes payment of medical and hospital benefits.

"Defer" means to postpone enrollment or interrupt enrollment in a PEBB health plan by a retiree or an eligible survivor.

"Dependent" means a person who meets eligibility requirements in WAC 182-12-260, except that "surviving spouses, state registered domestic partners, and dependent children" of emergency service personnel who are killed in the line of duty is defined in WAC 182-12-250.

"Dependent care assistance program" or "DCAP" means a benefit plan whereby state and public employees may pay for certain employment

related dependent care with pretax dollars as provided in the salary reduction plan (~~authorized in chapter 41.05 RCW~~) under this chapter pursuant to 26 U.S.C. Sec. 129 or other sections of the Internal Revenue Code.

"Director" means the director of the authority.

"Documents" means papers, letters, writings, electronic mail, electronic files, or other printed or written items.

"Employee" for the public employees benefits board program includes all employees of the state, whether or not covered by civil service; elected and appointed officials of the executive branch of government, including full-time members of boards, commissions, or committees; justices of the supreme court and judges of the court of appeals and the superior courts; and members of the state legislature. Pursuant to contractual agreement with the authority, "employee" may also include: (a) Employees of a county, municipality, or other political subdivision of the state and members of the legislative authority of any county, city, or town who are elected to office after February 20, 1970, if the legislative authority of the county, municipality, or other political subdivision of the state submits application materials to the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.04.205 and 41.05.021 (1)(g); (b) employees of employee organizations representing state civil service employees, at the option of each such employee organization, and, effective October 1, 1995, employees of employee organizations currently pooled with employees of school districts for the purpose of purchasing insurance benefits, at the option of each such employee organization; (c) employees of a school district if the authority agrees to provide any of the school districts' insurance programs by contract with the authority as provided in RCW 28A.400.350; (d) employees of a tribal government, if the governing body of the tribal government seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(f) and (g); (e) employees of the Washington health benefit exchange if the governing board of the exchange established in RCW 43.71.020 seeks and receives approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(g) and (n); and (f) employees of a charter school established under chapter 28A.710 RCW. "Employee" does not include: Adult family home providers; unpaid volunteers; patients of state hospitals; inmates; employees of the Washington state convention and trade center as provided in RCW 41.05.110; students of institutions of higher education as determined by their institution; and any others not expressly defined as employees under RCW 41.05.011 or by the authority under this chapter.

"Employer" for the public employees benefits board program means the state of Washington.

"Employer-based group health plan" means group medical and group dental related to a current employment relationship. It does not include medical or dental coverage available to retired employees, individual market medical or dental coverage, or government-sponsored programs such as medicare or medicaid.

"Employer-based group medical" means group medical related to a current employment relationship. It does not include medical coverage available to retired employees, individual market medical coverage, or government-sponsored programs such as medicare or medicaid.

"Employer contribution" means the funding amount paid to the authority by a state agency, employer group, or charter school for its

eligible employees as described in WAC 182-12-114 and 182-12-131(~~and the employee's eligible dependents as described in WAC 182-12-260~~)).

"Employer group" means those counties, municipalities, political subdivisions, the Washington health benefit exchange, tribal governments, school districts, educational service districts, and employee organizations representing state civil service employees, obtaining employee benefits through a contractual agreement with the authority as described in WAC 182-08-245.

"Employer group rate surcharge" means the rate surcharge described in RCW 41.05.050(2).

"Employer-paid coverage" means PEBB insurance coverage for which an employer contribution is made by a state agency, employer group, or charter school for employees eligible under WAC 182-12-114 and 182-12-131. It also means basic benefits described in RCW 28A.400.270(1) for which an employer contribution is made by school districts or an educational service district.

"Employing agency" for the public employees benefits board program means a division, department, or separate agency of state government, including an institution of higher education; a county, municipality, school district, educational service district, or other political subdivision; (~~charter school; or~~) and a tribal government covered by chapter 41.05 RCW.

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

"Exchange" means the Washington health benefit exchange established in RCW 43.71.020, and any other health benefit exchange established under the Affordable Care Act.

"Exchange coverage" means coverage offered by a qualified health plan through an exchange.

"Faculty" means an academic employee of an institution of higher education whose workload is not defined by work hours but whose appointment, workload, and duties directly serve the institution's academic mission, as determined under the authority of its enabling statutes, its governing body, and any applicable collective bargaining agreement.

"Health plan" means a plan offering medical or dental, or both, developed by the public employees benefits board and provided by a contracted vendor or self-insured plans administered by the HCA.

"Insignificant shortfall" means a premium balance owed that is less than or equal to the lesser of \$50 or ten percent of the premium required by the health plan as described in Treasury Regulation 26 C.F.R. 54.4980B-8.

"Institutions of higher education" means the state public research universities, the public regional universities, The Evergreen State College, the community and technical colleges, and the state board for community and technical colleges.

"Large claim" means a claim for more than \$25,000 in allowed costs for services in a quarter.

"Layoff," for purposes of this chapter, means a change in employment status due to an employer's lack of funds or an employer's organizational change.

"Life insurance" for eligible employees includes basic life insurance and accidental death and dismemberment (AD&D) insurance paid for by the employing agency, as well as optional life insurance and optional AD&D insurance offered to and paid for by employees for them-

selves and their dependents. Life insurance for eligible retirees includes retiree term life insurance offered to and paid for by retirees.

"LTD insurance" or "long-term disability insurance" includes any basic long-term disability insurance paid for by the employing agency and any supplemental long-term disability insurance offered to and paid by employees (~~on an optional basis~~).

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby eligible state and public employees may reduce their salary before taxes to pay for medical expenses not reimbursed by insurance as provided in the salary reduction plan (~~authorized in chapter 41.05 RCW~~) under this chapter pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"Ongoing large claim" means a claim where the patient is expected to need ongoing case management into the next quarter for which the expected allowed cost is greater than \$25,000 in the quarter.

"PEBB" means the public employees benefits board.

~~("PEBB appeals committee" means the committee that considers appeals relating to the administration of PEBB benefits by the PEBB program. The director has delegated the authority to hear appeals at the level below an administrative hearing to the PEBB appeals committee.)~~

"PEBB benefits" means one or more insurance coverages or other employee benefits administered by the PEBB program within the health care authority.

"PEBB insurance coverage" means any health plan, life insurance, long-term disability (LTD) insurance, long-term care insurance, or property and casualty insurance administered as a PEBB benefit.

"PEBB program" means the program within the HCA that administers insurance and other benefits for eligible employees (as described in WAC 182-12-114), eligible retired employees (as described in WAC 182-12-171(~~+~~),) and 182-12-180), eligible survivors (as described in WAC 182-12-180, 182-12-250, and 182-12-265), eligible dependents (as described in WAC 182-12-250 and 182-12-260) and others as defined in RCW 41.05.011.

"Plan year" means the time period established by the authority.

"Premium payment plan" means a benefit plan whereby state and public employees may pay their share of group health plan premiums with pretax dollars as provided in the salary reduction plan.

"Premium surcharge" means a payment required from a subscriber, in addition to the subscriber's medical premium contribution, due to an enrollee's tobacco use or ((a)) an enrolled subscriber's spouse or state registered domestic partner choosing not to enroll in ((~~his or her~~)) their employer-based group medical when:

- ((~~Premiums are~~)) The spouse's or state registered domestic partner's share of the medical premium is less than ninety-five percent of the additional cost an employee would be required to pay to enroll a spouse or state registered domestic partner in the Uniform Medical Plan (UMP) Classic ((~~premiums~~)); and

- The benefits have an actuarial value of ((~~benefits is~~)) at least ninety-five percent of the actuarial value of UMP Classic benefits.

"Qualified health plan" means a medical plan that is certified to be offered through an exchange.

"Salary reduction plan" means a benefit plan whereby state and public employees may agree to a reduction of salary on a pretax basis to participate in the dependent care assistance program (DCAP), medical flexible spending arrangement (FSA), or premium payment plan ((as

authorized in chapter 41.05 RCW)) offered pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"Special open enrollment" means a period of time when subscribers may make changes to their health plan enrollment and salary reduction elections outside of the annual open enrollment period when specific life events occur. During the special open enrollment subscribers may change health plans and enroll or remove dependents from coverage. Additionally, employees may enroll in or waive enrollment in PEBB medical. Employees eligible to participate in the salary reduction plan may enroll in or ~~((change))~~ revoke their election under the DCAP, medical FSA, or the premium payment plan and make a new election. For special open enrollment events related to specific PEBB benefits, see WAC 182-08-198, 182-08-199, 182-12-128, and 182-12-262.

"State agency" means an office, department, board, commission, institution, or other separate unit or division, however designated, of the state government and all personnel thereof. It includes the legislature, executive branch, and agencies or courts within the judicial branch, as well as institutions of higher education and any unit of state government established by law.

"Subscriber" means the employee, retiree, continuation coverage enrollee, or survivor who has been determined eligible by the PEBB program, employer group, state agency, or charter school and is the individual to whom the PEBB program and contracted vendors will issue all notices, information, requests, and premium bills on behalf of enrollees.

"Tobacco products" means any product made with or derived from tobacco that is intended for human consumption, including any component, part, or accessory of a tobacco product. This includes, but is not limited to, cigars, cigarettes, pipe tobacco, chewing tobacco, snuff, and other tobacco products. It does not include e-cigarettes or United States Food and Drug Administration (FDA) approved quit aids.

"Tobacco use" means any use of tobacco products within the past two months. Tobacco use, however, does not include the religious or ceremonial use of tobacco.

"Tribal government" means an Indian tribal government as defined in Section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, or an agency or instrumentality of the tribal government, that has government offices principally located in this state.

"Waive" means to interrupt an eligible employee's enrollment in a PEBB health plan because the employee is enrolled in other employer-based group medical, TRICARE plans, or medicare as allowed under WAC 182-12-128, or is on approved educational leave and obtains another employer-based group health plan as allowed under WAC 182-12-136.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-08-180 Premium payments and premium refunds. Premiums and applicable premium surcharges are due as described in this section, except when an employing agency is correcting its enrollment error as described in WAC 182-08-187 (3) or (4).

(1) **Premium payments.** Public employees benefits board (PEBB) insurance coverage premiums and applicable premium surcharges for all

subscribers become due the first of the month in which PEGB insurance coverage is effective.

Premiums and applicable premium surcharges are due from the subscriber for the entire month of PEGB insurance coverage and will not be prorated during any month.

(a) For subscribers not eligible for the employer contribution that are electing to enroll in PEGB 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)(a) through (f), 182-12-211, and 182-12-265; 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, the first premium payment and applicable premium surcharge are due to the health care authority (HCA) no later than forty-five 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 PEGB medical must be made to the HCA as well as premiums associated with continuing PEGB dental or long-term disability insurance coverage. Premiums associated with life 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.

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

~~((b))~~ (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 ~~(health care authority (HCA). A subscriber's)~~ HCA. For subscribers not eligible for the employer contribution or employees eligible for the employer contribution as described in WAC 182-12-138, monthly premiums or applicable premium surcharges that remain~~((s))~~ unpaid for thirty days will be considered delinquent. A subscriber is allowed a grace period of thirty days from the date the monthly premiums or applicable premium surcharges become~~((s))~~ delinquent to pay the unpaid premium balance or surcharges. If a subscriber's monthly premiums or applicable premium surcharges remain~~((s))~~ unpaid for sixty days from the original due date, the subscriber's PEGB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premiums and any applicable premium surcharges ~~((was))~~ were paid. If it is determined by the ~~((authority))~~ HCA that payment of the unpaid balance in a lump sum would be considered a hardship, the ~~((authority))~~ HCA may develop a reasonable ~~((repayment))~~ payment plan with the subscriber or the subscriber's legal representative upon request.

~~((e)-A))~~ (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 ~~((is))~~ are received by the ~~((authority))~~ HCA and the monthly premiums or applicable premium surcharges remain~~((s))~~ unpaid for thirty days; or

(ii) ~~((A))~~ Premium payments or applicable premium surcharges received by the ~~((authority-is))~~ HCA are underpaid by an amount greater than an insignificant shortfall and the monthly premiums or applicable premium surcharges remain~~((s))~~ underpaid for thirty days past the date

the monthly premiums or applicable premium surcharges ((was)) were due.

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

(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 three month adjustment period, except as indicated in WAC 182-12-148(5).

(b) If a PEBB subscriber, dependent, or beneficiary submits a written appeal as described in WAC ((182-16-025)) 182-16-2010, showing proof of extraordinary circumstances beyond ((his or her)) their control such that it was effectively impossible to submit the necessary information to accomplish an allowable enrollment change within sixty days after the event that created a change of premiums ((occurred)), the PEBB director, the director's designee, or the PEBB appeals ((committee)) unit may approve a refund of premiums and applicable premium surcharges which does not exceed twelve months of premiums.

(c) 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 ((he or she was)) they were enrolled under the federal program if approved by the PEBB director or the director's designee.

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

(e) Employing agency errors will be corrected by returning all excess premiums and applicable premium surcharges paid by the employee or beneficiary.

AMENDATORY SECTION (Amending WSR 16-20-080, filed 10/4/16, effective 1/1/17)

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 premium, when any enrollee, thirteen years and older, engages in tobacco use.

(a) A subscriber must attest to whether any enrollee, thirteen years and older, enrolled in ((his or her)) 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 ((his or her)) their attestation on that form. The employee must submit the ((attestation to his or her)) 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, thirteen years and older on the subscriber's PEBB medical, the subscriber must update ((his or her)) their attestation on the re-

quired form. An employee must submit the (~~updated attestation to his or her~~) form to their employing agency. Any other subscriber must submit (~~his or her updated attestation~~) their form to the PEBB program.

- 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, thirteen years and older, in PEBB medical as described in WAC 182-12-262, the subscriber must (~~update his or her attestation~~) at test for their dependent on the required form. An employee must submit the (~~updated attestation to his or her~~) form to their employing agency. Any other subscriber must submit (~~his or her updated attestation~~) 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, thirteen 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, or 182-12-270, must provide an attestation on the required form if (~~he or she has~~) they have not previously attested as described in (a) of this subsection. The enrollee must submit (~~his or her updated attestation~~) 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) (~~and~~) or (b), (~~or~~) 182-12-205 (6)(a) (~~(, (b), (c), (d), and (e))~~) through (f), or 182-12-211, must provide an attestation on the required form if (~~he or she has~~) they have not previously attested as described in (a) of this subsection. The employee or retiree must submit (~~his or her updated attestation~~) 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, thirteen 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 (~~he or she has~~) 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 (~~his or her~~) their attestation on that form. An employee must submit the (~~attestation to his or her~~) 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 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 according to WAC 182-12-128 is not required to provide an attestation and no premium surcharge will be applied to (~~his or her~~) their account as long as the employee (~~enrollment~~) 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 subsection (1)(a) of this section.

(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 the applicable reasonable alternative offered below:

(i) An enrollee who is eighteen years and older and uses tobacco products ~~((has access to a))~~ is currently enrolled in the free tobacco cessation program through ~~((his or her))~~ their PEBB medical.

(ii) An enrollee who is thirteen through seventeen years old and uses tobacco products ~~((may access))~~ accessed the information and resources aimed at teens on the Washington state department of health's web site at ~~((http://teen.smokefree.gov))~~ 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 premium, if an enrolled spouse or state registered domestic partner elected not to enroll in another employer-based group medical ~~((that has premiums))~~ where the spouse's or state registered domestic partner's share of the medical premium is less than ninety-five percent of the additional cost an employee would be required to pay to enroll a spouse or state registered domestic partner in the Uniform Medical Plan (UMP) ~~((Classic's premiums and benefits with))~~ Classic and the benefits have an actuarial value of at least ninety-five percent of the actuarial value of the UMP Classic's benefits.

(a) A subscriber who enrolled a spouse or state registered domestic partner under ~~((his or her))~~ 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 or during the annual open enrollment as described in WAC 182-12-262 (1)(a) or (b). A subscriber must complete the required form to enroll ~~((his or her))~~ their spouse or state registered domestic partner. The subscriber must include ~~((his or her))~~ their attestation on that form. The employee must submit the ~~((attestation to his or her))~~ form to their employing agency. Any other subscriber must submit ~~((an attestation))~~ 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) When a special open enrollment ~~((+SOE+))~~ event occurs as described in WAC 182-12-262 (1)(c). A subscriber must submit the required form to enroll a spouse or state registered domestic partner in PEBB medical. The subscriber must include ~~((his or her updated))~~ their attestation on that form. An employee must submit ~~((an updated attestation to his or her))~~ the form to their employing agency. Any other subscriber must submit ~~((an updated attestation))~~ the form to the PEBB program. If the subscriber's attestation results in a premium surcharge it will take effect 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 surcharge begins on that day))~~ same date as PEBB medical begins;

(iii) 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 ~~((his or her))~~ their employer-based group medical was more than ninety-five percent of the ~~((UMP Classic's premiums))~~ additional cost an employee would be required to pay to enroll a spouse or state registered domestic partner in the 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 ninety-five percent of the actuarial value of the UMP Classic's ~~((actuarial value))~~ benefits.

A subscriber must update ~~((his or her))~~ their attestation on the required form. An employee must submit ~~((an updated attestation to his or her))~~ the form to their employing agency. Any other subscriber must submit ~~((an updated attestation))~~ 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

(iv) When there is a change in the spouse's or state registered domestic partner's employer-based group medical. A subscriber must update their attestation on the required form. An employee must submit ~~((an updated attestation to his or her))~~ the form to their employing agency ~~((within))~~ no later than sixty days ~~((of when))~~ after the spouse's or state registered domestic partner's employer-based group medical status changes. Any other subscriber must submit ~~((an updated attestation))~~ the form to the PEBB program no later than sixty 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 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 according to WAC 182-12-128 is not required to provide an attestation and no premium surcharge will be applied to ~~((his or her))~~ their account as long as the employee remains in waived status.
- (3) An employee who covers ~~((his or her))~~ their spouse or state registered domestic partner who has waived ~~((his or her))~~ their own PEBB medical must attest, but a premium surcharge will not be applied.
- (4) A subscriber who covers ~~((his or her))~~ their spouse or state registered domestic partner who elected not to enroll in a TRICARE plan must attest, but a premium surcharge will not be applied.

