



PROPOSED RULE MAKING

CR-102 (December 2017) (Implements RCW 34.05.320)

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FILED

DATE: May 03, 2022

TIME: 2:06 PM

WSR 22-10-081

Agency: Health Care Authority, PEBB Admin #2022-01

Original Notice

Supplemental Notice to WSR _____

Continuance of WSR _____

Preproposal Statement of Inquiry was filed as WSR 22-04-098 ; 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); or

Proposal is exempt under RCW _____.

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

The following sections in chapter 182-08 WAC are revised:

182-08-015 Definitions.

182-08-180 Premium payments and premium refunds.

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

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 arrangement (FSA), or dependent care assistance program (DCAP)?

182-08-235 Employer group and board of directors for school districts and educational service districts application process.

The following sections in chapter 182-12 WAC are revised:

182-12-109 Definitions.

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

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?

182-12-146 When is an enrollee eligible to continue public employees benefits board (PEBB) benefits under Consolidated Omnibus Budget Reconciliation Act (COBRA)?

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

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

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

The following sections in chapter 182-16 WAC are revised or new:

182-16-020 Definitions.

182-16-058 Service or serve.

182-16-064 Applicable rules and laws.

182-16-066 Burden of proof, standard of proof, and presumptions.

182-16-2000 Brief adjudicative proceedings.

182-16-2005 Record—Brief adjudicative proceeding.

182-16-2050 How can an employee appeal a decision regarding the administration of benefits offered under the salary reduction plan?

182-16-2080 Who can appeal or represent a party in a brief adjudicative proceeding?

182-16-2085 Continuances.

182-16-2100 How to request a review of an initial order resulting from a brief adjudicative proceeding.

182-16-2105 Withdrawing the request for a brief adjudicative proceeding or review of an initial order.

182-16-2110 Final order.

182-16-2120 Request for reconsideration.

182-16-2135 Petitions for judicial review—Service on the authority. (New Section)

182-16-2150 Review officer or officers—Designation and authority.

182-16-2160 Conversion of a brief adjudicative proceeding to a formal administrative hearing.

182-16-3170 Final order deadline—Required information.

182-16-3175 How to request a review of an initial order by the office of administrative hearings. (New Section)

182-16-3210 Petitions for judicial review—Service on the authority. (New Section)

Hearing location(s):

Date:	Time:	Location: (be specific)	Comment:
June 7, 2022	10:00 AM	In response to the coronavirus disease 2019 (COVID-19) public health emergency, the Health Care Authority continues to hold public hearings virtually without a physical meeting place. This promotes social distancing and the safety of the residents of Washington State.	To attend the virtual public hearing, you must register in advance: Register in advance for this webinar: https://us02web.zoom.us/webinar/register/WN_edPzYSMR9CMXCEzVlvvWw If the link above opens with an error message, please try using a different browser. After registering, you will receive a confirmation email containing information about joining the public hearing.

Date of intended adoption: Not sooner than June 8, 2022 (Note: This is **NOT** the **effective** date)

Submit written comments to:

Name: HCA Rules Coordinator

Address: PO Box 42716, Olympia WA 98504-2716

Email: arc@hca.wa.gov

Fax: (360) 586-9727

Other:

By (date) June 7, 2022

Assistance for persons with disabilities:

Contact HCA Rules Coordinator

Phone: (360) 725-1305

Fax: (360) 586-9727

TTY: Telecommunication Relay Services (TRS): 711

Email: arc@hca.wa.gov

Other:

By (date) May 20, 2022

Purpose of the proposal and its anticipated effects, including any changes in existing rules: The purpose of this proposal is to amend some of the existing rules and to create new rules to support the Public Employees Benefits Board (PEBB) Program:

1. Make technical amendments:

- Amended WAC 182-08-187, 182-08-199, 182-12-146, and 182-16-2050 to implement limited purpose Flexible Spending Arrangement.
- Amended WAC 182-08-187 to clarify when an enrollment error is being corrected, PEBB medical and dental enrollment is effective the first day of the month following the date the enrollment error is identified,
- Amended WAC 182-08-198 to clarify that a subscriber or their dependent may change medical plans when they are no longer enrolled in a Health Savings Account.
- Amended WAC 182-08-198, 182-08-199, 182-12-128, and 182-12-262 to clarify a special open enrollment related to a subscriber's dependent has a change in their own employment status that affects their eligibility or their dependent's eligibility.
- Amended WAC 182-08-199 to include employees cannot enroll in a medical FSA or limited purpose FSA in the same year and which FSA they will be enrolled in and to provide a technical correction when an employee or an employee's dependent has a change in enrollment under an employer-based Dependent Care Assistance Program during its annual open enrollment.
- Amended WAC 182-08-235 to move the language describing the statement requirements for educational service districts and board members of school districts or educational service districts to a note.
- Amended WAC 182-12-128 to include an employee may not waive enrollment in PEBB medical if they are enrolled in PEBB retiree insurance coverage.
- Amended WAC 182-12-146 to remove a WAC citation.

- Amended WAC 182-12-262 to clarify a dependent with more than one source of eligibility for enrollment in PEBB and School Employees Benefits Board Programs is limited to a single enrollment in medical, dental, and vision plans in either program, to clarify when a National Medical Support Notice requires a subscriber to cover a dependent child in health plan coverage, clarified enrollment and disenrollment requirements for supplemental dependent life insurance or AD&D insurance, and to remove WAC references.
- Amended WAC 182-12-263 to update a WAC citation.
- Amended WAC 182-12-300 to clarify the wellness incentive's eligibility.
- Made global amendments in chapter 182-16 WAC to update the use of reviewing officer or officers.

2. Amend rules to improve the administration of the PEBB Program:

- Amended WAC 182-08-015 and 182-12-109 to update the definitions of annual open enrollment, life insurance, salary reduction plan, special open enrollment, and to create a new definition of limited purpose flexible spending arrangement or limited purpose FSA.
- Amended WAC 182-08-180 to include an employee who is on a leave of absence and maintains eligibility for the employer contribution will have their premiums waived for their employee-paid long-term disability insurance for the first 90 days.
- Amended WAC 182-12-114 to include an exception for seasonal employees who work a recurring, annual season with a duration of less than nine months are not eligible for the employee-paid LTD benefits.
- Amended WAC 182-12-262 to include a notification requirement for subscribers when a dependent is no longer eligible for supplemental dependent life insurance or AD&D insurance coverage and methods of submitting a request to remove an eligible dependent from supplemental dependent life insurance or AD&D insurance coverage.
- Amended WAC 182-16-020 to update the definitions of life insurance and salary reduction plan, and to create a new definition of limited purpose flexible spending arrangement or limited purpose FSA.
- Amended WAC 182-16-058 to clarify when service is complete.
- Amended WAC 182-16-066 to use preponderance of the evidence instead of substantial evidence when addressing presumptions.
- Amended WAC 182-16-2000 to clarify the authority may use the brief adjudicative proceedings for issues identified in the chapter.
- Amended WAC 182-16-2100 to include both the appellant and the authority may request review of an initial order and the appellant may request review of the initial order by filing a written request or making an oral request with the PEBB appeals unit.
- Created WAC 182-16-2135 to address petitions for judicial review – service on the authority.
- Amended WAC 182-16-2150 to include a reviewing officer or officers must make any inquiries necessary to ascertain whether the proceeding must be converted to a formal administrative hearing, and to remove the reviewing officer or officers will issue a final order that will convert the matter to a formal administrative hearing.
- Amended WAC 182-16-2160 to clarify the presiding officer or the reviewing officer or officers may convert a brief adjudicative proceeding to a formal administrative hearing at any time before the final order is issued on motion by the appellant and their representative and reviewing officer or officers.
- Amended WAC 182-16-3170 to include required information when the Office of Administrative Hearings is holding a formal administrative hearing on behalf of the authority and to clarify the final order will only be issued by the authority.
- Created WAC 182-16-3175 on how to request a review of an initial order issued by the office of administrative hearings.
- Created WAC 182-16-3210 to address petitions for judicial review-Service on the authority.

Reasons supporting proposal: See purpose statement.

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Statute being implemented: RCW 41.05.021, 41.05.160

Is rule necessary because of a:

Federal Law?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Federal Court Decision?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
State Court Decision?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

If yes, CITATION: 26 U.S.C. Sec. 125

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

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	PO Box 42716, Olympia WA 98504-2716	360-725-0883
Implementation:	Barbara Scott	PO Box 42716, Olympia WA 98504-2716	360-725-0830
Enforcement:	Jean Bui	PO Box 42716, Olympia WA 98504-2716	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:
- | | |
|---|--|
| <input type="checkbox"/> RCW 34.05.310 (4)(b)
(Internal government operations) | <input type="checkbox"/> RCW 34.05.310 (4)(e)
(Dictated by statute) |
| <input type="checkbox"/> RCW 34.05.310 (4)(c)
(Incorporation by reference) | <input type="checkbox"/> RCW 34.05.310 (4)(f)
(Set or adjust fees) |
| <input type="checkbox"/> RCW 34.05.310 (4)(d)
(Correct or clarify language) | <input type="checkbox"/> 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:

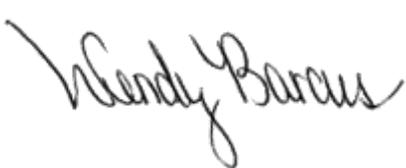
COMPLETE THIS SECTION ONLY IF NO EXEMPTION APPLIES

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. These rules do not apply to 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: May 3, 2022	Signature: 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

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

"Accidental death and dismemberment insurance" or "AD&D" means basic accidental death and dismemberment (AD&D) insurance paid for by the employing agency, as well as supplemental accidental death and dismemberment insurance offered to and paid for by employees for themselves and their dependents.

"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 by the HCA 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, enroll in coverage, or waive enrollment (see definition of "waive" in this section). Employees eligible to participate in the salary reduction plan may enroll in or change their election under the dependent care assistance program (DCAP) (~~((\oplus))~~), the medical flexible spending arrangement (FSA), or limited purpose FSA. 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, Sundays, and all state legal holidays as set forth in RCW 1.16.050.

"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 benefits available to enrollees under 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 the public employees benefits board's policies.

"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 PEBB insurance coverage 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 do-

mestic 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 employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan under chapter 41.05 RCW 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; (c) through December 31, 2019, employees of a school district or represented employees of an educational service district if the authority agrees to provide any of the school districts' or educational service 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); (f) through December 31, 2019, employees of a charter school established under chapter 28A.710 RCW; and (g) through December 31, 2023, nonrepresented employees of an educational service district. "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 HCA by a state agency or employer group for its eligible employees as described under WAC 182-12-114 and 182-12-131.

"Employer group" means those counties, municipalities, political subdivisions, the Washington health benefit exchange, tribal governments, employee organizations representing state civil service employees, and through December 31, 2019, school districts and charter schools, and through December 31, 2023, educational service districts obtaining employee benefits through a contractual agreement with the authority to participate in benefit plans developed by the public employees benefits board 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 or an employer group for employees eligible under WAC 182-12-114 and 182-12-131. It also means SEBB insurance coverage for which an employer contribution is made by a SEBB organization, or basic benefits described in RCW 28A.400.270(1) for which an employer contribution is made by 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, or other political subdivision; 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.

"Forms" or "form" means both paper forms and forms completed electronically.

"Health plan" means a plan offering medical or dental, or both, developed by the 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~~) 10 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" means basic life insurance paid for by the employing agency, as well as supplemental life insurance or supplemental dependent life insurance offered to and paid for by employees for themselves and their dependents. Life insurance for eligible retirees includes retiree term life insurance offered to and paid for by retirees.

"Limited purpose flexible spending arrangement" or "limited purpose FSA" means a benefit plan whereby eligible state employees may reduce their salary before taxes to pay for dental and vision expenses not reimbursed by insurance as provided in the salary reduction plan established under chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"Long-term disability insurance" or "LTD insurance" means employer-paid long-term disability insurance and employee-paid long-term disability insurance offered by the PEBB program.

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby eligible state employees may reduce their salary before taxes to pay for medical expenses not reimbursed by insurance as provided in the salary reduction plan established under chapter 41.05 RCW 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 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, accidental death and dismemberment 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, 182-12-180, and 182-12-211), 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 public employees may pay their share of group health plan premiums with pretax dollars as provided in the salary reduction plan under chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"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 an enrolled subscriber's spouse or state registered domestic partner choosing not to enroll in their employer-based group medical when:

- The spouse's or state registered domestic partner's share of the medical premium is less than (~~ninety-five~~) 95 percent of the additional cost an employee would be required to pay to enroll a spouse

or state registered domestic partner in the public employees benefits board (PEBB) Uniform Medical Plan (UMP) Classic; and

- The benefits have an actuarial value of at least (~~ninety-five~~) 95 percent of the actuarial value of PEBB UMP Classic benefits.

"Public employee" has the same meaning as employee.

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

"Salary reduction plan" means a benefit plan whereby public employees may agree to a reduction of salary on a pretax basis to participate in the dependent care assistance program, medical flexible spending arrangement, limited purpose flexible spending arrangement, or premium payment plan 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 (see definition of "waive" in this section). Employees eligible to participate in the salary reduction plan may enroll in or revoke their election under the DCAP, medical FSA, limited purpose 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. 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.

"State registered domestic partner" has the same meaning as defined in RCW 26.60.020(1) and substantially equivalent legal unions from other jurisdictions as defined in RCW 26.60.090.

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

"Supplemental coverage" means any life insurance or accidental death and dismemberment (AD&D) insurance coverage purchased by the employee in addition to the coverage provided by the employing agency.

"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 an eligible employee affirmatively declining enrollment in PEBB medical because the employee is enrolled in other employer-based group medical, a TRICARE plan, or medicare as allowed under WAC 182-12-128. An employee on approved educational leave who obtains another employer-based group health plan may waive enrollment as allowed under WAC 182-12-136. An employee may waive enrollment in PEBB medical to enroll in SEBB medical only if they are enrolled in SEBB dental and SEBB vision. An employee who waives enrollment in PEBB medical to enroll in SEBB medical also waives enrollment in PEBB dental.