(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 17-19-077, filed 9/15/17, effective 1/1/18)

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 (4) of this section.

(a) Failure to timely notify an employee of (~~his or her~~) 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 (~~his or her~~) their dependents in PEBB insurance coverage as elected by the employee, if the elections were timely;

(c) Failure to enroll PEBB insurance coverage as described in WAC 182-08-197 (1)(b); (~~or~~)

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

(e) Enrolling an employee or their dependents 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.

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 (~~(1)~~) (2) of this section, reconcile premium payments and applicable premium surcharges as described in subsection (~~(2)~~) (3) of this section, and provide recourse as described in subsection (~~(3)~~) (4) of this section.

Note: If the employing agency failed to provide the notice required in WAC 182-12-113 or the employer group contract before the end of the employee's thirty-one day enrollment period described in WAC 182-08-197 (1)(a), the employing agency must provide the employee a written notice of eligibility for PEBB benefits and offer a new enrollment period of thirty-one days. Employees who do not return the required enrollment forms by the due date required under the new enrollment period must be defaulted according to WAC 182-08-197 (1)(b). This notice requirement does not remove the ability to offer recourse.

(2) Enrollment or termination.

(a) PEBB medical and dental 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 (~~(3)~~) (4) of this section. If the enrollment error is identified on the first day of the month, the enrollment correction is effective that day;

(b) Basic life and basic long-term disability (LTD) insurance enrollment is retroactive to the first day of the month following the day the employee became newly eligible, or the first day of the month the employee regained eligibility, as described in WAC 182-08-197. If the employee became newly eligible on the first working day of a month, basic life and basic LTD insurance begins on that date;

(c) Optional life and optional LTD insurance enrollment is retroactive to the first day of the month following the day the employee became newly eligible if the employee elects to enroll in this coverage (or if previously elected, the first of the month following the signature date of the employee's application for this coverage). If an employing agency enrollment error occurred when the employee regained eligibility for the employer contribution following a period of leave as described in WAC 182-08-197(3):

(i) Optional life and optional LTD insurance is enrolled the first day of the month the employee regained eligibility, at the same level of coverage the employee continued during the period of leave, without evidence of insurability.

(ii) If the employee was not eligible to continue optional LTD insurance during the period of leave, optional LTD insurance is reinstated the first day of the month the employee regained eligibility, to the level of coverage the employee was enrolled in prior to the period of leave, without evidence of insurability.

(iii) If the employee was eligible to continue optional life insurance and optional LTD insurance under the period of leave but did not, the employee must provide evidence of insurability and receive approval from the contracted vendor.

(d) If the employee is eligible and elects (or elected) to enroll in the medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP), enrollment is limited to three months prior to the date enrollment is processed, but not earlier than the current plan year. If an employee was not enrolled in ~~((an))~~ a medical FSA or DCAP as elected, the ~~((employee may adjust his or her election. 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.

(e) 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 insurance coverage will be terminated prospectively effective as of the last day of the month.

(3) 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, and basic LTD from the date PEBB insurance coverage begins as described in subsections ~~((+1))~~ (2) and ~~((+3))~~ (4)(a)(i) of this section. If a state agency failed to notify a newly eligible employee of ~~((his or her))~~ 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 months following notification of a new enrollment period.

(b) When an employing agency fails to correctly enroll the amount of optional 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 twenty-four months of coverage. The employing agency is responsible for additional months of premiums.

(ii) When premium refunds are due to the employee, the optional LTD insurance vendor is responsible for premium refunds for the most recent twenty-four months of coverage. The employing agency is responsible for additional months of premium refunds.

(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.

(4) Recourse.

(a) Employee eligibility for PEBB benefits begins on the first day of the month following the date eligibility is established as described in WAC 182-12-114. 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 ~~((+1))~~ (2) of this section, the employing agency must work with the employee, and receive approval from the authority, to implement retroactive PEBB insurance coverage within the following parameters:

- (i) Retroactive enrollment in a PEBB health plan;
- (ii) Reimbursement of claims paid;

- (iii) Reimbursement of amounts paid for by the employee or dependent medical and dental premiums;
 - (iv) Other legal remedy received or offered; or
 - (v) 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 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-08-196 What happens if my health plan becomes unavailable due to a change in contracted service area or eligibility for medicare? (1) Subscribers must select a new health plan within sixty days of their chosen health plan becoming unavailable due to a change in contracting service area or the subscriber or subscriber's dependent ceasing to be eligible for their current plan because of (~~his or her~~) their enrollment in medicare.

(a) Employees must submit the required form to their employing agency electing their new health plan.

(b) All other subscribers must submit the required form to notify the PEBB program electing their new health plan.

(c) The effective date of the change in health plan will be the first day of the month following the later of the date the health plan becomes unavailable or the date the form is received.

(2) The PEBB program will change health plan enrollment as follows if the subscriber fails to select a new health plan as required under subsection (1) of this section:

(a) Employees who fail to select a new health plan within the required time period will be enrolled in a successor plan if one is available or an existing plan designated by the director.

(b) All other subscribers who fail to select a new health plan within the required time period will be enrolled in a successor plan if one is available or a plan designated by the director.

(3) Any subscriber enrolled in a health plan as described in subsection (2) of this section may not change health plans except as allowed in WAC 182-08-198.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-08-197 When must a newly eligible employee, or an employee who regains eligibility for the employer contribution, select public employees benefits board (PEBB) benefits and complete required forms? An employee who is newly eligible or who regains eligibility for the employer contribution toward public employees benefits board (PEBB) benefits enrolls as described in this section.

(1) When an employee is newly eligible for PEBB benefits:

(a) An employee must complete the required forms indicating (~~his or her~~) their enrollment elections, including an election to waive PEBB medical if the employee is eligible to waive PEBB medical and

elects to waive PEBB medical as described in WAC 182-12-128. The required forms must be returned to the employee's employing agency. Forms must be received by (~~his or her~~) their employing agency no later than thirty-one days after the employee becomes eligible for PEBB benefits under WAC 182-12-114.

(i) An employee may enroll in optional life and optional long-term disability (LTD) insurance up to the guaranteed issue without evidence of insurability if the required forms are returned to the employee's employing agency or contracted vendor as required. An employee may apply for enrollment in optional life and optional LTD insurance over the guaranteed issue at any time during the calendar year by submitting the required form to the contracted vendor for approval.

(ii) If an employee is eligible to participate in the state's salary reduction plan (see WAC 182-12-116), the employee will automatically enroll in the premium payment plan upon enrollment in PEBB medical so employee medical premiums are taken on a pretax basis. To opt out of the premium payment plan, a new employee must complete the required form and return it to (~~his or her~~) their state agency. The form must be received by (~~his or her~~) their state agency no later than thirty-one days after the employee becomes eligible for PEBB benefits.

(iii) If an employee is eligible to participate in the state's salary reduction plan (see WAC 182-12-116), the employee may enroll in the state's medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP) or both, except as limited by subsection (4) of this section. To enroll in these optional PEBB benefits, the employee must return the required form to (~~his or her~~) their state agency. The form must be received by the state agency no later than thirty-one days after the employee becomes eligible for PEBB benefits.

(b) If a newly eligible employee's employing agency, or contracted vendor in the case of life insurance, does not receive the employee's required forms indicating medical, dental, life insurance, and LTD insurance elections, and the employee's tobacco use status attestation within thirty-one days of the employee becoming eligible, (~~his or her~~) their enrollment will be as follows for those elections not received within thirty-one days:

- (i) Uniform Medical Plan Classic;
- (ii) Uniform Dental Plan;
- (iii) Basic life insurance;
- (iv) Basic long-term disability insurance;
- (v) Dependents will not be enrolled; and
- (vi) A tobacco use surcharge will be incurred as described in WAC 182-08-185 (1)(b).

(2) The employer contribution toward PEBB insurance coverage ends according to WAC 182-12-131. When an employee's employment ends, participation in the state's salary reduction plan ends.

(3) When an employee loses and later regains eligibility for the employer contribution toward PEBB insurance coverage following a period of leave described in WAC 182-12-133(1) and 182-12-142 (1) and (2). PEBB medical and dental begins on the first day of the month the employee is in pay status eight or more hours:

(a) The employee must complete the required forms indicating (~~his or her~~) their enrollment elections, including an election to waive PEBB medical if the employee chooses to waive PEBB medical as described in WAC 182-12-128. The required forms must be returned to the employee's employing agency except as described in (d) of this

subsection. Forms must be received by the employing agency, or life insurance contracted vendor, if required, no later than thirty-one days after the employee regains eligibility, except as described in subsection (3)(b) of this section:

(i) An employee who self-paid for optional life PEBB insurance coverage after losing eligibility will have that level of coverage reinstated without evidence of insurability effective the first day of the month in which the employee is in pay status eight or more hours;

(ii) An employee who was eligible to continue optional life (~~under continuation coverage~~) but discontinued that PEBB insurance coverage must submit evidence of insurability to the contracted vendor if ~~((he or she))~~ they choose~~((s))~~ to reenroll when ~~((he or she))~~ they regain~~((s))~~ eligibility for the employer contribution;

(iii) An employee who was eligible to continue optional LTD (~~under continuation coverage~~) insurance but discontinued that PEBB insurance coverage must submit evidence of insurability for optional LTD insurance to the contracted vendor when ~~((he or she))~~ they regain~~((s))~~ eligibility for the employer contribution.

(b) An employee in any of the following circumstances does not have to return a form indicating optional LTD insurance elections. ~~((His or her))~~ Their optional LTD insurance will be automatically reinstated effective the first day of the month ~~((he or she is))~~ they are in pay status eight or more hours:

(i) The employee continued to self-pay for ~~((his or her))~~ their optional LTD insurance after losing eligibility for the employer contribution;

(ii) The employee was not eligible to continue optional LTD insurance after losing eligibility for the employer contribution.

(c) If an employee's employing agency, or contracted vendor accepting forms directly, does not receive the required forms within thirty-one days of the employee regaining eligibility, medical, dental, life insurance, tobacco use surcharge, and LTD insurance enrollment will be as described in subsection (1)(b) of this section, except as described in (b) of this subsection.

(d) If an employee is eligible to participate in the state's salary reduction plan (see WAC 182-12-116) the employee may enroll in the state's medical FSA or DCAP or both, except as limited by subsection (4) of this section. To enroll in these optional PEBB benefits, the employee must return the required form to ~~((his or her))~~ the contracted vendor or their state agency. The ~~((form must be received by the))~~ contracted vendor or employee's state agency must receive the form no later than thirty-one days after the employee becomes eligible for PEBB benefits.

(4) If an employee who is eligible to participate in the state's salary reduction plan (see WAC 182-12-116) is hired into a new position that is eligible for PEBB benefits in the same year, the employee may not resume participation in DCAP or medical FSA until the beginning of the next plan year, unless the time between employments is ~~((less than))~~ thirty days ((and)) or less and within the current plan year. The employee ~~((notifies))~~ must notify their new state agency of the transfer by providing the new state ((agency and the DCAP or the medical FSA contracted vendor of his or her employment transfer within the current plan year)) agency's personnel, payroll, or benefits office the required form no later than thirty-one days after the employee's first day of work with the new state agency.

(5) An employee's PEBB insurance coverage elections remain the same when an employee transfers from one employing agency to another

employing agency without a break in PEBB insurance coverage for one month or more. This includes movement of an employee between any entities described in WAC 182-12-111 and participating in PEBB benefits. PEBB insurance coverage elections also remain the same when an employee has a break in employment that does not interrupt ~~((his or her))~~ their employer contribution toward PEBB insurance coverage.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

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

(1) **During annual open enrollment:** Subscribers may change health plans during the public employees benefits board (PEBB) annual open enrollment period. The subscriber must submit the required enrollment forms to change ~~((his or her))~~ their health plan. An employee submits the enrollment forms to ~~((his or her))~~ their employing agency. All other subscribers submit 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:** Subscribers may ~~((change))~~ revoke their health plan ~~((s))~~ election and make a new election outside of the annual open enrollment if a special open enrollment event occurs. The change in enrollment must be allowable under Internal Revenue Code (IRC) and 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. To make a health plan change, the subscriber must submit the required enrollment forms (and a completed disenrollment form, if required). The forms must be received no later than sixty days after the event occurs, except as described in (i) of this subsection. An employee submits the enrollment forms to ~~((his or her))~~ their employing agency. All other subscribers submit the enrollment forms to the PEBB program. Subscribers 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.

Exception: When a subscriber or their dependent is enrolled in a medicare advantage plan, the new health plan coverage will begin the first day of the month following the date the medicare advantage 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. 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 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 ~~((his or her))~~ their employer contribution toward ~~((his or her))~~ their employer-based group health plan;

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

Exception: For the purposes of special open enrollment "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. If the subscriber moves and the subscriber's current health plan is not available in the new location the subscriber must select a new health plan;

(f) A court order ~~((or national medical support notice (see also WAC 182-12-263)))~~ 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 becomes entitled to 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 a state children's health insurance program (CHIP);

(i) Subscriber or a subscriber's dependent becomes entitled to 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 medicare Part D plan. If the subscriber's current health plan becomes unavailable due to the subscriber's or a subscriber's dependent's entitlement to medicare, the subscriber must select a new health plan as described in WAC 182-08-196(1). A subscriber 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;

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

(k) Subscriber or a subscriber's dependent experiences a disruption of care that could function as a reduction in benefits for the subscriber or the subscriber's dependent for a specific condition or ongoing course of treatment. The 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 for up to ninety days or until medically stable; or
- (ii) Transplant within the last twelve months; or
- (iii) Scheduled surgery within the next sixty days (elective procedures within the next sixty days do not qualify for continuity of care); or
- (iv) Recent major surgery still within the postoperative period of up to eight weeks; or
- (v) Third trimester of pregnancy.

If the employee is having premiums taken from payroll on a pretax basis, a health 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 17-19-077, filed 9/15/17, effective 1/1/18)

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

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

(2) **During annual open enrollment:** An eligible employee may elect to enroll in or ~~((waive his or her))~~ opt out of participation under the state's 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 medical FSA, DCAP, or both during the annual open enrollment ~~((For the state's premium payment plan, the required form must be submitted to his or her employing agency. To enroll or reenroll in medical FSA or DCAP the employee must submit the required form to his or her employing agency or the applicable contracted vendor))~~ by submitting the required forms to their employing agency or applicable contracted vendor. 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.

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

(3) **During a special open enrollment:** An employee who is eligible to participate in the salary reduction plan may enroll or ~~((change his or her))~~ revoke their election and make a new election under the state's premium payment plan, medical FSA, or DCAP outside of the annual open enrollment if a special open enrollment event occurs. The enrollment or change in 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 ~~((as instructed on the forms. The))~~ to their employing agency. The em-

ploying agency must receive the required form~~((s must be received))~~ and evidence of the event that created the special open enrollment no later than sixty days after the event occurs. ~~((The employee must provide evidence of the event that created the special open enrollment.))~~

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 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 ~~((change his or her election under))~~ 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 ~~((change in))~~ 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 domestic partnership when the dependent is a tax dependent of the subscriber;
- 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'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 twenty-six 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 ~~((his or her))~~ their employer contribution toward ~~((his or her))~~ their employer-based group health plan;

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

Exception: For the purposes of special open enrollment "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;

(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;

(ix) A court order (~~or national medical support notice (see also WAC 182-12-263)~~) 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 becomes entitled to 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 health plan coverage from medicaid or a state children's health insurance program (CHIP);

(xii) Employee or an employee's dependent becomes entitled to 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 health 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 that could function as a reduction in benefits for the employee or the employee's dependent for a specific condition or ongoing course of treatment. The employee may not change (~~his or her~~) 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 for up to ninety days or until medically stable; or
- Transplant within the last twelve months; or
- Scheduled surgery within the next sixty days (elective procedures within the next sixty days do not qualify for continuity of care); or
- Recent major surgery still within the postoperative period of up to eight weeks; or
- Third trimester of pregnancy.

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

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

(b) **Medical flexible spending arrangement (FSA).** An employee may enroll or (~~change his or her~~) revoke their election and make a new election under the medical 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 (~~change in~~) 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 domestic partnership if the domestic partner qualifies as a tax dependent of the subscriber;
- 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'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 twenty-six 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 or an employee's dependent has a change in employment status that affects the employee's or a dependent's eligibility for the medical FSA;

(v) A court order (~~or national medical support notice~~) 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 becomes entitled to 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 becomes entitled to coverage under medicare.

(c) **Dependent care assistance program (DCAP)**. An employee may enroll or (~~change his or her~~) 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 (~~change in~~) 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 domestic partnership if the domestic partner qualifies as a tax dependent of the subscriber;
- 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 group health plan 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.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

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

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

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

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

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

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

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

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

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

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

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

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

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

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-08-235 Employer group and charter school application process. This section applies to employer groups as defined in WAC 182-08-015 and to charter schools. An employer group or charter school may apply to obtain public employees benefits board (PEBB) insurance coverage through a contract with the health care authority (HCA).

(1) Employer groups and charter schools with less than five hundred employees must apply at least sixty days before the requested coverage effective date. Employer groups and charter schools with five hundred or more employees but with less than five thousand employees must apply at least ninety days before the requested effective date.

Employer groups and charter schools with five thousand or more employees must apply at least one hundred twenty days before the requested coverage effective date. To apply, employer groups and charter schools must submit the documents and information described in subsection (2) of this section to the PEBB program as follows:

(a) School districts, educational service districts, and charter schools are required to provide the documents described in subsections (2)(a) through (c) of this section;

Exception: School districts and educational service districts required by the superintendent of public instruction to purchase PEBB insurance coverage provided by the authority are required to submit documents and information described in subsection (2)(a)(iii), (b), and (c) of this section.