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

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

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

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

(a) For subscribers not eligible for the employer contribution that are electing to enroll in PEBB retiree insurance coverage as described in WAC 182-12-171 (1)(a), 182-12-180 (3)(a), 182-12-200 (3)(a) or (b), 182-12-205 (6) or (7), 182-12-211, and 182-12-265; 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 surcharges are due to the health care authority (HCA) or the contracted vendor no later than (~~forty-five~~) 45 days after the election period ends as described within the Washington Administrative Code applicable to the subscriber. Premiums and applicable premium surcharges associated with continuing PEBB medical must be made to the HCA as well as premiums associated with continuing PEBB dental or long-term disability (LTD) insurance coverage. Any medicare part D late enrollment penalty associated with the medicare advantage-prescription drug plan must be made to the contracted vendor. Premiums associated with life insurance and accidental death and dismemberment (AD&D) insurance coverage must be made to the contracted vendor. Following the first premium payment, premiums and applicable premium surcharges must be paid as premiums become due.

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

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

(c) Unpaid or underpaid premiums or applicable premium surcharges for all subscribers must be paid, and are due from the employing agency, subscriber, or a subscriber's legal representative to the HCA or contacted vendor. For subscribers not eligible for the employer contribution, monthly premiums or applicable premium surcharges that remain unpaid for (~~(thirty)~~) 30 days will be considered delinquent. A subscriber is allowed a grace period of (~~(thirty)~~) 30 days from the date the monthly premiums or applicable premium surcharges become delinquent to pay the unpaid premium balance or applicable premium surcharges. If a subscriber's monthly premiums or applicable premium surcharges remain unpaid for (~~(sixty)~~) 60 days from the original due date, the subscriber's PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premiums and any applicable premium surcharges were paid. If it is determined by the HCA that payment of the unpaid balance in a lump sum would be considered a hardship, the HCA may develop a reasonable payment plan of up to (~~(twelve)~~) 12 months in duration with the subscriber or the subscriber's legal representative upon request.

Exception: For a subscriber enrolled in a medicare advantage or a medicare advantage-prescription drug plan a notice will be sent to them notifying them that they are delinquent on their monthly premiums and that the enrollment will be terminated prospectively to the end of the month after the notice is sent.

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

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

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

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

(a) When a subscriber submits an enrollment change affecting subscriber or dependent eligibility, HCA may allow up to three months of accounting adjustments. HCA will refund to the individual or the employing agency any excess premiums and applicable premium surcharges paid during the (~~(sixty)~~) 60 day 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 182-16-2010, and provides clear and convincing evidence of extraordinary circumstances, such that the subscriber could not timely submit the necessary information to accomplish an allowable enrollment change within (~~(sixty)~~) 60 days after the event that created a change of premiums, the PEBB director, the PEBB director's designee, or the PEBB appeals unit may:

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

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

(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 they were enrolled under the federal program if approved by the PEBB director or the PEBB 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 as described in WAC 182-08-187 (4) and (5).

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

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

(1) An employing agency or contracted vendor that makes one or more of the following enrollment errors must correct the error as described in subsections (2) through (5) of this section.

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

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

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

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

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

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

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

(3) Enrollment or termination.

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

(b) Basic life, basic accidental death and dismemberment (AD&D), employer-paid long-term disability (LTD) insurance, and employee-paid LTD insurance (unless the employee declines the employee-paid LTD insurance as described in WAC 182-08-197(1)) 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, basic

AD&D, employer-paid LTD insurance, and employee-paid LTD insurance begin on that date;

(c) Supplemental life, supplemental AD&D, and employee-paid 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 on 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) Supplemental life, supplemental AD&D, and employee-paid 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 employee-paid LTD insurance during the period of leave as described in WAC 182-12-133, employee-paid 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 supplemental life insurance, supplemental AD&D insurance, and employee-paid 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), limited purpose FSA, or dependent care assistance program (DCAP), enrollment is limited to (~~sixty~~) 60 days prior to the date enrollment is processed, but not earlier than the current plan year. If an employee was not enrolled in a medical FSA, limited purpose FSA, or DCAP as elected, the employee may either participate at the amount originally elected with a corresponding increase in contributions for the balance of the plan year, or participate at a reduced amount for the plan year by maintaining the per-pay period contribution in effect;

(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 benefits will be terminated prospectively effective as of the last day of the month.

(4) **Premium payments.**

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

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

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

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

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

(5) **Recourse.**

(a) 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 (3)(b), (c) and (d) of this section, the employing agency must work with the employee, and receive approval from the authority, to implement retroactive PEBB benefits within the following parameters:

(i) Retroactive enrollment in a PEBB insurance coverage;

(ii) Reimbursement of claims paid;

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

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

(v) Other legal remedy received or offered; or

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

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

AMENDATORY SECTION (Amending WSR 21-13-106, filed 6/18/21, effective 1/1/22)

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

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

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

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

Exception: When a subscriber or their dependent is enrolled in a medicare advantage or medicare advantage-prescription drug plan, they may disenroll during a special enrollment period as allowed under 42 C.F.R. Secs. 422.62(b) and 423.38(c). The new medical plan coverage will begin the first day of the month following the date the 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. If the special open enrollment is due to the enrollment of an extended dependent or a dependent with a disability, the change in health plan coverage will begin the first day of the month following the later of the event date or eligibility certification. Any one of the following events may create a special open enrollment:

(a) Subscriber acquires a new dependent due to:

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

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

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

Note: A subscriber may not change their health plan if their state registered domestic partner or state registered domestic partner's child is not a tax dependent.

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

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

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

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

(e) Subscriber or a subscriber's dependent has a change in residence that affects health plan availability. 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, otherwise there will be limited accessibility to network providers and covered services;

Exception: A dental plan is considered available if a provider is located within ~~((fifty))~~ 50 miles of the subscriber's new residence.

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

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

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

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

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

(ii) A subscriber enrolled in PEBB retiree insurance coverage or an eligible subscriber enrolled in Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage has seven months to enroll in a medicare advantage or medicare advantage-prescription drug plan that begins three months before they or their dependent first enrolled in both medicare Part A and Part B and ends three months after the month of medicare eligibility. A subscriber may also enroll themselves or their dependent in a medicare advantage or medicare advantage-prescription drug plan before their last day of the medicare Part B initial enrollment period. The forms must be received by the PEBB program no later than the last day of the month prior to the month the subscriber or the subscriber's dependent enrolls in the medicare advantage or medicare advantage-prescription drug plan.

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

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

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

(ii) Treatment following a recent organ transplant;

- (iii) A scheduled surgery;
- (iv) Recent major surgery still within the postoperative period;

or

- (v) Treatment for a high-risk pregnancy.

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

AMENDATORY SECTION (Amending WSR 20-16-062, filed 7/28/20, effective 1/1/21)

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

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

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

Notes:

1. Employees (~~enrolled~~) cannot enroll in a medical FSA and a limited purpose FSA in the same year.

2. 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~~) enrollment in the CDHP with a HSA and a medical FSA will instead be enrolled in the limited purpose FSA.

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

(3) **During a special open enrollment:** An employee who is eligible to participate in the salary reduction plan may enroll or revoke their election and make a new election under the premium payment plan, medical FSA, limited purpose FSA, or DCAP outside of the annual open enrollment if a special open enrollment event occurs. The enrollment or change in election must be allowable under Internal Revenue Code (IRC) and Treasury regulations, and correspond to and be consistent with the event that creates the special open enrollment. To make a change or enroll, the employee must submit the required form to their employing agency. The employing agency must receive the required form and evidence of the event that created the special open enrollment no later than (~~sixty~~) 60 days after the event occurs.

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

ner unless the state registered domestic partner otherwise qualifies as a dependent for tax purposes under IRC 26 U.S.C. Sec. 152.

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

(i) Employee acquires a new dependent due to:

- Marriage;
- Registering a state registered domestic partnership when the dependent is a tax dependent of the employee;
- Birth, adoption, or when the employee has assumed a legal obligation for total or partial support in anticipation of adoption; or
- A child becoming eligible as an extended dependent through legal custody or legal guardianship.

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

- Employee has a change in marital status;
- Employee's domestic partnership with a state registered domestic partner who is a tax dependent is dissolved or terminated;
- An eligible dependent child turns age (~~twenty-six~~) 26 or otherwise does not meet dependent child eligibility criteria;
- An eligible dependent ceases to be eligible as an extended dependent or as a dependent with a disability; or
- An eligible dependent dies.

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

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

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

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

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

(vii) Employee or an employee's dependent has a change in residence that affects health plan availability;

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

(ix) A court order requires the employee or any other individual to provide insurance coverage for an eligible dependent of the sub-

scriber (a former spouse or former state registered domestic partner is not an eligible dependent);

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

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

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

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

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

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

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

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

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

(i) Employee acquires a new dependent due to:

- Marriage;
- Registering a state registered domestic partnership if the domestic partner qualifies as a tax dependent of the employee;
- Birth, adoption, or when the employee has assumed a legal obligation for total or partial support in anticipation of adoption; or

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

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

• Employee has a change in marital status;

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

• An eligible dependent child turns age (~~(twenty-six)~~) 26 or otherwise does not meet dependent child eligibility criteria;

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

• An eligible dependent dies.

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

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

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

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

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

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

(i) Employee acquires a new dependent due to:

• Marriage;

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

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

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

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

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

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

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

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

AMENDATORY SECTION (Amending WSR 20-16-062, filed 7/28/20, effective 1/1/21)

WAC 182-08-235 Employer group and board of directors for school districts and educational service districts application process. This section applies to employer groups as defined in WAC 182-08-015 and board members of school districts and educational service districts. An employer group or board member of a school district or an educational service district may apply to obtain public employees benefits board (PEBB) insurance coverage through a contract with the health care authority (HCA).

(1) Employer groups and board members of school districts and educational service districts with less than (~~five hundred~~) 500 employees must apply at least (~~sixty~~) 60 days before the requested coverage effective date. Employer groups with (~~five hundred~~) 500 or more employees but with less than (~~five thousand~~) 5,000 employees must apply at least (~~ninety~~) 90 days before the requested effective date.

Employer groups with (~~five thousand~~) 5,000 or more employees must apply at least (~~one hundred twenty~~) 120 days before the requested coverage effective date. To apply, employer groups must submit the documents and information described in subsection (2) of this section to the PEBB program as follows:

(a) Board members of school districts and educational service districts and educational service districts applying for their nonrepresented employees are required to provide the documents described in subsection (2)(a) through (c) of this section;

Exception: 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~~) 5,000 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~~) 5,000 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 board members of school district or educational service district tax ID number (TIN); and

(iv) A statement of whether the group is applying to obtain only medical or all available PEBB insurance coverages. (~~Educational service districts applying for its nonrepresented employees must purchase medical, dental, life, and long-term disability insurance. Board members of school districts or educational service districts must provide a statement of whether the group is applying to obtain medical, dental, and life insurance.~~)

Note: Educational service districts applying for its nonrepresented employees must provide a statement that the group is agreeing to obtain medical, dental, life, and long-term disability insurance. Board members of school districts or educational service districts must provide a statement that the group is agreeing to obtain medical, dental, and life 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) Birth sex;

(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~~) 24 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.

(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~~) 24 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.

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

"Accidental death and dismemberment insurance" or "AD&D" means basic accidental death and dismemberment (AD&D) insurance paid for by the employing agency, as well as supplemental accidental death and dismemberment insurance offered to and paid for by employees for themselves and their dependents.

"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 by the HCA 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, enroll in coverage, or waive enrollment (see definition of "waive" in this section). Employees eligible to participate in the salary reduction plan may enroll in or change their election under the dependent care assistance program (DCAP) (~~(DCAP)~~), the medical flexible spending arrangement (FSA), or limited purpose FSA. 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, Sundays, and all state legal holidays as set forth in RCW 1.16.050.

"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 benefits available to enrollees under 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 the public employees benefits board's policies.

"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 PEBB insurance coverage 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 employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan under chapter 41.05 RCW 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; (c) through December 31, 2019, employees of a school district or represented employees of an educational service district if the authority agrees to provide any of the school districts' or educational service 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); (f) through December 31, 2019, employees of a charter school established under chapter 28A.710 RCW; and (g) through December 31, 2023, nonrepresented employees of an educational service district. "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 HCA by a state agency or employer group for its eligible employees as described under WAC 182-12-114 and 182-12-131.

"Employer group" means those counties, municipalities, political subdivisions, the Washington health benefit exchange, tribal governments, employee organizations representing state civil service employees, and through December 31, 2019, school districts and charter schools, and through December 31, 2023, educational service districts obtaining employee benefits through a contractual agreement with the authority to participate in benefit plans developed by the public employees benefits board 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 or an employer group for employees eligible in WAC 182-12-114 and 182-12-131. It also means SEBB insurance coverage for which an employer contribution is made by a SEBB organization, or basic benefits described in RCW 28A.400.270(1) for which an employer contribution is made by 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, or other political subdivision; 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.

"Forms" or "form" means both paper forms and forms completed electronically.

"Health plan" means a plan offering medical or dental, or both, developed by the 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" means basic life insurance paid for by the employing agency, as well as supplemental life insurance or supplemental dependent life insurance offered to and paid for by employees for themselves and their dependents. Life insurance for eligible retirees includes retiree term life insurance offered to and paid for by retirees.

"Limited purpose flexible spending arrangement" or "limited purpose FSA" means a benefit plan whereby eligible state employees may reduce their salary before taxes to pay for dental and vision expenses not reimbursed by insurance as provided in the salary reduction plan established under chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"Long-term disability insurance" or "LTD insurance" means employer-paid long-term disability insurance and employee-paid long-term disability insurance offered by the PEBB program.

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby eligible state employees may reduce their salary before taxes to pay for medical expenses not reimbursed by insurance as provided in the salary reduction plan established under chapter 41.05 RCW 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 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, accidental death and dismemberment 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, 182-12-180, and 182-12-211), 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 public employees may pay their share of group health plan premiums with pretax dollars as provided in the salary reduction plan under chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"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 an enrolled subscriber's spouse or state registered domestic partner choosing not to enroll in their employer-based group medical when:

- The spouse's or state registered domestic partner's share of the medical premium is less than (~~ninety-five~~) 95 percent of the ad-

ditional cost an employee would be required to pay to enroll a spouse or state registered domestic partner in the public employees benefits board (PEBB) Uniform Medical Plan (UMP) Classic; and

- The benefits have an actuarial value of at least (~~ninety-five~~) 95 percent of the actuarial value of PEBB UMP Classic benefits.

"Public employee" has the same meaning as employee.