(b) Counties, municipalities, political subdivisions, and tribal governments with fewer than five thousand employees are required to

provide the documents and information described in subsection (2)(a) through (f) of this section;

(c) Counties, municipalities, political subdivisions, and tribal governments with five thousand or more employees will have their application approved or denied through the evaluation criteria described in WAC 182-08-240 and are required to provide the documents and information described in subsection (2)(a) through (d), (f), and (g) of this section; and

(d) All employee organizations representing state civil services employees and the Washington health benefit exchange, regardless of the number of employees, will have their application approved or denied through the evaluation criteria described in WAC 182-08-240 and are required to provide the documents and information described in subsection (2)(a) through (d), (f), and (g) of this section.

(2) Documents and information required with application:

(a) A letter of application that includes the information described in (a)(i) through (iv) of this subsection:

(i) A reference to the group's authorizing statute;

(ii) A description of the organizational structure of the group and a description of the employee bargaining unit or group of nonrepresented employees for which the group is applying;

(iii) Employer group or charter school tax ID number (TIN); and

(iv) A statement of whether the group is applying to obtain only medical or all available PEBB insurance coverages. School districts and educational service districts must purchase medical, dental, life, and (~~LTD~~) long-term disability insurance.

(b) A resolution from the group's governing body authorizing the purchase of PEBB insurance coverage.

(c) A signed governmental function attestation document that attests to the fact that employees for whom the group is applying are governmental employees whose services are substantially all in the performance of essential governmental functions.

(d) A member level census file for all of the employees for whom the group is applying. The file must be provided in the format required by the authority and contain the following demographic data, by member, with each member classified as employee, spouse or state registered domestic partner, or child:

(i) Employee ID (any identifier which uniquely identifies the employee; for dependents the employee's unique identifier must be used);

(ii) Age;

(iii) Gender;

(iv) First three digits of the member's zip code based on residence;

(v) Indicator of whether the employee is active or retired, if the group is requesting to include retirees; and

(vi) Indicator of whether the member is enrolled in coverage.

(e) Historical claims and cost information that include the following:

(i) Large claims history for twenty-four months by quarter that excludes the most recent three months;

(ii) Ongoing large claims management report for the most recent quarter provided in the large claims history;

(iii) Summary of historical plan costs; and

(iv) The director or the director's designee may make an exception to the claims and cost information requirements based on the size of the group, except that the current health plan does not have a case management program, then the primary diagnosis code designated by the

authority must be reported for each large claimant. If the code indicates a condition which is expected to continue into the next quarter, the claim is counted as an ongoing large claim. If historical claims and cost information as described in (e)(i) through (iii) of this subsection are unavailable, the director or the director's designee may make an exception to allow all of the following alternative requirements:

- A letter from their carrier indicating they will not or cannot provide claims data.
- Provide information about the health plan most employees are enrolled in by completing the actuarial calculator authorized by the PEBB program.
- Current premiums for the health plan.

(Exception: If the current health plan does not have a case management program then the primary diagnosis code designated by the authority must be reported for each large claimant. If the code indicates a condition which is expected to continue into the next quarter, the claim is counted as an ongoing large claim.))

(f) If the application is for a subset of the group's employees (e.g., bargaining unit), the group must provide a member level census file of all employees eligible under their current health plan who are not included on the member level census file in (d) of this subsection. This includes retired employees participating under the group's current health plan. The file must include the same demographic data by member.

(g) Employer groups described in subsection (1)(c) and (d) of this section must submit to an actuarial evaluation of the group provided by an actuary designated by the PEBB program. The group must pay for the cost of the evaluation. This cost is nonrefundable. A group that is approved will not have to pay for an additional actuarial evaluation if it applies to add another bargaining unit within two years of the evaluation. Employer groups of this size must provide the following:

- (i) Large claims history for twenty-four months, by quarter that excludes the most recent three months;
- (ii) Ongoing large claims management report for the most recent quarter provided in the large claims history;
- (iii) Executive summary of benefits;
- (iv) Summary of benefits and certificate of coverage; and
- (v) Summary of historical plan costs.

Exception: If the current health plan does not have a case management program then the primary diagnosis code designated by the authority must be reported for each large claimant. If the code indicates a condition which is expected to continue into the next quarter, the claim is counted as an ongoing large claim.

(3) The authority may automatically deny a group application if the group fails to provide the required information and documents described in this section.

AMENDATORY SECTION (Amending WSR 16-20-080, filed 10/4/16, effective 1/1/17)

WAC 182-08-240 How will the health care authority (HCA) decide to approve or deny a group application? This section ((only)) applies to ((employee organizations representing state civil service employees and the Washington health benefit exchange, regardless of the number of employees,)) counties, municipalities, political subdivisions, and tribal governments with five thousand or more employees. This section

also applies to employee organizations representing state civil service employees and the Washington health benefit exchange, regardless of the number of employees. Group applications for participation in public employees benefits board (PEBB) insurance coverage provided through the PEBB program are approved or denied by the health care authority (HCA) based upon the information and documents submitted by the group and the employer group evaluation (EGE) criteria described in this rule.

(1) Groups are evaluated as a single unit. To support this requirement the group must provide a census file, as described in WAC 182-08-235 (2)(d), and additional information as described in WAC 182-08-235 (2)(g) for all employees eligible to participate under the group's current health plan. If the group's application is for both employees and retirees, the census file data and additional information for retired employees participating under the group's current health plan must also be included.

(a) If the group's application is only for participation of its employees, the PEBB enrollment data used to evaluate the group will be state agency employee data.

(b) If a group's application is for participation of both its employees and retirees, the PEBB enrollment data used to evaluate the group will include data from the PEBB nonmedicare risk pool limited to state retiree enrollment data and state agency employee data.

(2) A group must pass the EGE criteria or the actuarial evaluation required in subsection (3) of this section as a single unit before the application can be approved. For purposes of this section a single unit includes all employees eligible under the group's current health plan. If the application is only for a bargaining unit, then the bargaining unit must be evaluated using the EGE criteria in addition to all eligible employees of the group as a single unit. If the group passes the EGE criteria as a single unit, but an individual bargaining unit does not, the group may only participate if all eligible employees of the entity participate.

(3) The authority will use the following criteria to evaluate the group.

(a) The member level census file demographic data must indicate a relative underwriting factor that is equal to or better than the relative underwriting factor as determined by the authority for the like population within the nonmedicare PEBB risk pool as described in subsection (1) of this section;

(b) One of the following two conditions must be met:

(i) The frequency of large claims must be less than or equal to the PEBB historical benchmark frequency for the PEBB like population within the nonmedicare population as described in subsection (1) of this section;

(ii) The ongoing large claims management report must demonstrate that the frequency of ongoing large claims is less than or equal to the recurring benchmark frequency for the PEBB like population within the nonmedicare population as described in subsection (1) of this section.

(c) Provide an executive summary of benefits;

(d) Provide a summary of benefits and certificate of coverage;

(e) Provide a summary of historical plan costs; and

(f) The evaluation of criteria in (c), (d), and (e) of this subsection must indicate that the historical cost of benefits for the group is equal to or less than the historical cost of the PEBB like

population within the nonmedicare population as described in subsection (1) of this section for a comparable plan design.

(4) An approved group application is valid for three hundred sixty-five calendar days after the date the application is approved by the authority. If a group applies to add additional bargaining units after the three hundred sixty-five calendar day period has ended, the group must be reevaluated.

(5) An entity whose group application is denied may appeal the authority's decision to the PEBB appeals (~~committee~~) unit through the process described in WAC (~~182-16-038~~) 182-16-2060.

(6) An entity whose group application is approved may purchase insurance for its employees under the participation requirements described in WAC 182-08-245.

WAC 182-12-109 Definitions. The following definitions apply throughout this chapter unless the context clearly indicates another meaning:

"Affordable Care Act" means the federal Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, P.L. 111-152, or federal regulations or guidance issued under the Affordable Care Act.

"Annual open enrollment" means an annual event set aside for a period of time when subscribers may make changes to their health plan enrollment and salary reduction elections for the following plan year. During the annual open enrollment, subscribers may transfer from one health plan to another, enroll or remove dependents from coverage, or enroll or waive enrollment in PEBB medical. Employees eligible to participate in the salary reduction plan may enroll in or change their election under the dependent care assistance program (DCAP)((~~7~~)) or the medical flexible spending arrangement (FSA)((~~7-09~~)). They may also enroll in or opt out of the premium payment plan.

"Authority" or "HCA" means the Washington state health care authority.

"Benefits-eligible position" means any position held by an employee who is eligible for benefits under WAC 182-12-114, with the exception of employees who establish eligibility under WAC 182-12-114 (2) or (3)(a)(ii).

"Blind vendor" means a "licensee" as defined in RCW 74.18.200.

"Board" means the public employees benefits board established under provisions of RCW 41.05.055.

"Calendar days" or "days" means all days including Saturdays and Sundays.

"Consolidated Omnibus Budget Reconciliation Act" or "COBRA" means continuation coverage as administered under 42 U.S.C. Secs. 300bb-1 through 300bb-8.

"Continuation coverage" means the temporary continuation of ((PEBB)) health plan coverage available to enrollees after a qualifying event occurs as administered under ((Title XXII of the Public Health Service (PHS) Act,)) the Consolidated Omnibus Budget Reconciliation Act (COBRA), 42 U.S.C. Secs. 300bb-1 through 300bb-8, the Uniformed Services Employment and Reemployment Rights Act (USERRA), 38 U.S.C. Secs. 4301 through 4335, or PEBB insurance coverage extended by the public employee benefits board under WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, and 182-12-270.

"Contracted vendor" means any person, persons, or entity under contract or agreement with the HCA to provide goods or services for the provision or administration of PEBB benefits. The term "contracted vendor" includes subcontractors of the HCA and subcontractors of any person, persons, or entity under contract or agreement with the HCA that provide goods or services for the provision or administration of PEBB benefits.

"Creditable coverage" means coverage that meets the definition of "creditable coverage" under RCW 48.66.020 (13)(a) and includes payment of medical and hospital benefits.

"Defer" means to postpone enrollment or interrupt enrollment in a PEBB health plan by a retiree or an eligible survivor.

"Dependent" means a person who meets eligibility requirements in WAC 182-12-260, except that "surviving spouses, state registered domestic partners, and dependent children" of emergency service personnel who are killed in the line of duty is defined in WAC 182-12-250.

"Dependent care assistance program" or "DCAP" means a benefit plan whereby state and public employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan (~~authorized in chapter 41.05 RCW~~) under this chapter pursuant to 26 U.S.C. Sec. 129 or other sections of the Internal Revenue Code.

"Director" means the director of the authority.

"Documents" means papers, letters, writings, electronic mail, electronic files, or other printed or written items.

"Effective date of enrollment" means the first date when an enrollee is entitled to receive covered benefits.

"Employee" for the public employees benefits board program includes all employees of the state, whether or not covered by civil service; elected and appointed officials of the executive branch of government, including full-time members of boards, commissions, or committees; justices of the supreme court and judges of the court of appeals and the superior courts; and members of the state legislature. Pursuant to contractual agreement with the authority, "employee" may also include: (a) Employees of a county, municipality, or other political subdivision of the state and members of the legislative authority of any county, city, or town who are elected to office after February 20, 1970, if the legislative authority of the county, municipality, or other political subdivision of the state submits application materials to the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.04.205 and 41.05.021 (1)(g); (b) employees of employee organizations representing state civil service employees, at the option of each such employee organization, and, effective October 1, 1995, employees of employee organizations currently pooled with employees of school districts for the purpose of purchasing insurance benefits, at the option of each such employee organization; (c) employees of a school district if the authority agrees to provide any of the school districts' insurance programs by contract with the authority as provided in RCW 28A.400.350; (d) employees of a tribal government, if the governing body of the tribal government seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(f) and (g); (e) employees of the Washington health benefit exchange if the governing board of the exchange established in RCW 43.71.020 seeks and receives approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(g) and (n); and (f) employees of a charter school established under chapter 28A.710 RCW. "Employee" does not include: Adult family home providers; unpaid volunteers; patients of state hospitals; inmates; employees of the Washington state convention and trade center as provided in RCW 41.05.110; students of institutions of higher education as determined by their institution; and any others not expressly defined as employees under RCW 41.05.011 or by the authority under this chapter.

"Employer" for the public employees benefits board program means the state of Washington.

"Employer-based group dental" means group dental related to a current employment relationship. It does not include dental coverage

available to retired employees, individual market dental coverage, or government-sponsored programs such as medicaid.

"Employer-based group health plan" means group medical and group dental related to a current employment relationship. It does not include medical or dental coverage available to retired employees, individual market medical or dental coverage, or government-sponsored programs such as medicare or medicaid.

"Employer-based group medical" means group medical related to a current employment relationship. It does not include medical coverage available to retired employees, individual market medical coverage, or government-sponsored programs such as medicare or medicaid.

"Employer contribution" means the funding amount paid to the authority by a state agency, employer group, or charter school for its eligible employees as described under WAC 182-12-114 and 182-12-131 (~~and the employee's eligible dependents as described in WAC 182-12-260~~).

"Employer group" means those counties, municipalities, political subdivisions, the Washington health benefit exchange, tribal governments, school districts, educational service districts, and employee organizations representing state civil service employees, obtaining employee benefits through a contractual agreement with the authority as described in WAC 182-08-245.

"Employer-paid coverage" means PEBB insurance coverage for which an employer contribution is made by a state agency, employer group or charter school for employees eligible in WAC 182-12-114 and 182-12-131. It also means basic benefits described in RCW 28A.400.270(1) for which an employer contribution is made by school districts or an educational service district.

"Employing agency" for the public employees benefits board means a division, department, or separate agency of state government, including an institution of higher education; a county, municipality, school district, educational service district, or other political subdivision; (~~charter school; or~~) and a tribal government covered by chapter 41.05 RCW.

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

"Exchange" means the Washington health benefit exchange established in RCW 43.71.020, and any other health benefit exchange established under the Affordable Care Act.

"Exchange coverage" means coverage offered by a qualified health plan through an exchange.

"Faculty" means an academic employee of an institution of higher education whose workload is not defined by work hours but whose appointment, workload, and duties directly serve the institution's academic mission, as determined under the authority of its enabling statutes, its governing body, and any applicable collective bargaining agreement.

"Federal retiree medical plan" means the Federal Employees Health Benefits program (FEHB) or TRICARE plans which are not employer-based group medical.

"Health plan" means a plan offering medical or dental, or both, developed by the public employees benefits board and provided by a contracted vendor or self-insured plans administered by the HCA.

"Institutions of higher education" means the state public research universities, the public regional universities, The Evergreen

State College, the community and technical colleges, and the state board for community and technical colleges.

"Layoff," for purposes of this chapter, means a change in employment status due to an employer's lack of funds or an employer's organizational change.

"Life insurance" for eligible employees includes basic life insurance and accidental death and dismemberment (AD&D) insurance paid for by the employing agency, as well as optional life insurance and optional AD&D insurance offered to and paid for by employees for themselves and their dependent. Life insurance for eligible retirees includes retiree term life insurance offered to and paid for by retirees.

"LTD insurance" or "long-term disability insurance" includes any basic long-term disability insurance paid for by the employing agency and any supplemental long-term disability insurance offered to and paid by employees (~~on an optional basis~~).

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby eligible state and public employees may reduce their salary before taxes to pay for medical expenses not reimbursed by insurance as provided in the salary reduction plan (~~authorized in chapter 41.05 RCW~~) under this chapter pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

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

"PEBB" means the public employees benefits board.

~~("PEBB appeals committee" means the committee that considers appeals relating to the administration of PEBB benefits by the PEBB program. The director has delegated the authority to hear appeals at the level below an administrative hearing to the PEBB appeals committee.)~~

"PEBB benefits" means one or more insurance coverages or other employee benefits administered by the PEBB program within the health care authority.

"PEBB insurance coverage" means any health plan, life insurance, long-term disability (LTD) insurance, long-term care insurance, or property and casualty insurance administered as a PEBB benefit.

"PEBB program" means the program within the HCA that administers insurance and other benefits for eligible employees (as described in WAC 182-12-114), eligible retired employees (as described in WAC 182-12-171 and 182-12-180), eligible survivors (as described in WAC 182-12-180, 182-12-250, and 182-12-265), eligible dependents (as described in WAC 182-12-250 and 182-12-260) and others as defined in RCW 41.05.011.

"Plan year" means the time period established by the authority.

"Premium payment plan" means a benefit plan whereby state and public employees may pay their share of group health plan premiums with pretax dollars as provided in the salary reduction plan.

"Premium surcharge" means a payment required from a subscriber, in addition to the subscriber's medical premium contribution, due to an enrollee's tobacco use or a subscriber's spouse or state registered domestic partner choosing not to enroll in (~~his or her~~) their employer-based group medical when:

- (~~Premiums are~~) The spouse's or state registered domestic partner's share of the medical premium is less than ninety-five percent of the additional cost an employee would be required to pay to enroll a spouse or state registered domestic partner in the Uniform Medical Plan (UMP) Classic (~~premiums~~); and

• The benefits have an actuarial value of ~~((benefits— is))~~ at least ninety-five percent of the actuarial value of UMP Classic benefits.

"Qualified health plan" means a medical plan that is certified to be offered through an exchange.

"Salary reduction plan" means a benefit plan whereby ~~((state and))~~ public employees may agree to a reduction of salary on a pretax basis to participate in the dependent care assistance program (DCAP), medical flexible spending arrangement (FSA), or premium payment plan ((as authorized in chapter 41.05 RCW)) offered pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"Season" means any recurring annual period of work at a specific time of year that lasts three to eleven consecutive months.

"Seasonal employee" means an employee hired to work during a recurring, annual season with a duration of three months or more, and anticipated to return each season to perform similar work.

"Special open enrollment" means a period of time when subscribers may make changes to their health plan enrollment and salary reduction elections outside of the annual open enrollment period when specific life events occur. During the special open enrollment subscribers may change health plans and enroll or remove dependents from coverage. Additionally, employees may enroll in or waive enrollment in PEBB medical. Employees eligible to participate in the salary reductions plan may enroll in or ~~((change))~~ revoke their election under the DCAP, medical FSA, or the premium payment plan and make a new election. For special open enrollment events related to specific PEBB benefits, see WAC 182-08-198, 182-08-199, 182-12-128, and 182-12-262.

"State agency" means an office, department, board, commission, institution, or other separate unit or division, however designated, of the state government and all personnel thereof. It includes the legislature, executive branch, and agencies or courts within the judicial branch, as well as institutions of higher education and any unit of state government established by law.

"Subscriber" means the employee, retiree, continuation coverage enrollee, or survivor who has been determined eligible by the PEBB program, employer group, state agency, or charter school and is the individual to whom the PEBB program and contracted vendors will issue all notices, information, requests, and premium bills on behalf of enrollees.

"Tobacco products" means any product made with or derived from tobacco that is intended for human consumption, including any component, part, or accessory of a tobacco product. This includes, but is not limited to, cigars, cigarettes, pipe tobacco, chewing tobacco, snuff, and other tobacco products. It does not include e-cigarettes or United States Food and Drug Administration (FDA) approved quit aids.

"Tobacco use" means any use of tobacco products within the past two months. Tobacco use, however, does not include the religious or ceremonial use of tobacco.

"Tribal government" means an Indian tribal government as defined in Section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, or an agency or instrumentality of the tribal government, that has government offices principally located in this state.

"Waive" means to interrupt an eligible employee's enrollment in a PEBB health plan because the employee is enrolled in other employer-based group medical, TRICARE plans, or medicare as allowed under WAC

182-12-128, or is on approved educational leave and obtains another employer-based group health plan as allowed under WAC 182-12-136.

AMENDATORY SECTION (Amending WSR 16-20-080, filed 10/4/16, effective 1/1/17)

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

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

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

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

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

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

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

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

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

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

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

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

WAC 182-12-114 How do employees establish eligibility for public employees benefits board (PEBB) benefits? Eligibility for an employee whose work circumstances are described by more than one of the eligibility categories in subsections (1) through (5) of this section shall be determined solely by the criteria of the category that most closely describes the employee's work circumstances.

Hours that are excluded in determining eligibility include stand-by hours and any temporary increases in work hours, of six months or less, caused by training or emergencies that have not been or are not anticipated to be part of the employee's regular work schedule or pattern. Employing agencies must request the public employees benefits board (PEBB) program's approval to include temporary training or emergency hours in determining eligibility.

For how the employer contribution toward PEBB insurance coverage is maintained after eligibility is established under this section, see WAC 182-12-131.

(1) Employees are eligible for PEBB benefits as follows, except as described in subsections (2) through (5) of this section:

(a) **Eligibility.** An employee is eligible if (~~(he or she is)~~) they are anticipated to work an average of at least eighty hours per month and (~~(is)~~) are anticipated to work for at least eight hours in each month for more than six consecutive months.

(b) **Determining eligibility.**

(i) **Upon employment:** An employee is eligible from the date of employment if the employing agency anticipates the employee will work according to the criteria in (a) of this subsection.

(ii) **Upon revision of anticipated work pattern:** If an employing agency revises an employee's anticipated work hours or anticipated duration of employment such that the employee meets the eligibility criteria in (a) of this subsection, the employee becomes eligible when the revision is made.

(iii) **Based on work pattern:** An employee who is determined to be ineligible, but later meets the eligibility criteria in (a) of this subsection, becomes eligible the first of the month following the six-month averaging period.

(c) **Stacking of hours.** As long as the work is within one state agency, employees may "stack" or combine hours worked in more than one position or job to establish eligibility and maintain the employer contribution toward PEBB insurance coverage. Employees must notify their employing agency if they believe they are eligible through stacking. Stacking includes work situations in which:

(i) The employee works two or more positions or jobs at the same time (concurrent stacking);

(ii) The employee moves from one position or job to another (consecutive stacking); or

(iii) The employee combines hours from a seasonal position with hours from a nonseasonal position or job. An employee who establishes eligibility by stacking hours from a seasonal position or job with hours from a nonseasonal position or job shall maintain the employer contribution toward PEBB insurance coverage as described in WAC 182-12-131(1).

(d) **When PEBB insurance coverage begins.** Medical, dental, basic life insurance, and basic long-term disability (LTD) insurance begin

on the first day of the month following the date an employee becomes eligible. If the employee becomes eligible on the first working day of a month, then PEBB insurance coverage begins on that date.

(2) **Seasonal employees**, as defined in WAC 182-12-109, are eligible as follows:

(a) **Eligibility.** A seasonal employee is eligible if (~~he or she is~~) they are anticipated to work an average of at least eighty hours per month and (~~is~~) are anticipated to work for at least eight hours in each month of at least three consecutive months of the season.

(b) **Determining eligibility.**

(i) **Upon employment:** A seasonal employee is eligible from the date of employment if the employing agency anticipates that (~~he or she~~) they will work according to the criteria in (a) of this subsection.

(ii) **Upon revision of anticipated work pattern.** If an employing agency revises an employee's anticipated work hours or anticipated duration of employment such that the employee meets the eligibility criteria in (a) of this subsection, the employee becomes eligible when the revision is made.

(iii) **Based on work pattern.** An employee who is determined to be ineligible for benefits, but later works an average of at least eighty hours per month and works for at least eight hours in each month and works for more than six consecutive months, becomes eligible the first of the month following a six-month averaging period.

(c) **Stacking of hours.** As long as the work is within one state agency, employees may "stack" or combine hours worked in more than one position or job to establish eligibility and maintain the employer contribution toward PEBB insurance coverage. Employees must notify their employing agency if they believe they are eligible through stacking. Stacking includes work situations in which:

(i) The employee works two or more positions or jobs at the same time (concurrent stacking);

(ii) The employee moves from one position or job to another (consecutive stacking); or

(iii) The employee combines hours from a seasonal position or job with hours from a nonseasonal position or job. An employee who establishes eligibility by stacking hours from a seasonal position or job with hours from a nonseasonal position or job shall maintain the employer contribution toward PEBB insurance coverage as described in WAC 182-12-131(1).

(d) **When PEBB insurance coverage begins.** Medical, dental, basic life insurance, and basic (~~long term disability~~) LTD insurance begin on the first day of the month following the day the employee becomes eligible. If the employee becomes eligible on the first working day of a month, then PEBB insurance coverage begins on that date.

(3) **Faculty** are eligible as follows:

(a) **Determining eligibility.** "Half-time" means one-half of the full-time academic workload as determined by each institution, except that half-time for community and technical college faculty employees is governed by RCW 28B.50.489.

(i) **Upon employment:** Faculty who the employing agency anticipates will work half-time or more for the entire instructional year, or equivalent nine-month period, are eligible from the date of employment.

(ii) **For faculty hired on quarter/semester to quarter/semester basis:** Faculty who the employing agency anticipates will not work for the entire instructional year, or equivalent nine-month period, are

eligible at the beginning of the second consecutive quarter or semester of employment in which (~~he or she is~~) they are anticipated to work, or has actually worked, half-time or more. Spring and fall are considered consecutive quarters/semesters when first establishing eligibility for faculty that work less than half-time during the summer quarter/semester.

(iii) **Upon revision of anticipated work pattern:** Faculty who receive additional workload after the beginning of the anticipated work period (quarter, semester, or instructional year), such that their workload meets the eligibility criteria as described in (a)(i) or (ii) of this subsection become eligible when the revision is made.

(b) **Stacking.** Faculty may establish eligibility and maintain the employer contribution toward PEBB insurance coverage by working as faculty for more than one institution of higher education. Faculty workloads may only be stacked with other faculty workloads to establish eligibility under this section or maintain eligibility as described in WAC 182-12-131(3). When a faculty works for more than one institution of higher education, the faculty must notify (~~his or her~~) their employing agencies that (~~he or she~~) they work(~~s~~) at more than one institution and may be eligible through stacking.

(c) **When PEBB insurance coverage begins.**

(i) Medical, dental, basic life insurance, and basic (~~long-term disability~~) LTD insurance begin on the first day of the month following the day the faculty becomes eligible. If the faculty becomes eligible on the first working day of a month, then PEBB insurance coverage begins on that date.

(ii) For faculty hired on a quarter/semester to quarter/semester basis under (a)(ii) of this subsection, medical, dental, basic life insurance, and basic (~~long-term disability~~) LTD insurance begin the first day of the month following the beginning of the second consecutive quarter/semester of half-time or more employment. If the first day of the second consecutive quarter/semester is the first working day of the month, then PEBB insurance coverage begins at the beginning of the second consecutive quarter/semester.

(4) **Elected and full-time appointed officials of the legislative and executive branches of state government** are eligible as follows:

(a) **Eligibility.** A legislator is eligible for PEBB benefits on the date (~~his or her~~) their term begins. All other elected and full-time appointed officials of the legislative and executive branches of state government are eligible on the date their terms begin or the date they take the oath of office, whichever occurs first.

(b) **When PEBB insurance coverage begins.** Medical, dental, basic life insurance, and basic (~~long-term disability~~) LTD insurance begin on the first day of the month following the day the employee becomes eligible. If the employee becomes eligible on the first working day of a month, then PEBB insurance coverage begins on that date.

(5) **Justices and judges** are eligible as follows:

(a) **Eligibility.** A justice of the supreme court and judges of the court of appeals and the superior courts become eligible for PEBB benefits on the date they take the oath of office.

(b) **When PEBB insurance coverage begins.** Medical, dental, basic life insurance, and basic (~~long-term disability~~) LTD insurance begin on the first day of the month following the day the employee becomes eligible. If the employee becomes eligible on the first working day of a month, then PEBB insurance coverage begins on that date.

WAC 182-12-123 Is dual enrollment prohibited? Public employees benefits board (PEBB) health plan coverage is limited to a single enrollment per individual.

(1) An individual who has more than one source of eligibility for enrollment in PEBB health plan coverage (called "dual eligibility") is limited to one enrollment.

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

(3) A dependent enrolled in a PEBB health plan 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 (~~(1)(a)~~).

(a) If the employee does not waive enrollment in PEBB medical, the employee is not eligible to remain enrolled in (~~his or her~~) their spouse's, state registered domestic partner's, or parent's PEBB health plan as a dependent. If the employee's spouse, state registered domestic partner, or parent does not remove the employee (who is enrolled as a dependent) from (~~his or her~~) their subscriber account, the PEBB program will terminate the employee's enrollment as a dependent the last day of the month before the employee's employer-paid coverage begins.

Exception: An enrolled dependent who becomes newly eligible for PEBB benefits as an employee may be dual-enrolled in PEBB coverage 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 (~~his or her~~) their enrollment in PEBB medical, the employee will remain enrolled in PEBB medical under (~~his or her~~) their spouse's, state registered domestic partner's, or parent's PEBB health plan as a dependent.

(4) A child who is eligible for medical and dental under two subscribers may be enrolled as a dependent under the health plan of only one subscriber.

(5) When an employee is eligible for the employer contribution towards PEBB insurance coverage 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 seek 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 (~~he or she chose~~) they may choose to enroll (~~under~~) as described in (a) of this subsection, the employee must notify (~~his or her~~) their other employing agency no later than sixty days from the date PEBB coverage ends through the employing agency described in (a) of this subsection to transfer coverage.

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

(6) A retiree who defers enrollment in a PEBB health plan as described in WAC 182-12-200 by enrolling as an eligible dependent in a

health plan sponsored by PEBB, a Washington state school district, a Washington state ~~((education))~~ educational service district, or a Washington state charter school and who loses the employer contribution for such coverage must enroll in PEBB retiree insurance coverage as described in WAC ~~((182-12-171))~~ 182-12-200 or defer enrollment as described in WAC 182-12-205.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-128 When may an employee waive enrollment in public employees benefits board (PEBB) medical and when may ~~((he or she))~~ they enroll in PEBB medical after having waived enrollment? An employee may waive enrollment in public employees benefits board (PEBB) medical if ~~((he or she is))~~ they are enrolled in other employer-based group medical, a TRICARE plan, or medicare. An employee who waives enrollment in PEBB medical must enroll in dental, basic life insurance, and basic long-term disability (LTD) insurance (unless the employing agency does not participate in these PEBB insurance coverages).

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

(a) **When the employee becomes eligible:** An employee enrolled in other employer-based group medical, a TRICARE plan, or medicare may waive PEBB medical when ~~((he or she))~~ they become~~((s))~~ eligible for PEBB benefits. The employee must indicate ~~((his or her))~~ their election to waive enrollment in PEBB medical on the required form and submit the form to ~~((his or her))~~ their employing agency. The ~~((form must be received by the))~~ employing agency must receive the form no later than thirty-one days after the date the employee becomes eligible (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 as described in subsection (4) of this section.

The employee must submit the required form to ~~((his or her))~~ their employing agency. The employing agency must receive the form ~~((must be received))~~ no later than sixty 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.

(2) If an employee waives PEBB medical, the employee's eligible dependents may not be enrolled in 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 (~~change his or her enrollment~~) 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 (~~his or her~~) their employing agency. The employing agency must receive the form (~~must be received~~) no later than sixty 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 will begin as follows:

(i) For a newly born child, PEBB medical will begin the date of birth;

(ii) For a newly adopted child, PEBB medical will begin on the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier;

(iii) For an employee enrolling in order to enroll a newly born or newly adopted child, PEBB medical will begin the first day of the month in which the event occurs;

(iv) For the spouse or state registered domestic partner of an employee, PEBB medical will begin the first day of the month in which the event occurs.

(4) **Special open enrollment:** Any one of the events in (a) through (k) of this subsection may create a special open 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 for a state 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 (~~his or her~~) their employer contribution toward (~~his or her~~) their employer-based group medical;

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

Exception: For the purposes of special open enrollment "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;

(g) A court order (~~or national medical support notice (see also WAC 182-12-263)~~) requires the employee or any other individual to provide a health plan for an eligible dependent of the subscriber (a former spouse or former state registered domestic partner is not an eligible dependent);

(h) Employee or an employee's dependent becomes entitled to 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;

(i) Employee or an employee's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from medicaid or a state children's health insurance program (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 16-20-080, filed 10/4/16, effective 1/1/17)

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

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

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

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

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

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-131 How do eligible employees maintain the employer contribution toward public employees benefits board (PEBB) insurance coverage? The employer contribution toward public employees benefits board (PEBB) insurance coverage begins on the day that PEBB benefits begin as described in WAC 182-12-114. This section describes under what circumstances employees maintain eligibility for the employer contribution toward PEBB insurance coverage.

(1) **Maintaining the employer contribution.** Except as described in subsections (2), (3), and (4) of this section, employees who have established eligibility for benefits as described in WAC 182-12-114 are eligible for the employer contribution each month in which they are in pay status eight or more hours per month.

(2) **Maintaining the employer contribution - Benefits-eligible seasonal employees.**

(a) Benefits-eligible seasonal employees (eligible as described in WAC 182-12-114(2)) who work a season of less than nine months are eligible for the employer contribution in any month of the season in which they are in pay status eight or more hours during that month. The employer contribution toward PEBB insurance coverage for seasonal employees returning after their off season begins on the first day of the first month of the season in which they are in pay status eight hours or more.

(b) Benefits-eligible seasonal employees (eligible as described in WAC 182-12-114(2)) who work a season of nine months or more are eligible for the employer contribution:

(i) In any month of the season in which they are in pay status eight or more hours during that month; and

(ii) Through the off season following each season worked, but the eligibility may not exceed a total of twelve consecutive calendar months for the combined season and off season.

(3) **Maintaining the employer contribution - Eligible faculty.**

(a) Benefits-eligible faculty anticipated to work half time or more the entire instructional year or equivalent nine-month period (eligible as described in WAC 182-12-114 (3)(a)(i)) are eligible for the employer contribution each month of the instructional year, except as described in subsection (7) of this section.

(b) Benefits-eligible faculty who are hired on a quarter/semester to quarter/semester basis (eligible as described in WAC 182-12-114 (3)(a)(ii)) are eligible for the employer contribution each quarter or semester in which employees work half-time or more.

(c) Summer or off-quarter/semester coverage: All benefits-eligible faculty (eligible as described in WAC 182-12-114 (3)(a) and (b)) who work an average of half-time or more throughout the entire instructional year or equivalent nine-month period and work each quarter/semester of the instructional year or equivalent nine-month period are eligible for the employer contribution toward summer or off-quarter/semester PEBB insurance coverage.

Exception: Eligibility for the employer contribution toward summer or off-quarter/semester PEBB insurance coverage ends on the end date specified in an employing agency's termination notice or an employee's resignation letter, whichever is earlier, if the employing agency has no anticipation that the employee will be returning as faculty at any institution of higher education where the employee has employment. If the employing agency deducted the employee's premium for PEBB insurance coverage after the employee was no longer eligible for the employer contribution, PEBB insurance coverage ends the last day of the month for which employee premiums were deducted.

(d) **Two-year averaging:** All benefits-eligible faculty (eligible as described in WAC 182-12-114 (3)(a) and (b)) who worked an average of half-time or more in each of the two preceding academic years are potentially eligible to receive uninterrupted employer contribution toward PEBB insurance coverage. "Academic year" means summer, fall, winter, and spring quarters or summer, fall, and spring semesters and begins with summer quarter/semester. In order to be eligible for the employer contribution through two-year averaging, the faculty must provide written notification of (~~his or her~~) their potential eligibility to (~~his or her~~) their employing agency or agencies within the deadlines established by the employing agency or agencies. Faculty continue to receive uninterrupted employer contribution for each academic year in which they:

(i) Are employed on a quarter/semester to quarter/semester basis and work at least two quarters or two semesters; and

(ii) Have an average workload of half-time or more for three quarters or two semesters.