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

"Salary reduction plan" means a benefit plan whereby public employees may agree to a reduction of salary on a pretax basis to participate in the dependent care assistance program, medical flexible spending arrangement, limited purpose flexible spending arrangement, or premium payment plan offered pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"School employee" includes:

(a) Through December 31, 2023, all employees of school districts and charter schools established under chapter 28A.710 RCW, and represented employees of educational service districts. For the exclusive purpose of eligibility for PEBB retiree insurance coverage, the term "school employee" also includes nonrepresented employees of an educational service district; and

(b) Effective January 1, 2024, all employees of school districts, educational service districts, and charter schools established under chapter 28A.710 RCW.

"SEBB" means the school employees benefits board.

"SEBB insurance coverage" means any medical, dental, vision, life insurance, accidental death and dismemberment insurance, or long-term disability insurance administered as a SEBB benefit.

"SEBB organization" means a public school district or educational service district or charter school established under chapter 28A.710 RCW that is required to participate in benefit plans provided by the school employees benefits board.

"Season" means any recurring annual period of work at a specific time of year that lasts three to (~~eleven~~) 11 consecutive months.

"Seasonal employee" means a state 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 (see definition of "waive" in this section). Employees eligible to participate in the salary reduction(~~s~~) plan may enroll in or revoke their election under the DCAP, medical FSA, limited purpose 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. 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.

"State registered domestic partner" has the same meaning as defined in RCW 26.60.020(1) and substantially equivalent legal unions from other jurisdictions as defined in RCW 26.60.090.

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

"Supplemental coverage" means any life insurance or accidental death and dismemberment (AD&D) insurance coverage purchased by the employee in addition to the coverage provided by the employing agency.

"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 an eligible employee affirmatively declining enrollment in PEBB medical because the employee is enrolled in other employer-based group medical, a TRICARE plan, or medicare as allowed under WAC 182-12-128. An employee on approved educational leave who obtains another employer-based group health plan may waive enrollment as allowed under WAC 182-12-136. An employee may waive enrollment in PEBB medical to enroll in SEBB medical only if they are enrolled in SEBB dental and SEBB vision. An employee who waives enrollment in PEBB medical to enroll in SEBB medical also waives enrollment in PEBB dental.

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

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 (except governor-declared emergencies) that have not been or are not anticipated to be part of the employee's regular work schedule or pattern. Any hours worked in direct response to a governor-declared emergency are not excludable and must be included in determining eligibility. In order to include excluded hours in determining eligibility, employing agencies must re-

quest and receive the public employees benefits board (PEBB) program's approval.

For how the employer contribution toward PEBB benefits 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 they are anticipated to work an average of at least (~~eighty~~) 80 hours per month and 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 benefits. Employees become eligible through stacking when they meet the requirements described in (a) of this subsection. They 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 benefits as described in WAC 182-12-131(1).

(d) **When PEBB benefits begin.** Medical, dental, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, employer-paid long-term disability (LTD) insurance, employee-paid LTD insurance (unless the employee declines the employee-paid LTD insurance as described in WAC 182-08-197(1)), and if eligible, benefits under the salary reduction plan 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 coverage begins on that date. Supplemental life insurance and supplemental AD&D insurance begin on the first day of the month following the date the contracted vendor receives the required form or approves the enrollment.

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

(a) **Eligibility.** A seasonal employee is eligible if they are anticipated to work an average of at least (~~eighty~~) 80 hours per month

and 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 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~~) 80 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 benefits. Employees become eligible through stacking when they meet the requirements described in (a) of this subsection. They 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 benefits as described in WAC 182-12-131(1).

(d) **When PEBB benefits begin.** Medical, dental, basic life insurance, basic AD&D insurance, employer-paid LTD insurance, employee-paid LTD insurance (unless the employee declines the employee-paid LTD insurance as described in WAC 182-08-197(1)), and if eligible, benefits under the salary reduction plan 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 coverage begins on that date. Supplemental life insurance and supplemental AD&D insurance begin on the first day of the month following the date the contracted vendor receives the required form or approves the enrollment.

Exception: Seasonal employees who work a recurring, annual season with a duration of less than nine months are not eligible for the employee-paid LTD insurance benefit.

(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 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 benefits 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). A faculty becomes eligible through stacking when they meet the requirements as described in (a) of this subsection. When a faculty works for more than one institution of higher education, the faculty must notify their employing agencies that they work at more than one institution and may be eligible through stacking.

(c) **When PEBB benefits begin.**

(i) Medical, dental, basic life insurance, basic AD&D insurance, employer-paid LTD insurance, employee-paid LTD insurance (unless the faculty declines the employee-paid LTD insurance as described in WAC 182-08-197(1)), and if eligible, benefits under the salary reduction plan 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 coverage begins on that date. Supplemental life insurance and supplemental AD&D insurance begin on the first day of the month following the date the contracted vendor receives the required form or approves the enrollment.

(ii) For faculty hired on a quarter/semester to quarter/semester basis under (a)(ii) of this subsection, medical, dental, basic life insurance, basic AD&D insurance, employer-paid LTD insurance, employee-paid LTD insurance (unless the faculty declines the employee-paid LTD insurance as described in WAC 182-08-197(1)), and if eligible, benefits under the salary reduction plan 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 coverage begins at the beginning of the second consecutive quarter/semester. Supplemental life insurance and supplemental AD&D insurance begin on the first day of the month following the date the contracted vendor receives the required form or approves the enrollment.

(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 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 benefits begin.** Medical, dental, basic life insurance, basic AD&D insurance, employer-paid LTD insurance, employee-paid

LTD insurance (unless the employee declines the employee-paid LTD insurance as described in WAC 182-08-197(1)), and if eligible, benefits under the salary reduction plan 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 coverage begins on that date. Supplemental life insurance and supplemental AD&D insurance begin on the first day of the month following the date the contracted vendor receives the required form or approves the enrollment.

(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 benefits begin.** Medical, dental, basic life insurance, basic AD&D insurance, employer-paid LTD insurance, employee-paid LTD insurance (unless the employee declines the employee-paid LTD insurance as described in WAC 182-08-197(1)), and if eligible, benefits under the salary reduction plan 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 coverage begins on that date. Supplemental life insurance and supplemental AD&D insurance begin on the first day of the month following the date the contracted vendor receives the required form or approves the enrollment.

AMENDATORY SECTION (Amending WSR 21-13-102, filed 6/18/21, effective 1/1/22)

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

Exception: An employee may waive their enrollment in PEBB medical to enroll in school employees benefits board (SEBB) medical only if they are enrolled in SEBB dental and SEBB vision. An employee who waives enrollment in PEBB medical to enroll in SEBB medical also waives enrollment in PEBB dental.

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

(a) **When the employee becomes eligible:** An employee may waive PEBB medical when they become eligible for PEBB benefits. The employee must indicate their election to waive enrollment in PEBB medical on the required form and submit the form to their employing agency. The

employing agency must receive the form no later than (~~thirty-one~~) 31 days after the date the employee becomes eligible for PEBB benefits (see WAC 182-08-197). PEBB medical will be waived as of the date the employee becomes eligible for PEBB benefits.

(b) **During the annual open enrollment:** An employee may waive PEBB medical during the annual open enrollment. The required form must be received by the employee's employing agency before the end of the annual open enrollment. PEBB medical will be waived beginning January 1st of the following year.

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

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

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

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

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

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

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

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

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

If an employee who is eligible for the employer contribution toward PEBB benefits was enrolled as a dependent in SEBB medical, SEBB dental, and SEBB vision and is removed by the SEBB subscriber, the health care authority will notify the employee of their removal from the SEBB subscriber's account and that they have experienced a special enrollment event. The employee will be required to return from waived enrollment and elect PEBB medical and PEBB dental. If the employee's employing agency does not receive the employee's required forms indicating their medical and dental elections within (~~sixty~~) 60 days of the employee losing SEBB medical, SEBB dental, and SEBB vision, they will be defaulted into employee-only PEBB medical and PEBB dental as described in WAC 182-08-197 (1)(b)(i) and (ii).

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

(a) Employee acquires a new dependent due to:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

AMENDATORY SECTION (Amending WSR 20-16-062, filed 7/28/20, effective 1/1/21)

WAC 182-12-146 When is an enrollee eligible to continue public employees benefits board (PEBB) benefits under Consolidated Omnibus Budget Reconciliation Act (COBRA)? (1) An employee or an employee's dependent who loses eligibility for the employer contribution toward public employees benefits board (PEBB) benefits and who qualifies for continuation coverage under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) may continue coverage for PEBB medical, dental, or both.

(2) 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 PEBB medical, dental, or both for the remaining difference in months.

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

(4) A retiree or a dependent of a retiree, who is no longer eligible as described in WAC 182-12-171, 182-12-180, or 182-12-260 may continue PEBB medical, dental, or both.

(5) 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.

(6) A board member who no longer qualifies as described in WAC 182-12-111 (5)(c) may continue enrollment in PEBB medical, dental, or both for the maximum number of months allowed under COBRA as described in this section.

(7) An enrollee may continue PEBB medical, dental, or both under COBRA by self-paying the premium and applicable premium surcharges set by the health care authority (HCA):

(a) The election must be received by the PEBB program no later than (~~sixty~~) 60 days from the date the enrollee's PEBB health plan coverage ended or from the postmark date on the election notice sent by the PEBB program, whichever is later;

(b) The first premium payment under COBRA coverage and applicable premium surcharges are due to the HCA no later than (~~forty-five~~) 45 days after the 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)(c);

(c) COBRA continuation coverage enrollees who voluntarily terminate their COBRA coverage will not be eligible to reenroll in COBRA coverage unless they regain eligibility as described in WAC 182-12-114. Those who request to terminate their COBRA coverage must do so in writing. COBRA coverage will end on the last day of the month in which the PEBB program receives the termination request or on the last day of the month specified in the COBRA enrollee's termination request, whichever is later. 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;

(d) An employee enrolled in a medical flexible spending arrangement (FSA) or limited purpose FSA and the employee's dependents will have an opportunity to continue making contributions to their medical FSA or limited purpose FSA by electing COBRA if on the date of the qualifying event, as described under 42 U.S.C. Sec. 300bb-3, the employee's medical FSA or limited purpose FSA has a greater amount in remaining benefits than remaining contribution payments for the current year. The election must be received by the contracted vendor no later than (~~sixty~~) 60 days from the date the PEBB health plan coverage ended or from the postmark date on the election notice sent by the contracted vendor, whichever is later. The first premium payment under COBRA coverage is due to the contracted vendor no later than (~~forty-five~~) 45 days after the election period ends as described above.

(8) A subscriber's state registered domestic partner and the state registered domestic partner's children may continue PEBB medical, dental, or both on the same terms and conditions as spouses and other eligible dependents under COBRA as described under RCW 26.60.015.

(9) Medical and dental coverage under COBRA begin on the first day of the month following the day the COBRA enrollee loses eligibility for PEBB health plan coverage as described in WAC 182-12-131, 182-12-133, 182-12-141, 182-12-142, 182-12-148, 182-12-171, 182-12-180, 182-12-250, 182-12-260, or 182-12-265.

AMENDATORY SECTION (Amending WSR 21-13-106, filed 6/18/21, effective 1/1/22)

WAC 182-12-262 When may subscribers enroll or remove eligible dependents? (1) **Enrolling dependents in public employees benefits board (PEBB) health plan coverage (~~and the effective date of~~), supplemental dependent life insurance, and accidental death and dismemberment (AD&D) insurance.** A dependent must be enrolled in the same health plan coverage as the subscriber(~~, and~~) except as described in WAC 182-12-171 (1)(c). The subscriber must be enrolled in health plan coverage to enroll their dependent in health plan coverage except as provided in WAC 182-12-205 (3)(c). A dependent with more than one source of eligibility for enrollment in the PEBB and school employees benefits board (SEBB) programs is limited to a single enrollment in medical, dental, and vision plans in either the PEBB or SEBB program. Subscribers must satisfy the enrollment requirements as described in subsection (4) of this section and may enroll eligible dependents at the following times:

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

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

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

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

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

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

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

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

(a) **A dependent's eligibility for enrollment in PEBB health plan coverage or supplemental dependent life insurance or AD&D insurance ends the last day of the month the dependent** meets the eligibility criteria as described in WAC 182-12-250 or 182-12-260. Subscribers must provide notice when a dependent is no longer eligible due to divorce, annulment, dissolution, or qualifying event of a dependent ceasing to be eligible as a dependent child, as described in WAC 182-12-260(3). For supplemental dependent life insurance or AD&D insurance, subscribers must notify the contracted vendor on the required form, in writing, or by telephone when a dependent is no longer eligible. Contact information for the contracted vendor may be found at hca.wa.gov/employees-contact-plan. For PEBB health plan coverage, the notice must be received within (~~sixty~~) 60 days of the last day of the month the dependent loses eligibility (~~for PEBB health plan coverage~~). Employees must notify their employing agency when a dependent is no longer eligible for PEBB health plan coverage, except as required under WAC 182-12-260 (3)(g)(ii). All other subscribers must notify the PEBB program. Consequences for not submitting notice within the required (~~sixty~~) 60 days include, but are not limited to:

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

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

(iii) The subscriber may not be able to recover subscriber-paid insurance premiums for dependents that lost their eligibility; and
(iv) The subscriber may be responsible for premiums paid by the state for the dependent's health plan coverage after the dependent lost eligibility.

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

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

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

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

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

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

(3) **Special open enrollment.**

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

(i) PEBB health plan coverage will begin the first of the month following the later of the event date or the date the required form is received. If that day is the first of the month, the change in enrollment begins on that day.

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

(iii) The dependent will be removed from the subscriber's PEBB health plan coverage the last day of the month following the later of

the event date or the date the required form and proof of the event is received. If that day is the first of the month, the change in enrollment will be made the last day of the previous month.

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

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

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

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

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

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

(i) Subscriber acquires a new dependent due to:

- Marriage or registering a state registered domestic partnership;

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

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

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

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

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

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

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

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

(vii) A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the

subscriber (a former spouse or former state registered domestic partner is not an eligible dependent);

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

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

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

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

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

(a) If a subscriber wants to enroll their eligible dependents in PEBB health plan coverage when the subscriber becomes eligible to enroll in PEBB benefits, the subscriber must include the dependent's enrollment information on the required forms and submit them within the required time frame described in WAC 182-08-197, (~~(182-08-187)~~) 182-12-171, 182-12-180, 182-12-211, or 182-12-250. If an employee enrolls a dependent in supplemental dependent life insurance or AD&D insurance, the required form must be submitted within the required time frame described in WAC 182-08-197 (~~or 182-08-187~~).