Eligibility for the employer contribution under two-year averaging ceases immediately if the eligibility criteria is not met or if the eligibility criteria becomes impossible to meet.

(e) Faculty who lose eligibility for the employer contribution: All benefits-eligible faculty (eligible as described in WAC 182-12-114 (3)(a) and (b)) who lose eligibility for the employer contribution will regain it if they return to a faculty position where it is anticipated that they will work half-time or more for the quarter/semester no later than the twelfth month after the month in which they lost eligibility for the employer contribution. The employer contribution begins on the first day of the month in which the quarter/semester begins.

(4) Maintaining the employer contribution - Employees on leave and under the special circumstances listed below.

(a) Employees who are on approved leave under the federal Family and Medical Leave Act (FMLA) continue to receive the employer contribution as long as they are approved under the act.

(b) Unless otherwise indicated in this section, employees in the following circumstances receive the employer contribution only for the months they are in pay status eight hours or more:

(i) Employees on authorized leave without pay;

(ii) Employees on approved educational leave;

(iii) Employees receiving time-loss benefits under workers' compensation;

(iv) Employees called to active duty in the uniformed services as defined under the Uniformed Services Employment and Reemployment Rights Act (USERRA); or

(v) Employees applying for disability retirement.

(5) Maintaining the employer contribution - Employees who move from an eligible to an otherwise ineligible position due to a layoff maintain the employer contribution toward PEBB insurance coverage as described in WAC 182-12-129.

(6) Employees who are in pay status less than eight hours in a month. Unless otherwise indicated in this section, when there is a

month in which employees are not in pay status for at least eight hours, employees:

(a) Lose eligibility for the employer contribution for that month; and

(b) Must reestablish eligibility for PEBB benefits as described in WAC 182-12-114 in order to be eligible for the employer contribution again.

(7) **The employer contribution toward PEBB insurance coverage ends** in any one of these circumstances for all employees:

(a) When employees fail to maintain eligibility for the employer contribution as indicated in the criteria in subsection (1) through (6) of this section.

(b) When the employment relationship is terminated. As long as the employing agency has no anticipation that the employee will be re-hired, the employment relationship is terminated:

(i) On the date specified in an employee's letter of resignation; or

(ii) On the date specified in any contract or hire letter or on the effective date of an employer-initiated termination notice.

(c) When employees move to a position that is not anticipated to be eligible for PEBB benefits as described in WAC 182-12-114, not including changes in position due to a layoff.

The employer contribution toward PEBB benefits cease for employees and their enrolled dependents the last day of the month in which employees are eligible for the employer contribution under this section.

Exception: If the employing agency deducted the employee's premium for PEBB insurance coverage after the employee was no longer eligible for the employer contribution, PEBB insurance coverage ends the last day of the month for which employee premiums were deducted.

(8) **Options for continuation coverage by self-paying.** During temporary or permanent loss of the employer contribution toward PEBB insurance coverage, employees have options for providing continuation coverage for themselves and their dependents by self-paying the premium and applicable premium surcharge set by the health care authority (HCA). These options are available as described in WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, and 182-12-270.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-133 What options for continuation coverage are available to employees and their dependents during certain types of leave or when employment ends due to a layoff? Employees who have established eligibility for public employees benefits board (PEBB) benefits as described in WAC 182-12-114 may continue coverage for themselves and their dependents during certain types of leave or when their employment ends due to a layoff.

(1) Employees who are no longer eligible for the employer contribution toward PEBB insurance coverage due to an event described in (b)(i) through (vi) of this subsection may continue PEBB insurance coverage by self-paying the premium and applicable premium surcharge set by the health care authority (HCA) from the date eligibility for the employer contribution is lost:

(a) Employees may continue any combination of medical, dental, and life insurance; however, only employees on approved educational

leave or called in to active duty in the uniformed services as defined under the Uniformed Services Employment and Reemployment Rights Act (USERRA) may continue either basic or both basic and optional long-term disability (LTD) insurance.

(b) Employees in the following circumstances qualify to continue coverage under this subsection:

(i) Employees who are on authorized leave without pay;

(ii) Employees who are on approved educational leave;

(iii) Employees who are receiving time-loss benefits under workers' compensation;

(iv) Employees who are called to active duty in the uniformed services as defined under USERRA;

(v) Employees whose employment ends due to a layoff as defined in WAC 182-12-109; or

(vi) Employees who are applying for disability retirement.

(c) The employee's election must be received by the PEBB program no later than sixty days from the date the employee's PEBB health plan coverage ended or from the postmark date on the election notice sent by the ((HCA)) PEBB program, whichever is later.

(d) Employees may self-pay for a maximum of twenty-nine months. The employee's first premium payment and applicable premium surcharge is due to the HCA no later than forty-five days after the ~~((employee's election is received by the HCA))~~ election period ends as described in (c) of this subsection.

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 or LTD insurance coverage. Premiums associated with continuing life insurance coverage must be made to the contracted vendor. Following the employee's first premium payment, the employee must pay the premium amounts for PEBB insurance coverage and applicable premium surcharges as premiums become due.

(e) If the employee's monthly premium or applicable premium surcharge remains unpaid for sixty days from the original due date, the employee's PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharge was paid as described in WAC 182-08-180 (1)((~~b~~)) (c).

(2) The number of months that employees self-pay the premium while eligible as described in subsection (1) of this section will count toward the total months of continuation coverage allowed under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). Employees who are no longer eligible for continuation coverage as described in subsection (1) of this section but who have not used the maximum number of months allowed under COBRA coverage may continue medical, dental, or both for the remaining difference in months by self-paying the premium and applicable premium surcharge as described in WAC 182-12-146.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-138 What options are available if an employee is approved for the federal Family and Medical Leave Act (FMLA)? (1) An employee on approved leave under the federal Family and Medical Leave

Act (FMLA) may continue to receive the employer contribution toward public employees benefits board (PEBB) insurance coverage in accordance with the federal FMLA. The employee may also continue current optional life and optional long-term disability (LTD) insurance. The employee's employing agency is responsible for determining if the employee is eligible for leave under FMLA and the duration of such leave.

(2) If an employee's monthly premium or applicable premium surcharge remains unpaid for sixty days from the original due date, the employee's PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharge was paid.

(3) If an employee exhausts the period of leave approved under FMLA, PEBB insurance coverage may be continued by self-paying the premium and applicable premium surcharge set by the HCA, with no contribution from the employer, as described in WAC 182-12-133(1) while on approved leave.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-141 If an employee reverts from an eligible position, what happens to ((his or her)) their public employees benefits board (PEBB) insurance coverage? (1) If an employee reverts for reasons other than a layoff and is not eligible for the employer contribution toward public employees benefits board (PEBB) insurance coverage under this chapter, ((he or she)) they may continue PEBB insurance coverage by self-paying the premium and applicable premium surcharge set by the health care authority (HCA) for up to eighteen months under the same terms as an employee who is granted leave without pay under WAC 182-12-133(1):

(a) The employee's election must be received by the PEBB program no later than sixty days from the date the employee's PEBB health plan coverage ended or from the postmark date on the election notice sent by the ((HCA)) PEBB program, whichever is later;

(b) The employee's first premium payment and applicable premium surcharge is due to the HCA no later than forty-five days after the ((employee's election is received by the HCA)) election period ends as described in (a) of this subsection. 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. Premiums associated with continuing life insurance coverage must be made to the contracted vendor;

(c) Following the employee's first premium payment, the employee must pay the premium amounts associated with PEBB insurance coverage and applicable premium surcharges as premiums become due; and

(d) If the employee's monthly premium or applicable premium surcharge remains unpaid for sixty days from the original due date, the employee's PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharge was paid as described in WAC 182-08-180 (1)((~~b~~)) (c).

(2) If an employee is reverted due to a layoff, the employee may be eligible for the employer contribution toward PEBB insurance cover-

age under the criteria of WAC 182-12-129. If determined not to be eligible under WAC 182-12-129, the employee may continue PEBB insurance coverage by self-paying the premium and applicable premium surcharge set by the HCA under WAC 182-12-133.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-142 What options for continuation coverage are available to faculty and seasonal employees who are between periods of eligibility? (1) **Faculty** may continue any combination of medical, dental, and life insurance by self-paying the premium and applicable premium surcharge set by the health care authority (HCA), with no contribution from the employer, for a maximum of twelve months between periods of eligibility:

(a) The employee's election must be received by the public employees benefits board (PEBB) program no later than sixty days from the date the employee's PEBB health plan coverage ended or from the postmark date on the election notice sent by the ((HCA)) PEBB program, whichever is later;

(b) The employee's first premium payment and applicable premium surcharge is due to the HCA no later than forty-five days after the ((~~employee's election is received by the HCA~~)) election period ends as described in (a) of this subsection. 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. Premiums associated with continuing life insurance coverage must be made to the contracted vendor;

(c) Following the employee's first premium payment, the employee must pay the premium amounts associated with PEBB insurance coverage and applicable premium surcharges as premiums become due; and

(d) If the employee's monthly premium or applicable premium surcharge remains unpaid for sixty days from the original due date, the employee's PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharge was paid as described in WAC 182-08-180 (1)((~~b~~)) (c).

(2) **Benefits-eligible seasonal employees** may continue any combination of medical, dental, and life insurance by self-paying the premium and applicable premium surcharge set by the HCA, with no contribution from the employer, for a maximum of twelve months between periods of eligibility:

(a) The employee's election must be received by the PEBB program no later than sixty days from the date the employee's PEBB health plan coverage ended or from the postmark date on the election notice sent by the ((HCA)) PEBB program, whichever is later;

(b) The employee's first premium payment and applicable premium surcharge is due to the HCA no later than forty-five days after the ((~~employee's election is received by the HCA~~)) election period ends as described in (a) of this subsection. 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. Premiums associated with continuing life insurance coverage must be made to the contracted vendor;

(c) Following the employee's first premium payment, the employee must pay the premium amounts associated with PEBB insurance coverage and applicable premium surcharges as premiums become due; and

(d) If the employee's monthly premium or applicable premium surcharge remains unpaid for sixty days from the original due date, the employee's PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharge was paid as described in WAC 182-08-180 (1)(~~(b)~~) (c).

(3) **COBRA.** An employee who is no longer eligible for continuation coverage as described in subsections (1) and (2) of this section, but who has not used the maximum number of months allowed under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), may continue medical (~~and~~), dental, or both for the remaining difference in months by self-paying the premium and applicable premium surcharge set by the HCA under COBRA as described in WAC 182-12-146. The number of months that a faculty or seasonal employee self-pays premiums under the criteria in subsection (1) or (2) of this section will count toward the total months of continuation coverage allowed under COBRA.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-146 When is an enrollee eligible to continue public employee's benefits board (PEBB) health plan coverage under Consolidated Omnibus Budget Reconciliation Act (COBRA)? (1) An enrollee may continue public employee's benefits board (PEBB) health plan coverage under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) by self-paying the premium and applicable premium surcharge set by the health care authority (HCA):

Note: Based on RCW 26.60.015 and public employee benefits board policy resolution that extended PEBB coverage for dependents not otherwise eligible for COBRA, an employee's state registered domestic partner and the state registered domestic partner's children may continue PEBB insurance coverage on the same terms and conditions as spouses and other eligible dependents under COBRA.

(a) The enrollee's election must be received by the PEBB program no later than sixty days from the date the enrollee's PEBB health plan coverage ended or from the postmark date on the election notice sent by the (~~HCA~~) PEBB program, whichever is later;

(b) The enrollee's first premium payment and applicable premium surcharge is due to the HCA no later than forty-five days after the (~~enrollee's election is received by the HCA~~) election period ends as described in (a) of this subsection. Following the enrollee's first premium payment, premiums and applicable premium surcharges must be paid as described in WAC 182-08-180 (1)(~~(b)~~) (c);

(c) Enrollees who request to voluntarily terminate their COBRA coverage must do so in writing. The written termination request must be received by the PEBB program. Enrollees who terminate their COBRA coverage will not be eligible to reenroll in COBRA coverage unless they regain eligibility. COBRA coverage will end on the last day of the month in which the PEBB program receives the termination request. If the termination request is received on the first day of the month, COBRA coverage will end on the last day of the previous month; and

(d) Medical flexible spending arrangement (FSA) enrollees who on the date of the qualifying event, have a greater number of remaining benefits than remaining contribution payments for the current year,

will have an opportunity to continue making contributions to their medical FSA by electing COBRA. The enrollee's first premium payment is due to the contracted vendor no later than forty-five days after the ~~((enrollee's election is received by the contracted vendor))~~ election period ends as described below. The enrollee's election must be received by the contracted vendor no later than sixty days from the date the enrollee's PEBB health plan coverage ended or from the postmark date on the election notice sent by the contracted vendor, whichever is later.

(2) An employee or an employee's dependent who loses eligibility for the employer contribution toward PEBB insurance coverage and who qualifies for continuation coverage under COBRA may continue medical, dental, or both.

(3) An employee or an employee's dependent who loses eligibility for continuation coverage described in WAC 182-12-133, 182-12-138, 182-12-141, 182-12-142, or 182-12-148 but who has not used the maximum number of months allowed under COBRA may continue medical, dental, or both for the remaining difference in months.

(4) A retired employee who loses eligibility for PEBB retiree insurance because an employer group, with the exception of school districts, educational service districts, and charter schools ceases participation in PEBB insurance coverage may continue medical, dental, or both.

(5) A retired employee, or a dependent of a retired employee, who is no longer eligible to continue coverage as described in WAC 182-12-171 may continue medical, dental, or both.

(6) A blind vendor who ceases to actively operate a facility as described in WAC 182-12-111 (5)(a) may continue enrollment in PEBB medical for the maximum number of months allowed under COBRA as described in this section.

A blind vendor is not eligible for PEBB retiree insurance coverage.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

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

- (a) The personnel resources board;
- (b) An arbitrator; or
- (c) A grievance or appeals committee established under a collective bargaining agreement for union represented employees.

(2) The employee must pay premium amounts and applicable premium surcharges associated with PEBB insurance coverage as premiums and applicable premium surcharges become due. If the monthly premium or applicable premium surcharge remains unpaid for sixty days from the original due date, PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and

applicable premium surcharge was paid as described in WAC 182-08-180 (1)(~~(b)~~) (c).

(3) If the dismissal is upheld, all PEBB insurance coverage will end at the end of the month in which the decision is entered, or the date to which premiums have been paid, whichever is later, with the exception described in subsection (4) of this section.

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

(5) If the board, arbitrator, committee, or court sustains the employee in the appeal and directs reinstatement of employer paid PEBB insurance coverage retroactively, the employing agency must forward to HCA the full employer contribution for the period directed by the board, arbitrator, committee, or court and collect from the employee the employee's share of premiums due, if any.

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

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

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-171 When is a retiring employee eligible to enroll in public employees benefits board (PEBB) retiree insurance coverage? A retiring employee is eligible to continue enrollment or defer enrollment in public employees benefits board (PEBB) insurance coverage as a retiree if (~~(he or she)~~) they meet(~~(s)~~) procedural and substantive eligibility requirements as described in subsections (1), (2), and (3) of this section. An elected (~~(state official or)~~) and full-time appointed (~~(state)~~) official of the legislative (~~(or)~~) and executive branch of state government is eligible as described in WAC 182-12-180.

(1) **Procedural requirements.** A retiring employee must enroll or defer enrollment in PEBB retiree insurance coverage as described in (a)(~~(, (b), and (e))~~) through (d) of this subsection:

(a) To enroll in PEBB retiree insurance coverage, the required form must be received by the PEBB program no later than sixty days after the employee's employer-paid coverage, Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage, or continuation coverage ends.

The effective date of PEBB retiree insurance coverage is the first day of the month after the employee's employer-paid coverage, COBRA coverage, or continuation coverage ends;

(b) The employee's first premium payment and applicable premium surcharge is due to the health care authority (HCA) no later than forty-five days after the ((employee's election is received by the HCA)) election period ends as described in (a) of this subsection. Following the employee's first premium payment, premiums and applicable premium surcharges must be paid as described in WAC 182-08-180 (1)((+b)) (c); and

(c) If a retiring employee 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 retiring employee;

Exception:

If a retiring employee selects a medicare supplement plan, nonmedicare enrollees will be enrolled in the Uniform Medical Plan (UMP) Classic. If a retiring employee selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees.

(d) To defer enrollment in a PEBB health plan, the employee must meet substantive eligibility requirements in subsection (2) of this section and defer enrollment as described in WAC 182-12-200 or 182-12-205.

(2) Substantive eligibility requirements.

(a) An employee as defined in WAC 182-12-109 who is eligible for PEBB benefits or an employee who is enrolled in basic benefits through a Washington state school district, educational service district as defined in RCW 28A.400.270, or a charter school and ends public employment after becoming vested in a Washington state-sponsored retirement plan may enroll or defer enrollment in PEBB retiree insurance coverage if ((he or she)) they meet ((s)) procedural and substantive eligibility requirements.

To be eligible to continue enrollment or defer enrollment in PEBB insurance coverage as a retiree, the employee must be eligible to retire under a Washington state-sponsored retirement plan when the employee's employer-paid coverage, COBRA coverage, or continuation coverage ends.

(b) A retiring employee of a state agency must immediately begin to receive a monthly retirement plan payment, with exceptions described below:

(i) A retiring employee who receives a ((lump sum)) lump sum payment instead of a monthly retirement plan payment is only eligible if the department of retirement systems offered the employee the choice between a lump sum actuarially equivalent payment and the ongoing monthly payment, as allowed by the plan; or

(ii) A retiring employee who is a member of a Plan 3 retirement plan, also called a separated employee (defined in RCW 41.05.011((+21)) (25)), must meet ((his or her)) their Plan 3 retirement eligibility criteria. The employee does not have to receive a retirement plan payment to enroll in PEBB retiree insurance coverage ((+)).