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

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

(d) If a subscriber wants to enroll a newborn or child whom the subscriber has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption in PEBB health plan coverage, the subscriber should notify the PEBB program by submitting the required forms as soon as possible to ensure timely payment of claims.

If adding the child increases the premium, the required forms must be received no later than (~~sixty~~) 60 days after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption. An employee enrolling a dependent in supplemental dependent life insurance or AD&D insurance must submit the required form to the contracted vendor for approval no later than 60 days after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption. A newly born child must be at least (~~fourteen~~) 14 days old before supplemental dependent life insurance or AD&D insurance coverage can become effective.

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

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

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

(g) An employee may enroll a dependent in supplemental dependent life insurance or AD&D insurance at any time during the calendar year by submitting the required form to the contracted vendor for approval. Evidence of insurability may be required for supplemental dependent life insurance but will not be required for supplemental AD&D insurance.

AMENDATORY SECTION (Amending WSR 21-13-102, filed 6/18/21, effective 1/1/22)

WAC 182-12-263 National Medical Support Notice (NMSN). (1) When a National Medical Support Notice (NMSN) requires a subscriber to provide health plan coverage for a dependent child the following provisions apply:

(a) The subscriber may enroll their dependent child and request changes to their health plan coverage as described under subsection (c) of this section. Employees submit the required forms to their employing agency. Subscribers on continuation coverage or PEBB retiree insurance coverage submit the required forms to the public employees benefits board (PEBB) program.

(b) 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 (c) of this subsection upon request of:

- (i) The child's other parent; or
- (ii) Child support enforcement program.

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

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

(ii) 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;

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

(iv) 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;

(v) If the dependent is enrolled in both school employees benefits board medical and PEBB medical as a dependent as described in WAC 182-12-123 (6) ~~((+f))~~ (g) and there is a NMSN in place, enrollment will be in accordance with the NMSN; or

(vi) If the subscriber is eligible for and elects Consolidated Omnibus Budget Reconciliation Act (COBRA) or other continuation coverage, the NMSN will be enforced and the dependent must be covered in accordance with the NMSN.

(d) Changes to health plan coverage or enrollment as described in (c)(i) through (iii) of this subsection will begin the first day of the month following receipt by the employing agency of the NMSN. If the NMSN is received by the employing agency 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 (c)(iv) of this subsection 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.

(2) When a NMSN requires a spouse, former spouse, or other individual to provide health plan coverage for a dependent who is already enrolled in PEBB coverage, and that health plan coverage is in fact provided, the dependent may be removed from the subscriber's PEBB health plan coverage prospectively.

AMENDATORY SECTION (Amending WSR 21-13-105, filed 6/18/21, effective 1/1/22)

WAC 182-12-300 Public employees benefits board (PEBB) wellness incentive program eligibility and procedural requirements. The board 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 as described in RCW 41.05.080(3), are eligible to participate in the PEBB wellness incentive program.

(2) Effective January 1, 2020, 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 following deadline:

(a) For subscribers continuing enrollment in PEBB medical and subscribers enrolling in PEBB medical with an effective date in January through September, the deadline is November 30th; or

(b) For subscribers enrolling in PEBB medical with an effective date in October through 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 contracted vendor 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) A 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~~) to participate in the PEBB wellness incentive program and is enrolled in a PEBB medical plan 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.

WAC 182-16-020 Definitions. The following definitions apply throughout this chapter unless the context clearly indicates another meaning:

"Accidental death and dismemberment insurance" or "AD&D" means basic accidental death and dismemberment (AD&D) insurance paid for by the employing agency, as well as supplemental accidental death and dismemberment insurance offered to and paid for by employees for themselves and their dependents.

"Appellant" means a person who requests a brief adjudicative proceeding with the PEBB appeals unit about the action of the employing agency, the HCA, or its contracted vendor.

"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.

"Brief adjudicative proceeding" means the process described in RCW 34.05.482 through 34.05.494 and in WAC 182-16-2000 through 182-16-2160.

"Business days" means all days except Saturdays, Sundays, and all state legal holidays as set forth in RCW 1.16.050.

"Calendar days" or "days" means all days including Saturdays, Sundays, and all state legal holidays as set forth in RCW 1.16.050.

"Continuance" means a change in the date or time of when a brief adjudicative proceeding or formal administrative hearing will occur.

"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.

"Denial" or "denial notice" means an action by, or communication from, an employing agency, contracted vendor, or the PEBB program that aggrieves a subscriber, a dependent, or an applicant, with regard to PEBB benefits including, but not limited to, actions or communications expressly designated as a "denial," "denial notice," or "cancellation notice."

"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 employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan under chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 129 or other sections of the Internal Revenue Code.

"Director" means the director of the authority.

"Dispositive motion" means a motion made to a presiding officer, (~~(review)~~) reviewing officer, or hearing officer to decide a claim or case in favor of the moving party without further proceedings.

"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; (c) through December 31, 2019, employees of a school district or represented employees of an educational service district if the authority agrees to provide any of the school districts' or educational service 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); (f) through December 31, 2019, employees of a charter school established under chapter 28A.710 RCW; and (g) through December 31, 2023, nonrepresented employees of an educational service district. "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-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 group" means those counties, municipalities, political subdivisions, the Washington health benefit exchange, tribal governments, employee organizations representing state civil service employees, and through December 31, 2019, school districts and charter schools, and through December 31, 2023, educational service districts obtaining employee benefits through a contractual agreement with the authority to participate in benefit plans developed by the public employees benefits board as described in WAC 182-08-245.

"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, or other political subdivision; 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.

"File" or "filing" means the act of delivering documents to the office of the presiding officer, ((review)) reviewing officer, or hearing officer. A document is considered filed when it is received by the authority or its designee. A document may be filed by one or more of the following:

- Personal delivery to the authority at Cherry Street Plaza, 626 8th Avenue S.E., Olympia, Washington 98501;

- First class, registered, or certified mail to the authority to the following mailing address:

Health Care Authority
Attn: PEBB Appeals Unit
P.O. Box 45504
Olympia, WA 98504-5504;

- Fax: 360-763-4709; or

- Submission online through the designated submission portal.

The identified methods are the exclusive methods for a document to be filed, and submission of documents by any other fashion to the authority shall not constitute filing unless agreed to in advance by the authority.

"Final order" means an order that is the final health care authority decision.

"Formal administrative hearing" means a proceeding before a hearing officer that gives an appellant an opportunity for an evidentiary hearing as described in RCW 34.05.413 through 34.05.476 and WAC 182-16-3000 through 182-16-3200.

"HCA hearing representative" means a person who is authorized to represent the PEBB program in a formal administrative hearing. The person may be an assistant attorney general or authorized HCA employee.

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

"Hearing officer" means an impartial decision maker who presides at a formal administrative hearing, and is:

- A director-designated HCA employee; or

- When the director has designated the office of administrative hearings (OAH) as a hearing body, an administrative law judge employed by the OAH.

"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.