(c) A retiring employee of a Washington higher education institution who is a member of a higher education retirement plan (HERP) must immediately begin to receive a monthly retirement plan payment, or meet ((his or her)) their HERP plan's retirement eligibility criteria, or be at least age fifty-five with ten years of state service;

(d) A retiring employee of an employer group participating in PEBB insurance coverage under contractual agreement with the authority must be eligible to retire as described in (i) or (ii) of this subsection to be eligible to continue PEBB insurance coverage as a retiree,

except for a school district, educational service district, or charter school employee who must meet the requirements as described in subsection (2)(e) of this section.

(i) A retiring employee who is eligible to retire under a retirement plan sponsored by an employer group or tribal government that is not a Washington state-sponsored retirement plan must meet the same age and years of service requirements as if ~~((he or she was))~~ they were a member of public employees retirement system Plan 1 or Plan 2 during ~~((his or her))~~ their employment with that employer group or tribal government.

(ii) A retiring employee who is eligible to retire under a Washington state-sponsored retirement plan must immediately begin to receive a monthly retirement plan payment, with exceptions described in subsection (2)(b)(i) and (ii) of this section.

(iii) A retired employee of an employer group, except a Washington state school district, educational service district, or charter school that ends participation in PEBB insurance coverage is no longer eligible to continue enrollment in PEBB retiree insurance coverage if ~~((he or she))~~ they enrolled after September 15, 1991. Any retiree who loses eligibility for this reason may continue health plan enrollment as described in WAC 182-12-146.

(iv) A retired employee of a tribal government employer that ends participation in PEBB insurance coverage is no longer eligible to continue enrollment in PEBB retiree insurance coverage. Any retiree who loses eligibility for this reason may continue health plan enrollment as described in WAC 182-12-146.

(e) A retiring employee of a Washington state school district, Washington state educational service district, or a Washington state charter school must immediately begin to receive a monthly retirement plan payment, with exceptions described below:

(i) A retiring employee who ends employment before October 1, 1993; or

(ii) A retiring employee who receives a ~~((lump sum))~~ lump sum payment instead of a monthly retirement plan payment is only eligible if the department of retirement systems offered the employee the choice between a lump sum actuarially equivalent payment and the ongoing monthly payment, as allowed by the plan, or the employee enrolled before 1995; or

(iii) A retiring employee who is a member of a Plan 3 retirement system, also called a separated employee (defined in RCW 41.05.011~~((+21))~~ (25)), must meet ~~((his or her))~~ their Plan 3 retirement eligibility criteria; or

(iv) An employee who retired as of September 30, 1993, and began receiving a monthly retirement plan payment from a Washington state-sponsored retirement system (as defined in chapters 41.32, 41.35 or 41.40 RCW) is eligible if ~~((he or she))~~ they enrolled in a PEBB health plan no later than the HCA's annual open enrollment period for the year beginning January 1, 1995.

(3) A retiring employee and ~~((his or her))~~ their enrolled dependents who are entitled to medicare must enroll and maintain enrollment in both medicare Parts A and B if the employee retired after July 1, 1991. If a retiree or an enrolled dependent becomes entitled to medicare after enrollment in PEBB retiree insurance coverage, ~~((he or she))~~ they must enroll and maintain enrollment in medicare Parts A and B to remain enrolled in a PEBB retiree health plan. If an enrollee who is entitled to medicare does not meet this procedural requirement, the enrollee is no longer eligible for enrollment in a PEBB retiree ~~((in-~~

surance coverage)) health plan. The enrollee may continue PEBB health plan enrollment as described in WAC 182-12-146.

(4) Washington state-sponsored retirement plans include:

(a) Higher education retirement plans;
(b) Law enforcement officers' and firefighters' retirement system;

(c) Public employees' retirement system;

(d) Public safety employees' retirement system;

(e) School employees' retirement system;

(f) State judges/judicial retirement system;

(g) Teachers' retirement system; and

(h) State patrol retirement system.

(i) The two federal retirement systems, Civil Service Retirement System and Federal Employees' Retirement System, are considered Washington state-sponsored retirement systems for Washington State University Extension for an employee covered under PEBB insurance coverage at the time of retirement.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-180 When is an elected (~~(state official,)~~) and full-time appointed ((state)) official of the legislative ((or)) and executive branch of state government, or their survivor eligible to continue enrollment in public employees benefits board (PEBB) retiree insurance coverage?

(1) (~~The following officials are~~) An elected and full-time appointed official of the legislative and executive branch of state government is eligible to continue enrollment or defer enrollment in public employees benefits board (PEBB) retiree insurance coverage under the same terms as an outgoing legislator((s)), when they voluntarily or involuntarily leave public office((r)). The following officials are eligible if they meet the procedural requirements as described in subsection (3) of this section:

(a) A member of the state legislature;

(b) A statewide elected official of the executive branch;

(c) An executive official appointed directly by the governor as the single head of an executive branch agency; or

(d) An official appointed directly by a state legislative committee as the single head of a legislative branch agency or an official appointed to secretary of the senate or chief clerk of the house of representatives.

(2) The spouse, state registered domestic partner, or child of an official described in subsection (1) of this section who loses eligibility due to the death of the official may enroll or defer enrollment as a survivor under PEBB retiree insurance coverage as described in (a) and (b) of this subsection and must meet procedural requirements as described in subsection (3)((b) and (e)) of this section.

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

(b) The official's child may continue health plan enrollment until they lose eligibility as described in WAC 182-12-260.

(3) **Procedural requirements.** An official described in subsection (1) of this section or their survivor described in subsection (2) of this section must enroll or defer enrollment in PEBB retiree insurance

coverage (~~no later than sixty days after the official leaves public office or the death of the official~~) as described in (a) through (d) of this subsection:

(a) For an official to enroll in PEBB retiree insurance coverage the required forms must be received by the PEBB program no later than sixty days after the official leaves public office (~~or the death of the official~~). The effective date of PEBB retiree insurance coverage is the first day of the month after the official leaves public office (~~or the death of the official~~);

For a survivor to enroll in PEBB retiree insurance coverage, the required forms must be received by the PEBB program no later than sixty days after the later of the date of the official's death or the date the survivor's PEBB insurance coverage ends. The effective date of PEBB retiree insurance coverage is the first day of the month after the date of the official's death or the first day of the month after the survivor's PEBB insurance coverage ends;

(b) The official's or survivor's first premium payment and applicable premium surcharge is due to the health care authority (HCA) no later than forty-five days after the official's or survivor's (~~election is received by the PEBB program~~) election period ends as described in (a) of this subsection. Following the official's or survivor's first premium payment, premiums and applicable premium surcharges must be paid as described in WAC 182-08-180 (1)(~~(b)~~) (c);

(c) If an official 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 official or survivor;

Exception:

If an official or a survivor selects a medicare supplement plan, nonmedicare enrollees will be enrolled in the Uniform Medical Plan (UMP) Classic. If an official or a survivor selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees.

(d) To defer enrollment in a PEBB health plan the official or the survivor must meet deferral enrollment requirements as described in WAC 182-12-200 or 182-12-205.

(4) If the official, an enrolled dependent, or their survivor is entitled to medicare or becomes entitled to medicare after enrollment in PEBB retiree insurance coverage, (~~he or she~~) they must enroll and maintain enrollment in medicare Parts A and B to remain enrolled in a PEBB retiree (~~insurance coverage~~) health plan. If an enrollee who is entitled to medicare does not meet this procedural requirement, the enrollee is no longer eligible for enrollment in a PEBB retiree health plan. The enrollee may continue PEBB health plan enrollment as described in WAC 182-12-146.

(5) An official described in subsection (1) of this section shall be included in the term "retiree" or "retiring employee" as used in chapters 182-08, 182-12, and 182-16 WAC.

AMENDATORY SECTION (Amending WSR 16-20-080, filed 10/4/16, effective 1/1/17)

WAC 182-12-200 (~~How does a retiree who is~~) May a retiring employee or a retiree enrolled as a dependent in a health plan sponsored by public employees benefits board (PEBB), a Washington state school district, a Washington state educational service district, or a Washington state charter school defer PEBB health plan enrollment under PEBB retiree insurance coverage? (1) A (~~retiree~~) retiring employee

may defer enrollment in a public employees benefits board (PEBB) health plan ~~((during the period of time he or she is))~~ at retirement or after enrolling in PEBB retiree insurance coverage. Enrollment in a PEBB health plan may be deferred when they are enrolled as a dependent in a health plan sponsored by PEBB, a Washington state school district, a Washington state ((education)) educational service district, or a Washington state charter school, including such coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or continuation coverage. A retiring employee who defers enrollment at retirement must meet substantive eligibility requirements as described in WAC 182-12-171(2) or requirements as described in WAC 182-12-180(1).

(2) A retiree who defers enrollment in medical must defer enrollment in dental. Retirees must be enrolled in medical to enroll in dental. A retiree who defers enrollment in a PEBB health plan also defers enrollment for all eligible dependents.

(3) A retiree who defers ~~((coverage))~~ enrollment may later enroll in a PEBB health plan if ~~((he or she))~~ they provide~~((s))~~ evidence of continuous enrollment in a health plan sponsored by PEBB, a Washington state school district, a Washington state educational service district, or a Washington state charter school and submits the required form as described in (a) and (b) of this subsection:

(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 plan sponsored by PEBB, a Washington state school district, a Washington state educational service district, or a Washington state charter school ends, or such coverage under COBRA or continuation coverage ends. ~~((The retiree must submit the required form to enroll or defer enrollment as described in WAC 182-12-171(1)(a).))~~ The required forms to enroll must be received by the PEBB program no later than sixty 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.

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

Exception:

If a retiree selects a medicare supplement plan, nonmedicare enrollees will be enrolled in the Uniform Medical Plan (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.

AMENDATORY SECTION (Amending WSR 16-20-080, filed 10/4/16, effective 1/1/17)

WAC 182-12-205 May a retiree((s)) or a survivor defer or voluntarily terminate public employees benefits board (PEBB) health plan enrollment under ((public employees benefits board (PEBB))) PEBB retiree insurance coverage ((at or after retirement))? (1) The following ~~((provisions apply when retirees defer or voluntarily terminate enrollment under))~~ individuals may defer enrollment in a public employees benefits board (PEBB) ((retiree insurance coverage when enrolled in other coverage)) health plan:

~~((1))~~ Retirees) (a) A retiring employee;

(b) A dependent becoming eligible as a survivor; or

(c) A retiree or a survivor enrolled in PEBB retiree insurance coverage.

(2) A subscriber described in subsection (1) of this section who defers enrollment in a PEBB health plan also defers enrollment for all eligible dependents, except as described in subsection ((+2+)) (3)(c) of this section.

~~((+2) Retirees may)~~ (3) A subscriber described in subsection (1) of this section who defers enrollment in a PEBB health plan ((at or after retirement if continuously enrolled)) must maintain continuous enrollment in other medical as described in this section or WAC 182-12-200. ((Retirees who)) A subscriber who defers enrollment in medical must defer enrollment in dental. ((Retirees)) A subscriber must be enrolled in medical to enroll in dental.

(a) Beginning January 1, 2001, ((retirees may defer)) enrollment in a PEBB health plan ((if they are)) may be deferred when the subscriber is enrolled in employer-based group medical as an employee or the dependent of an employee, or such medical insurance continued under Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage or continuation coverage.

(b) Beginning January 1, 2001, ((retirees may defer)) enrollment in a PEBB health plan ((if they are)) may be deferred when the subscriber is enrolled as a retiree or the dependent of a retiree in a federal retiree medical plan.

(c) Beginning January 1, 2006, ((retirees may defer)) enrollment in a PEBB health plan ((if they are)) may be deferred when the subscriber is enrolled in medicare Parts A and B and a medicaid program that provides creditable coverage as described in this chapter. ((The retiree's)) Dependents may continue their PEBB health plan enrollment if they meet PEBB eligibility criteria and are not eligible for creditable coverage under a medicaid program.

(d) Beginning January 1, 2014, ((retirees)) subscribers who are not eligible for Parts A and B of medicare may defer enrollment in a PEBB health plan ((if they are)) when the subscriber is enrolled in exchange coverage.

~~((+3+))~~ (e) Beginning July 17, 2018, enrollment in a PEBB health plan may be deferred when the subscriber is enrolled as a retiree or the dependent of a retiree in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).

(4) To defer PEBB health plan enrollment, ((retiring employees or enrolled subscribers must submit)) the required forms must be submitted to the PEBB program.

(a) ((If)) For a retiring employee((s submit the required forms to defer enrollment in a PEBB health plan after their employer-paid coverage, COBRA coverage, or continuation coverage ends)) who meets the substantive eligibility requirements as described in WAC 182-12-171 ((+1)(b)) (2), enrollment will be deferred the first of the month following the date their employer-paid coverage, COBRA coverage, or continuation coverage ends. The forms must be received by the PEBB program no later than sixty days after the employer-paid coverage, COBRA coverage, or continuation coverage ends.

(b) ((If enrolled subscribers)) For an official leaving public office who meets the requirements as described in WAC 182-12-180(1), enrollment will be deferred the first of the month following the date the official leaves public office. The forms must be received by the PEBB program no later than sixty days after the official leaves public office.

(c) For an employee determined to be retroactively eligible for disability retirement who meets the requirements as described in WAC 182-12-211 (1)(a) through (c), enrollment will be deferred as described in WAC 182-12-211 (2) or (3). The forms and formal determination letter must be received by the PEBB program no later than sixty days after the date on the determination letter.

(d) For an eligible survivor, the dependent must meet the requirements described below and the forms must be received by the PEBB program within the time described:

(i) For a survivor of an employee who meets the requirements as described in WAC 182-12-265 (1) or (3), enrollment will be deferred the first of the month following the later of the date of the employee's death or the date the survivor's PEBB insurance coverage, school district coverage, educational service district coverage, or charter school coverage ends. The forms must be received by the PEBB program no later than sixty days after the later of the date of the employee's death or the date the survivor's PEBB insurance coverage, school district coverage, educational service district coverage, or charter school coverage ends.

(ii) For a survivor of an official who meets the requirements as described in WAC 182-12-180(2), enrollment will be deferred the first of the month following the later of the date of the official's death or the date the survivor's PEBB insurance coverage ends. The forms must be received by the PEBB program no later than sixty days after the later of the date of the official's death or the date the survivor's PEBB insurance coverage ends.

(iii) For a survivor of a retiree who meets the requirements as described in WAC 182-12-265(2), enrollment will be deferred the first of the month following the date of the retiree's death. The forms must be received by the PEBB program no later than sixty days after the retiree's death.

(iv) For a survivor of an emergency service personnel killed in the line of duty who meets the requirements as described in WAC 182-12-250, enrollment will be deferred the first of the month following the later of one of the events described in WAC 182-12-250 (5)(a) through (d). The forms must be received by the PEBB program no later than one hundred eighty days after the later of one of the events described in WAC 182-12-250 (5)(a) through (d).

(e) For an enrolled retiree or survivor who submits the required forms to defer enrollment in a PEBB health plan, enrollment will be deferred effective the first of the month following the date the required forms ~~((is))~~ are received by the PEBB program. If the forms ~~((is))~~ are received on the first day of the month, ~~((coverage will end on the last day of the previous month.~~

~~(4) Retirees who defer enrollment while enrolled in coverage as described in subsection (2)(a) through (d) of this section and lose such coverage must enroll in a PEBB retiree health plan as described in WAC 182-12-171 or defer enrollment as described in this section or WAC 182-12-200)) enrollment will be deferred effective that day.~~

Exception: When a subscriber or their dependent is enrolled in a medicare advantage plan, then enrollment in a PEBB health plan will be deferred effective the first of the month following the date the medicare advantage plan disenrollment form is received.

(5) A retiree~~((s))~~ who meets substantive eligibility requirements in WAC 182-12-171(2) and whose employer-paid coverage, COBRA coverage, or continuation coverage ended between January 1, 2001, and December 31, 2001, was not required to ~~((submit))~~ have submitted the deferral form at that time, but must ~~((have met))~~ meet all procedural requirements as stated in this section, WAC 182-12-171, and 182-12-200.

~~(6) ((Retirees who defer))~~ A subscriber described in subsection (1) of this section who defers enrollment while enrolled in qualifying coverage as described in subsection (3)(a) through (e) of this section may later enroll themselves and their dependents in a PEBB health plan ((as follows)) by submitting the required forms as described below and evidence of continuous enrollment in one or more qualifying coverages as described in subsection (3)(a) through (e) of this section:

~~(a) ((Retirees))~~ A subscriber who defers enrollment while enrolled in employer-based group medical or such medical insurance continued under COBRA coverage or continuation coverage may enroll in a PEBB health plan by submitting the required forms and evidence of continuous enrollment ~~((in such coverage))~~ to the PEBB program:

(i) During the PEBB annual open enrollment period. The required forms 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

(ii) When their employer-based group medical or such coverage under COBRA coverage or continuation coverage ends. The required forms and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after ~~((such))~~ coverage ends. PEBB health plan coverage begins the first day of the month after the employer-based group medical coverage, COBRA coverage, or continuation coverage ends.

~~(b) ((Retirees))~~ A subscriber who defers enrollment while enrolled as a retiree or dependent of a retiree in a federal retiree medical plan will have a one-time opportunity to enroll in a PEBB health plan by submitting the required forms and evidence of continuous enrollment ~~((in such coverage))~~ to the PEBB program:

(i) During the PEBB annual open enrollment period. The required forms 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

(ii) When the federal retiree medical plan coverage ends. The required forms and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after ~~((such))~~ coverage ends. PEBB health plan coverage begins the first day of the month after coverage under the federal retiree medical plan ends.

~~(c) ((Retirees))~~ A subscriber who defers enrollment while enrolled in medicare Parts A and B and a medicaid program that provides creditable coverage as described in this chapter may enroll in a PEBB health plan by submitting the required forms and evidence of continuous enrollment ~~((in such coverage))~~ to the PEBB program:

(i) During the PEBB annual open enrollment period. The required forms 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

(ii) When their medicaid coverage ends. The required forms and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after ~~((such))~~ coverage ends. PEBB health plan coverage begins the first day of the month after the medicaid coverage ends; or

(iii) No later than the end of the calendar year when their medicaid coverage ends if the retiree or survivor was also determined eligible under 42 U.S.C. § 1395w-114 and subsequently enrolled in a medicare Part D plan. Enrollment in the PEBB health plan will begin January 1st following the end of the calendar year when the medicaid coverage ends. The required forms must be received by the PEBB program no

later than the last day of the calendar year in which the ~~((retiree's))~~ medicaid coverage ends.

(d) ~~((Retirees))~~ A subscriber who defers enrollment while enrolled in exchange coverage will have a one-time opportunity to enroll or reenroll in a PEBB health plan by submitting the required forms and evidence of continuous enrollment ~~((in such coverage))~~ to the PEBB program:

(i) During the PEBB annual open enrollment period. The required forms 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

(ii) When exchange coverage ends. The required forms and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after ~~((such))~~ coverage ends. PEBB health plan coverage begins the first day of the month after exchange coverage ends.

(e) ~~((Retirees))~~ A subscriber who defers enrollment while enrolled as a retiree or dependent of a retiree in CHAMPVA will have a one-time opportunity to enroll in a PEBB health plan by submitting the required forms and evidence of continuous enrollment to the PEBB program:

(i) During the PEBB annual open enrollment period. The required forms 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

(ii) When CHAMPVA coverage ends. The required forms and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after coverage ends. PEBB health plan coverage begins the first day of the month after CHAMPVA coverage ends.

(f) A subscriber who defers enrollment may enroll in a PEBB health plan if ~~((the retiree))~~ they receive ~~((s))~~ formal notice that the authority has determined it is more cost-effective to enroll ~~((the retiree or the retiree's))~~ them or their eligible dependents in PEBB medical than a medical assistance program.

(g) If a subscriber 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 subscriber.

Exception:

If a subscriber selects a medicare supplement plan, nonmedicare enrollees will be enrolled in the Uniform Medical Plan (UMP) Classic. If a subscriber selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees.

(7) ~~((Retirees))~~ An enrolled retiree or a survivor who requests to voluntarily terminate their enrollment in a PEBB ~~((retiree insurance coverage))~~ health plan must do so in writing. The written termination request must be received by the PEBB program. A retiree ~~((s))~~ or a survivor who voluntarily terminates their enrollment in a PEBB ~~((retiree insurance coverage))~~ health plan also terminates enrollment for all eligible dependents. Once coverage is terminated, a retiree or a survivor may not enroll again in the future unless they reestablish eligibility for PEBB insurance coverage by becoming newly eligible. Enrollment in a PEBB ~~((insurance coverage))~~ health plan will ~~((end))~~ terminate on the last day of the month in which the PEBB program receives the termination request. If the termination request is received on the first day of the month, enrollment in a PEBB ~~((insurance coverage))~~ health plan will ~~((end))~~ terminate on the last day of the previous month.

Exception:

When a ~~((member))~~ subscriber or their dependent is enrolled in a medicare advantage plan, then enrollment in a PEBB ~~((insurance coverage will end))~~ health plan will terminate on the last day of the month when the medicare advantage plan disenrollment form is received.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-207 When can a retiree or an eligible dependent's public employees benefits board (PEBB) insurance coverage be ~~((can-eeled))~~ terminated by the health care authority (HCA)? A retiree or an eligible dependent's public employees benefits board (PEBB) insurance coverage can be terminated by the health care authority (HCA) for the following reasons:

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

(2) Knowingly providing false information;

(3) Failure to pay the monthly premium or applicable premium surcharge when due as described in WAC 182-08-180 (1)~~((+b))~~ (c);

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

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

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

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

AMENDATORY SECTION (Amending WSR 16-20-080, filed 10/4/16, effective 1/1/17)

WAC 182-12-208 What are the requirements regarding enrollment in dental under public employees benefits board (PEBB) retiree insurance coverage? The following provisions apply to a subscriber and ~~((his or her))~~ their dependents enrolled under public employees benefits board (PEBB) retiree insurance coverage:

(1) A subscriber ~~((and his or her dependents))~~ enrolling in dental must meet procedural and eligibility requirements ~~((as described in WAC 182-12-171(1) and 182-12-262) and eligibility requirements (as described in WAC 182-12-171(2) and 182-12-260))~~ under one of the following: WAC 182-12-171, 182-12-180, 182-12-200, 182-12-205, 182-12-211, 182-12-250, 182-12-262, or 182-12-265. The subscriber's dependents must meet eligibility criteria as described in WAC 182-12-250 or 182-12-260.

(2) A subscriber and ~~((his or her))~~ their dependents must be enrolled in medical to enroll in dental. If a subscriber elects to enroll dependents in PEBB dental coverage, the dependents must be enrolled in the same PEBB dental plan as the subscriber.

(3) A subscriber enrolling in dental must stay enrolled for at least two years before dental can be dropped unless ~~((he or she))~~ they defer~~((s))~~ or terminate medical and dental coverage as described in

WAC 182-12-200 or 182-12-205, or drops dental as described in subsection (4) of this section.

(4) A subscriber enrolled in PEBB dental who becomes eligible for, and enrolls in, employer-based group dental as an employee or the dependent of an employee, or such coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA), or continuation coverage may drop PEBB dental, before completing the two-year enrollment requirement. Coverage will end on the last day of the month in which the required form is received by the PEBB program. If that day is the first of the month, the change in enrollment will be made the last day of the previous month.

(a) A subscriber may enroll, terminate, or change their election in PEBB dental 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. The change in PEBB dental begins January 1st of the following year.

(b) A subscriber may enroll in PEBB dental after ~~((his or her))~~ their employer-based group dental or such coverage under COBRA coverage or continuation coverage ends. The required form must be received by the PEBB program no later than sixty days after such coverage ends. PEBB dental begins the first day of the month after the employer-based group dental coverage or continuation coverage under COBRA ends.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-209 Who is eligible for retiree term life insurance?

Eligible employees who participate in public employees benefits board (PEBB) life insurance as an employee and meet qualifications for PEBB retiree insurance coverage as provided in WAC 182-12-171 or 182-12-180 are eligible for ~~((PEBB))~~ retiree term life insurance. They must submit the required forms to the PEBB program. Forms for a retiring employee as described in WAC 182-12-171, must be received by the PEBB program no later than sixty days after the date their PEBB employee life insurance ends. Forms for an official leaving public office as described in WAC 182-12-180, must be received by the PEBB program no later than sixty days after the official leaves public office.

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

(2) Retirees may not defer enrollment in retiree term life insurance, except as allowed in subsection (3)(b) of this section.

(3) If a retiree returns to active employment status and becomes eligible for the employer contribution toward PEBB employee life insurance, ~~((he or she))~~ they may choose:

(a) To continue to self-pay premiums and keep retiree term life insurance, the employee must pay retiree term life insurance premiums directly to the contracted vendor during the period ~~((he or she is))~~ they are eligible for PEBB employee life insurance; or

(b) To stop self-paying retiree term life insurance premiums during the period ~~((he or she is))~~ they are eligible for PEBB employee life insurance and reelect retiree term life insurance when ~~((he or she is))~~ they are no longer eligible for the employer contribution toward PEBB employee life insurance.

WAC 182-12-211 May an employee who is determined to be retroactively eligible for disability retirement enroll in public employees benefits board (PEBB) retiree insurance coverage? (1) An employee who is determined to be retroactively eligible for a disability retirement is eligible to enroll or defer enrollment (as described in WAC 182-12-200 or 182-12-205) in public employees benefits board (PEBB) retiree insurance coverage if:

(a) The employee submits the required form and a copy of the formal determination letter (~~(he or she)~~) they received from the Washington state department of retirement systems (DRS) or the appropriate higher education authority;

(b) The employee's form and a copy of (~~(his or her)~~) their Washington state-sponsored retirement system's formal determination letter are received by the PEBB program no later than sixty days after the date on the determination letter; and

(c) The employee immediately begins to receive a monthly pension benefit or a supplemental retirement plan benefit under (~~(his or her)~~) their higher education retirement plan (HERP), with exceptions described (~~(in)~~) below from WAC 182-12-171(2)(~~(+a)-~~):

(i) A retiring employee of a state agency, Washington state school district, Washington state educational service district, Washington state charter school, or an employer group participating under a Washington state sponsored retirement plan, who receives a lump sum payment instead of a monthly retirement plan payment is only eligible if the department of retirement systems offered the employee the choice between a lump sum actuarially equivalent payment and the ongoing monthly payment, as allowed by the plan; or

(ii) A retiring employee of a state agency, Washington state school district, Washington state educational service district, Washington state charter school, or an employer group participating under a Washington state sponsored retirement plan, who is a member of a Plan 3 retirement plan, also called a separated employee (defined in RCW 41.05.011(25)), must meet their Plan 3 retirement eligibility criteria. The employee does not have to receive a retirement plan payment to enroll in PEBB retiree insurance coverage; or

(iii) A retiring employee of a Washington higher education institution who is a member of a higher education retirement plan (HERP) must immediately begin to receive a monthly retirement plan payment, or meet their HERP plan's retirement eligibility criteria, or be at least age fifty-five with ten years of state service.

(2) Premiums and applicable premium surcharges are due from the effective date of enrollment in PEBB retiree insurance coverage. The employee, at (~~(his or her)~~) their option, must indicate the effective date of PEBB retiree insurance coverage on the form. The employee may choose from the following dates:

(a) The employee's retirement date as stated in the formal determination letter; or

(b) The first day of the month following the date the formal determination letter was written.

(3) The director may make an exception to the date PEBB retiree insurance coverage begins; however, such request must demonstrate extraordinary circumstances beyond the control of the retiree.

(4) If a retiring employee 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 retiring employee.

Exception:

If a retiring employee selects a medicare supplement plan, nonmedicare enrollees will be enrolled in the Uniform Medical Plan (UMP) Classic. If a retiring employee selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-250 Public employees benefits board (PEBB) insurance coverage eligibility for survivors of emergency service personnel killed in the line of duty. Surviving spouses, state registered domestic partners, and dependent children of emergency service personnel who are killed in the line of duty are eligible to enroll or defer enrollment in public employees benefits board (PEBB) retiree insurance coverage.

(1) This section applies to the surviving spouse, the surviving state registered domestic partner, and dependent children of emergency service personnel "killed in the line of duty" as determined by the Washington state department of labor and industries.

(2) "Emergency service personnel" means law enforcement officers and firefighters as defined in RCW 41.26.030, members of the Washington state patrol retirement fund as defined in RCW 43.43.120, and reserve officers and firefighters as defined in RCW 41.24.010.

(3) "Surviving spouse, state registered domestic partner, and dependent children" means:

(a) A lawful spouse;

(b) An ex-spouse as defined in RCW 41.26.162;

(c) A state registered domestic partner as defined in RCW 26.60.020(1); and

(d) Children. The term "children" includes children of the emergency service worker up to age twenty-six. Children with disabilities as defined in RCW 41.26.030(6) are eligible at any age. "Children" is defined as:

(i) Biological children (including the emergency service worker's posthumous children);

(ii) Stepchildren or children of a state registered domestic partner;

(iii) Legally adopted children;

(iv) Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child;

(v) Children specified in a court order or divorce decree; or

(vi) Children as defined in RCW (~~26.26.101~~) 26.26A.100.

(4) Surviving spouses, state registered domestic partners, and children who are entitled to medicare must enroll in both Parts A and B of medicare.

(5) The survivor (or agent acting on (~~his or her~~)) their behalf) must submit the required forms to the PEBB program to either enroll or defer enrollment in PEBB retiree insurance coverage as described in subsection (7) of this section. The forms must be received by the PEBB program no later than one hundred eighty days after the later of:

(a) The death of the emergency service worker;

(b) The date on the letter from the department of retirement systems or the board for volunteer firefighters and reserve officers that informs the survivor that (~~he or she is~~) they are determined to be an eligible survivor;

(c) The last day the surviving spouse, state registered domestic partner, or child was covered under any health plan through the emergency service worker's employer; or

(d) The last day the surviving spouse, state registered domestic partner, or child was covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage from the emergency service worker's employer.

(6) Survivors who do not choose to defer enrollment in PEBB retiree insurance coverage may choose among the following options for when their enrollment in a PEBB health plan will begin:

(a) June 1, 2006, for survivors whose required forms are received by the PEBB program no later than September 1, 2006;

(b) The first of the month that is not earlier than sixty days before the date that the PEBB program receives the required forms (for example, if the PEBB program receives the required forms on August 29, the survivor may request health plan enrollment to begin on July 1st); or

(c) The first of the month after the date that the PEBB program receives the required forms.

For surviving spouses, state registered domestic partners, and children who enroll, monthly health plan premiums and applicable premium surcharges must be paid by the survivor as described in WAC 182-08-180 (1)(~~(b)~~) (c) except as provided in RCW 41.26.510(5) and 43.43.285 (2)(b).

(7) Survivors must choose one of the following two options to maintain eligibility for PEBB retiree insurance coverage:

(a) Enroll in a PEBB health plan:

(i) Enroll in medical; or

(ii) Enroll in medical and dental.

(iii) Survivors enrolling in dental must stay enrolled for at least two years before dental can be dropped, unless they defer medical and dental coverage as described in WAC 182-12-205, or drop dental as described in WAC 182-12-208(4).

(iv) Dental only is not an option.

(b) Defer enrollment:

(i) Survivors may defer enrollment in a PEBB health plan if continuously enrolled in (~~either~~) qualifying coverage as described in WAC 182-12-205(~~(+2)~~) (3).

(ii) Survivors may enroll in a PEBB health plan as described in WAC 182-12-205(~~(+4)~~) (6) when they lose other coverage. Survivors must provide evidence that they were continuously enrolled in (~~either such coverage~~) one or more qualifying coverages as described in WAC 182-12-205 (3)(a) through (e) when enrolling in a PEBB health plan. The required form and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after such coverage ends.

(iii) PEBB health plan enrollment and premiums will begin the first day of the month following the day that the other coverage ended for eligible spouses and children who enroll.

(8) Survivors may change their health plan during the annual open enrollment. In addition to the annual open enrollment, survivors may change health plans as described in WAC 182-08-198.

(9) Survivors will lose their right to enroll in PEBB retiree insurance coverage if they:

(a) Do not apply to enroll or defer PEBB health plan enrollment within the timelines as described in subsection (5) of this section; or

(b) Do not maintain continuous enrollment in other qualifying coverage during the deferral period, as described in subsection (7)(b)(i) of this section.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-260 Who are eligible dependents? To be enrolled in a health plan, a dependent must be eligible under this section and the subscriber must comply with enrollment procedures outlined in WAC 182-12-262.

The public employees benefits board (PEBB) program verifies the eligibility of all dependents and will request documents from subscribers that provide evidence of a dependent's eligibility. The PEBB program reserves the right to review a dependent's eligibility at any time. The PEBB program will remove a subscriber's enrolled dependents from health plan enrollment if the PEBB program is unable to verify a dependent's eligibility. The PEBB program will not enroll or reenroll dependents into a health plan if the PEBB program is unable to verify a dependent's eligibility.

The subscriber must notify the PEBB program, in writing, when ~~((his or her))~~ their dependent is not eligible under this section. The notification must be received by the PEBB program no later than sixty days after the date ~~((his or her))~~ their dependent is no longer eligible under this section. See WAC 182-12-262 (2)(a) for the consequences of not removing an ineligible dependent from PEBB insurance coverage.

The following are eligible as dependents:

(1) ~~((Lawful))~~ Legal spouse. Former spouses are not eligible dependents upon finalization of a divorce or annulment, even if a court order requires the subscriber to provide health insurance for the former spouse.

(2) State registered domestic partner. State registered domestic partner as defined in RCW 26.60.020(1) and substantially equivalent legal unions from other jurisdictions as defined in RCW 26.60.090. Former state registered domestic partners are not eligible dependents upon dissolution or termination of a partnership, even if a court order requires the subscriber to provide health insurance for the former partner.

(3) Children. Children are eligible through the last day of the month in which their twenty-sixth birthday occurred except as described in ~~((+i))~~ (h) of this subsection. Children are defined as the subscriber's:

(a) Children based on establishment of a parent-child relationship as described in RCW ~~((26.26.101))~~ 26.26A.100, except when parental rights have been terminated;

~~((Biological children, where parental rights have not been terminated;~~

~~((Stepchildren.))~~ Children of the subscriber's spouse, based on the spouse's establishment of a parent-child relationship, except when

parental rights have been terminated. The stepchild's relationship to a subscriber (and eligibility as a ((PEBB)) dependent) ends(~~(, for purposes of this rule,)~~) on the same date the marriage with the spouse ends through divorce, annulment, dissolution, termination, or death;

~~((d) Legally adopted))~~ (c) Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of the child;

~~((e))~~ (d) Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child;

~~((f))~~ (e) Children of the subscriber's state registered domestic partner, based on the state registered domestic partner's establishment of a parent-child relationship, except when parental rights have been terminated. The child's relationship to the subscriber (and eligibility as a ((PEBB)) dependent) ends(~~(, for purposes of this rule,)~~) on the same date the subscriber's legal relationship with the state registered domestic partner (~~as defined in RCW 26.60.020(1)~~) ends through divorce, annulment, dissolution, termination, or death;

~~((g))~~ (f) Children specified in a court order or divorce decree for whom the subscriber has a legal obligation to provide support or health care coverage;

~~((h))~~ (g) Extended dependent((s)) in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or subscriber's state registered domestic partner. The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. ("Children") Extended dependent child does not include a foster (~~children for whom support payments are made to the subscriber through the state department of social and health services foster care program~~) child unless the subscriber, the subscriber's spouse, or the subscriber's state registered domestic partner has assumed a legal obligation for total or partial support in anticipation of adoption; and

~~((i))~~ (h) Children of any age with a developmental ((disability)) or physical ((handicap)) disability that renders the child incapable of self-sustaining employment and chiefly dependent upon the subscriber for support and maintenance provided such condition occurs before the age twenty-six:

(i) The subscriber must provide ((evidence)) proof of the disability (~~and evidence that the condition occurred before~~) and dependency within sixty days of the child's attainment of age twenty-six;

(ii) The subscriber must agree to notify the PEBB program, in writing, (~~when his or her dependent is not eligible under this section. The notification must be received by the PEBB program~~) no later than sixty days after the date that ((a)) the child (~~age twenty-six or older~~) is no longer ((qualifies)) eligible under this subsection;

(iii) A child with a developmental ((disability)) or physical ((handicap)) disability who becomes self-supporting is not eligible under this subsection as of the last day of the month in which ((he or she)) they become((s)) capable of self-support;

(iv) A child with a developmental ((disability)) or physical ((handicap)) disability age twenty-six and older who becomes capable of self-support does not regain eligibility under (i) of this subsection if ((he or she)) they later become((s)) incapable of self-support;

(v) The PEBB program with input from the applicable contracted vendor will periodically ((certify)) verify the eligibility of a dependent child with a disability beginning at age twenty-six, but no

more frequently than annually after the two-year period following the child's twenty-sixth birthday, which may require renewed proof from the subscriber.

(4) Parents.

(a) Parents covered under PEBB medical before July 1, 1990, may continue enrollment on a self-pay basis as long as:

(i) The parent maintains continuous enrollment in PEBB medical;

(ii) The parent qualifies under the Internal Revenue Code as a dependent of the subscriber;

(iii) The subscriber continues enrollment in PEBB insurance coverage; and

(iv) The parent is not covered by any other group medical plan.

(b) Parents eligible under this subsection may be enrolled with a different health plan than that selected by the subscriber. Parents may not add additional dependents to their PEBB insurance coverage.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-262 When may subscribers enroll or remove eligible dependents? (1) **Enrolling dependents in public employees benefits board (PEBB) benefits.** A dependent must be enrolled in the same health plan coverage as the subscriber, and the subscriber must be enrolled to enroll (~~his or her~~) their dependent except as provided in WAC 182-12-205 ((+2)) (3)(c). 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 public employees benefits board (PEBB) benefits. If eligibility is verified and the dependent is enrolled, the dependent's effective date will be the same as the subscriber's effective date, except if the employee enrolls a newborn child in optional dependent life insurance. The newborn child's dependent life insurance coverage will be effective on the date the child becomes fourteen days old.

(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. (~~The subscriber must satisfy the enrollment requirements as described in subsection (4) of this section.~~)

(2) **Removing dependents from a subscriber's health plan coverage.**

(a) **A dependent's eligibility for enrollment in health plan coverage ends the last day of the month the dependent** meets the eligibility criteria as described in WAC 182-12-250 or 182-12-260. Employees must notify their employing agency when a dependent is no longer eligible. All other subscribers must notify the PEBB program when a dependent is no longer eligible. Consequences for not submitting notice within sixty days of the last day of the month the dependent loses eligibility for health plan coverage may include, but are not limited to:

(i) The dependent may lose eligibility to continue health plan coverage under one of the continuation coverage options described in WAC 182-12-270;

(ii) The subscriber may be billed for claims paid by the health plan for services that were rendered after the dependent lost eligibility;

(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 dependents:**

(i) During the annual open enrollment. The dependent will be removed the last day of December; or

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

(c) **Retirees, survivors, and enrollees with PEBB continuation coverage as described in WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, or 182-12-148 may remove dependents** from their PEBB insurance coverage outside of the annual open enrollment or a special open enrollment by providing written notice to the PEBB program. (~~Unless otherwise approved by the PEBB program,~~) The dependent will be removed from the subscriber's PEBB insurance coverage prospectively. PEBB insurance coverage will end on the last day of the month in which the written notice is received by the PEBB program. If the written notice is received on the first day of the month, coverage will end on the last day of the previous month.

(3) **Special open enrollment.**

(a) Subscribers may enroll or remove their dependents outside of the annual open enrollment if a special open enrollment event occurs. The change in enrollment must 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 subscriber, the subscriber's dependents, or both.

(i) 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.

(ii) Enrollment of an extended dependent or a dependent with a disability will be the first day of the month following eligibility certification.

(iii) The dependent will be removed from the subscriber's health plan coverage 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, 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, health plan coverage will begin or end as follows:

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

- For a newly adopted child, 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, 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 health plan coverage the last day of the month in which the event occurred;

A newly born child must be at least fourteen days old before optional dependent life insurance coverage purchased by the employee becomes effective.

Any one of the following events may create a special open enrollment:

(b) Subscriber acquires a new dependent due to:

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

(ii) Birth, adoption, or when a 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.

(c) 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);

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

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

Exception: For the purposes of special open enrollment "employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 54.9801-6.

(f) 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;

(g) 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;

(h) A court order ~~((or national medical support notice (see also WAC 182-12-263)))~~ 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);

(i) Subscriber or a subscriber's dependent becomes entitled to 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;

(j) Subscriber or a subscriber's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from medicaid or a state children's health insurance program (CHIP).

(4) Enrollment requirements. A subscriber must submit the required forms within the time frames described in this subsection. Employees submit the required forms to their employing agency. All other subscribers 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.

(a) If a subscriber wants to enroll ~~((his or her))~~ their eligible dependents when the subscriber becomes eligible to enroll in PEBB benefits, the subscriber must include the dependent's enrollment information on the required forms that the subscriber submits within the rel-

evant time frame described in WAC 182-08-197, 182-08-187, 182-12-171, or 182-12-250.

(b) If a subscriber wants to enroll eligible dependents 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 sixty days after the dependent becomes eligible except as provided in (d) of this subsection.

(d) If a subscriber wants to enroll a newborn or child whom the subscriber has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption, the subscriber should notify the PEBB program by submitting the required form as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the required form must be received no later than twelve months after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption.

(e) If the subscriber wants to enroll a child age twenty-six or older as a child with a disability, the required forms must be received no later than sixty days after the last day of the month in which the child reaches age twenty-six or within the relevant time frame described in WAC 182-12-262 (4)(a), (b), and (f). To recertify an enrolled child with a disability, the required forms must be received by the PEBB program or contracted vendor by the child's scheduled PEBB coverage termination date.

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

AMENDATORY SECTION (Amending WSR 15-22-099, filed 11/4/15, effective 1/1/16)

WAC 182-12-263 National Medical Support Notice (NMSN). When a National Medical Support Notice (NMSN) requires a subscriber to provide health plan coverage for a dependent child the following provisions apply:

(1) The subscriber may enroll (~~(his or her)~~) their dependent child and request changes to (~~(his or her)~~) their health plan coverage as described under subsection (3) of this section. Employees submit the required forms to their employing agency. All other subscribers submit the required forms to the public employees benefits board (PEBB) program.

(2) If the subscriber fails to request enrollment or health plan coverage changes as directed by the NMSN, the employing agency or the PEBB program may make enrollment or health plan coverage changes according to subsection (3) of this section upon request of:

(a) The child's other parent; or

(b) Child support enforcement program.

(3) Changes to health plan coverage or enrollment are allowed as directed by the NMSN:

(a) The dependent will be enrolled under the subscriber's health plan coverage as directed by the NMSN;

(b) An employee who has waived PEBB medical under WAC 182-12-128 will be enrolled in medical as directed by the NMSN, in order to enroll the dependent;

(c) The subscriber's selected health plan will be changed if directed by the NMSN;

(d) If the dependent is already enrolled under another PEBB subscriber, the dependent will be removed from the other health plan coverage and enrolled as directed by the NMSN.

(e) If the subscriber is eligible for and elects COBRA or other continuation coverage, the NMSN will be enforced and the dependent must be covered in accordance with the NMSN.

(4) Changes to health plan coverage or enrollment as described in subsection (3)(a) through (c) of this section will begin the first day of the month following receipt of the NMSN. If the NMSN is received on the first day of the month, the change to health plan coverage or enrollment begins on that day. A dependent will be removed from the subscriber's health plan coverage as described in subsection (3)(d) of this section the last day of the month the NMSN 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.

(5) The subscriber may be eligible to make changes to ~~((his or her))~~ their health plan enrollment and salary reduction elections ~~((during a special open enrollment))~~ related to the NMSN as described in WAC 182-08-198(2), 182-08-199(3), 182-12-128(4), or 182-12-262(3).

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-265 What options for continuing health plan enrollment are available to ~~((widows, widowers and dependent children))~~ a surviving spouse, state registered domestic partner, or child, if the employee or retiree dies? The ~~((dependent))~~ survivor of an eligible employee or retiree who meets the eligibility criteria and submits the required forms as described in subsection (1), (2), or (3) of this section is eligible to enroll or defer enrollment as a survivor under public employees benefits board (PEBB) retiree insurance coverage. ~~((An eligible survivor must submit the required forms to enroll or defer enrollment in PEBB retiree insurance coverage. The forms must be received by the PEBB program no later than sixty days after the date of the employee's or retiree's death. The dependent's))~~ If enrolling in PEBB retiree insurance coverage, the survivor's first premium payment and applicable premium surcharge is due to the health care authority (HCA) no later than forty-five days after the ~~((dependent's election is received by the HCA))~~ election period ends as described in subsection (1), (2), or (3) of this section. Following the ~~((dependent's))~~ survivor's first premium payment, premiums and applicable premium surcharges must be paid as described in WAC 182-08-180 (1)~~((b))~~ (c).

(1) An employee's spouse, state registered domestic partner, or child who loses eligibility due to the death of an eligible employee may enroll or defer enrollment as a survivor under PEBB retiree insurance coverage provided they immediately begin receiving a monthly retirement benefit from any state of Washington sponsored retirement system. To satisfy the requirement to immediately receive a monthly

retirement benefit they must begin receiving monthly benefit payments no later than one hundred twenty days from the date of death of the employee. The required forms to enroll or defer enrollment must be received by the PEBB program no later than sixty days after the later of the date of the employee's death or the date the survivor's PEBB insurance coverage ends.

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

(b) The employee's children may continue health plan enrollment until they lose eligibility as described in WAC 182-12-260.

Notes: If a spouse, state registered domestic partner, or child of an eligible employee is not eligible for a monthly retirement benefit, ~~((the dependent is))~~ they are not eligible to enroll as a survivor under PEBB retiree insurance coverage. However, ~~((the dependent))~~ they may continue health plan enrollment as described in WAC 182-12-146. Eligibility for the surviving spouse, surviving state registered domestic partner, or surviving child of an employee of a participating employer group will cease at the end of the month in which the group's contract with the authority ends unless the employer group is a school district, educational service district, or charter school. Eligibility for the surviving spouse, surviving state registered domestic partner, or surviving child of an elected ~~((or))~~ and full-time appointed official of the legislative ~~((or))~~ and executive branches of state government is described in WAC 182-12-180.

(2) A retiree's spouse, state registered domestic partner, or child who loses eligibility due to the death of an eligible retiree may enroll or defer enrollment as a survivor under PEBB retiree insurance coverage. The required forms to enroll or defer enrollment must be received by the PEBB program no later than sixty days after the retiree's death.

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

(b) The retiree's children may continue health plan enrollment until they lose eligibility as described in WAC 182-12-260.

(c) If a spouse, state registered domestic partner, or child of an eligible retiree is not enrolled in a PEBB health plan at the time of the retiree's death, the ~~((dependent))~~ survivor is eligible to enroll or defer enrollment as a survivor under PEBB retiree insurance coverage. ~~((The dependent must submit the required form(s) to enroll or defer PEBB health plan enrollment.))~~ The required forms to enroll or defer enrollment must be received by the PEBB program no later than sixty days after the retiree's death. To enroll in a PEBB health plan, the ~~((dependent))~~ survivor must provide evidence of continuous enrollment in medical coverage from the most recent open enrollment for which the ~~((dependent))~~ survivor was not enrolled in a PEBB medical plan prior to the retiree's death.

Note: Eligibility for the surviving spouse, surviving state registered domestic partner, or surviving child of an employer group retiree will cease at the end of the month in which the group's contract with the authority ends unless the employer group is a school district, educational service district, or charter school.

(3) The spouse, state registered domestic partner, or child of a deceased school district, educational service district, or a charter school employee is eligible to enroll or defer enrollment as a survivor under PEBB retiree insurance coverage at the time of the employee's death provided the employee died on or after October 1, 1993. The ~~((dependent))~~ survivor must immediately begin receiving a retirement benefit allowance under chapter 41.32, 41.35 or 41.40 RCW ~~((and submit the required form to enroll or defer enrollment in PEBB retiree insurance coverage))~~. The required forms to enroll or defer enrollment must be received by the PEBB program no later than sixty days after the later of the date of the employee's death or the date the survivor's school district coverage, educational service district coverage, or charter school coverage ends.

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

(b) The employee's children may continue health plan enrollment until they lose eligibility as described in WAC 182-12-260.

(4) If a premium and applicable premium surcharge received by the ~~((authority))~~ HCA is sufficient as described in WAC 182-08-180 (1) ~~((e))~~ (d)(ii) to maintain PEBB health plan enrollment after the employee's or retiree's death, the PEBB program will consider the payment as notice of the survivor's intent to continue enrollment.

If the ~~((dependent's))~~ survivor's enrollment ended due to the death of the employee or retiree, the PEBB program will reinstate the survivor's enrollment without a gap subject to payment of premium and applicable premium surcharge.

(5) If 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 survivor.

Exception: If a survivor selects a medicare supplement plan, nonmedicare enrollees will be enrolled in the Uniform Medical Plan (UMP) Classic. If a survivor selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees.

(6) In order to avoid duplication of group medical coverage, ~~((surviving dependents))~~ a survivor may defer enrollment in a PEBB health plan as described in WAC 182-12-200 and 182-12-205.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-270 What options for continuation coverage are available to dependents who cease to meet the eligibility criteria as described in WAC 182-12-260? If eligible, dependents may continue health plan enrollment under one of the continuation coverage options in subsection (1) or (2) of this section by self-paying the premiums and applicable premium surcharges set by the health care authority (HCA), with no contribution from the employer, following their loss of eligibility under the subscriber's health plan coverage. The dependent's first premium payment and applicable premium surcharge is due to the HCA no later than forty-five days after the ~~((dependent's election is received by the HCA))~~ election period ends as described in WAC 182-12-146, 182-12-180, 182-12-250, or 182-12-265, whichever applies. Following the employee's first premium payment, the dependent must pay premium and applicable premium surcharge amounts associated with PEBB insurance coverage as premiums and applicable premium surcharges become due. If the monthly premium or applicable premium surcharge remain unpaid for sixty days from the original due date, PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharge was paid as described in WAC 182-08-180 (1)~~((b))~~ (c). The ~~((public employees benefits board (PEBB)))~~ PEBB program must receive the required forms as outlined in the *PEBB Initial Notice of COBRA and Continuation Coverage Rights*. Options for continuing health plan enrollment are based on the reason that eligibility was lost.

(1) Spouses, state registered domestic partners, or children who lose eligibility due to the death of an employee or retiree may be eligible to continue health plan enrollment as described in WAC 182-12-180, 182-12-250, or 182-12-265; or

(2) Dependents who lose eligibility because they no longer meet the eligibility criteria as described in WAC 182-12-260 are eligible

to continue health plan enrollment under provisions of the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). See WAC 182-12-146 for more information on COBRA.

(Exception: ~~A dependent who loses eligibility because a state registered domestic partnership is dissolved may continue health plan enrollment under PEBB continuation coverage for a maximum of thirty-six months.)~~)

Note: Based on RCW 26.60.015 and public employees benefits board policy resolution that extended PEBB coverage for dependents not otherwise eligible for COBRA, an employee's state registered domestic partner and the state registered partner's children may continue PEBB insurance coverage on the same terms and conditions as spouses and other eligible dependents under COBRA.

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

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-300 Public employees benefits board (PEBB) wellness incentive program eligibility and procedural requirements. The public employees benefits board (PEBB) annually determines the design of the PEBB wellness incentive program.

(1) All subscribers, except PEBB subscribers who are enrolled in both medicare parts A and B, and in the medicare risk pool, are eligible to participate in the PEBB wellness incentive program.

(2) Effective January 1, 2016, to receive the PEBB wellness incentive of a reduction to the subscriber's medical plan deductible or a deposit to the subscriber's health savings account for the following plan year, eligible subscribers must complete PEBB wellness incentive program requirements during the current plan year by the latest date below:

(a) For subscribers continuing enrollment in PEBB medical and subscribers enrolling in PEBB medical with an effective date in January, February, March, April, May, or June the deadline is September 30th; or

(b) For subscribers enrolling in PEBB medical with an effective date in July or August, the deadline is one hundred twenty days from the subscriber's PEBB medical effective date; or

(c) For subscribers enrolling in PEBB medical with an effective date in September, October, November, or December, the deadline is December 31st.

(3) Subscribers who do not complete the requirements according to subsection (2) of this section, except as noted, within the time frame described are not eligible to receive a PEBB wellness incentive the following plan year.

Note: All eligible subscribers can earn a wellness incentive. Subscribers who cannot complete the wellness incentive program requirements may be able to earn the same incentive by different means. The PEBB program will work with enrollees (and their physician, if they wish) to define an individual wellness program that provides the opportunity to qualify for the same incentive in light of the enrollee's health status.

(4) Effective January 1, 2018, an eligible subscriber will receive a separate PEBB wellness incentive for completing the SmartHealth well-being assessment on or before December 31st, of the current plan year. An eligible subscriber may only earn this separate PEBB wellness incentive once per plan year. Once earned, subscribers must claim the incentive on or before December 31st of the same calendar year it was earned.

(5) PEBB wellness incentive will be provided only if:

(a) For the wellness incentive described in subsection (2) of this section the subscriber is still eligible for the PEBB wellness incentive program in the year the incentive applies;

(b) The funding rate provided by the legislature is designed to provide a PEBB wellness incentive program or a PEBB wellness incentive, or both; or

(c) Specific appropriations are provided for wellness incentives.