"Life insurance" means basic life insurance paid for by the employing agency, as well as supplemental life insurance or supplemental dependent life insurance offered to and paid for by employees for themselves and their dependents. Life insurance for eligible retirees includes retiree term life insurance offered to and paid for by retirees.

"Limited purpose flexible spending arrangement" or "limited purpose FSA" means a benefit plan whereby eligible state employees may reduce their salary before taxes to pay for dental and vision expenses not reimbursed by insurance as provided in the salary reduction plan established under chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"Long-term disability insurance" or "LTD insurance" means employer-paid long-term disability insurance and employee-paid long-term disability insurance offered by the PEBB program.

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

"PEBB" means the public employees benefits board.

"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, accidental death and dismemberment 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, 182-12-180, and 182-12-211), 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.

"Prehearing conference" means a proceeding scheduled and conducted by a hearing officer to address issues in preparation for a formal administrative hearing.

"Premium payment plan" means a benefit plan whereby public employees may pay their share of group health plan premiums with pretax dollars as provided in the salary reduction plan under chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"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 an enrolled subscriber's spouse or state registered domestic partner choosing not to enroll in their employer-based group medical when:

- The spouse's or state registered domestic partner's share of the medical premiums is less than (~~ninety-five~~) 95 percent of the additional cost an employee would be required to pay to enroll a spouse or state registered domestic partner in the public employees benefits board (PEBB) Uniform Medical Plan (UMP) Classic; and

- The benefits have an actuarial value of at least (~~ninety-five~~) 95 percent of the actuarial value of PEBB UMP Classic benefits.

"Presiding officer" means an impartial decision maker who conducts a brief adjudicative proceeding and is a director-designated HCA employee.

"Public employee" has the same meaning as employee.

"(~~Review~~) Reviewing officer or officers" means one or more delegates from the director that consider appeals relating to the administration of PEBB benefits by the PEBB program.

"Salary reduction plan" means a benefit plan whereby public employees may agree to a reduction of salary on a pretax basis to participate in the dependent care assistance program, medical flexible spending arrangement, limited purpose flexible spending arrangement, or premium payment plan offered pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"Service" or "serve" means the process described in WAC 182-16-058.

"State agency" means an office, department, board, commission, institution, or other separate unit or division, however designated, of the state government. 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.

"State registered domestic partner" has the same meaning as defined in RCW 26.60.020(1) and substantially equivalent legal unions from other jurisdictions as defined in RCW 26.60.090.

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

"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.

AMENDATORY SECTION (Amending WSR 20-16-062, filed 7/28/20, effective 1/1/21)

WAC 182-16-058 Service or serve. (1) When the rules in this chapter or in other public employees benefits board (PEBB) program rules or statutes require a party to serve copies of documents on other parties, a party must send copies of the documents to all other parties or their representatives as described in this chapter. In this section, requirements for service or delivery by a party apply also when service is required by the presiding officer, (~~review~~) reviewing officer or officers, or hearing officer.

(2) Unless otherwise stated in applicable law, documents may be sent only as identified in this chapter to accomplish service. A party may serve someone by:

(a) Personal service (hand delivery);

(b) First class, registered, or certified mail sent via the United States Postal Service or Washington state consolidated mail services;

(c) Fax;

(d) Commercial delivery service; or

(e) Legal messenger service.

(3) A party must serve all other parties or their representatives whenever the party files a motion, pleading, brief, or other document

with the presiding officer, ((~~review~~)) reviewing officer or officers, or hearing officer's office, or when required by law.

(4) Unless otherwise stated in applicable law, service is complete when:

(a) Personal service is made;

(b) Mail is properly stamped, addressed, and deposited in the United States Postal Service;

(c) Mail is properly addressed, and deposited in the Washington state consolidated mail services;

(d) Fax produces proof of transmission;

(e) A parcel is delivered to a commercial delivery service with charges prepaid; or

(f) A parcel is delivered to a legal messenger service with charges prepaid.

(5) A party may prove service by providing any of the following:

(a) A signed affidavit of mailing or certificate of service;

(b) The certified mail receipt signed by the person who received the parcel;

(c) A signed receipt from the person who accepted the commercial delivery service or legal messenger service parcel;

(d) Proof of fax transmission.

(6) Service cannot be made by electronic mail unless mutually agreed to in advance and in writing by the parties.

(7) If the document is a subpoena, follow the compliance procedure as described in WAC 182-16-3130.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-064 Applicable rules and laws. (1) An employing agency must apply public employees benefits board (PEBB) program rules adopted in the Washington Administrative Code (WAC) and follow instructions from the authority.

(2) A presiding officer, ((~~review~~)) reviewing officer or officers, or hearing officer must first apply the applicable PEBB program rules adopted in the WAC. If no PEBB program rule applies, the presiding officer, ((~~review~~)) reviewing officer or officers, or hearing officer must decide the issue according to the best legal authority and reasoning available, including federal and Washington state constitutions, statutes, regulations, significant decisions indexed as described in WAC 182-16-130, and court decisions.

AMENDATORY SECTION (Amending WSR 20-16-062, filed 7/28/20, effective 1/1/21)

WAC 182-16-066 Burden of proof, standard of proof, and presumptions. (1) The burden of proof is a party's responsibility to provide evidence regarding disputed facts and persuade the presiding officer, ((~~review~~)) reviewing officer or officers, or hearing officer that a position is correct based on the standard of proof. Unless stated oth-

erwise in rules or law, the appellant has the burden of proof in a brief adjudicative proceeding or formal administrative hearing.

(2) Standard of proof refers to the amount of evidence needed to prove a party's position. Unless stated otherwise in rules or law, the standard of proof in a brief adjudicative proceeding or formal administrative hearing is a preponderance of the evidence, meaning that something is more likely to be true than not.

(3) Public officers and state agencies are presumed to have properly performed their duties and acted as described in the law, unless (~~substantial~~) preponderance of the evidence to the contrary is presented. A party challenging this presumption bears the burden of proof.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-2000 Brief adjudicative proceedings. Pursuant to RCW 34.05.482, the authority (~~will~~) may use brief adjudicative proceedings for issues identified in this chapter when doing so would not violate law, or when protection of the public interest does not require the authority to give notice and an opportunity to participate to persons other than the parties, or the issue and interests involved in the controversy do not warrant use of the procedures of RCW 34.05.413 through 34.05.476 which govern formal administrative hearings.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2005 Record—Brief adjudicative proceeding. The record in a brief adjudicative proceeding consists of any documents regarding the matter, considered or prepared by the presiding officer for the brief adjudicative proceeding or by the (~~review~~) reviewing officer or officers for any review. The authority's record does not have to constitute the exclusive basis for agency action, unless otherwise required by law.

AMENDATORY SECTION (Amending WSR 20-16-062, filed 7/28/20, effective 1/1/21)

WAC 182-16-2050 How can an employee appeal a decision regarding the administration of benefits offered under the salary reduction plan? (1) Any employee who disagrees with a decision that denies eligibility for, or enrollment in, a benefit offered under the salary reduction plan may appeal that decision by submitting a written request for administrative review to their state agency. The state agency must receive the written request for administrative review no later than (~~thirty~~) 30 days after the date of the denial. The contents of the

written request for administrative review are to be provided as described in WAC 182-16-2070.

(a) Upon receiving the written request for administrative review, the state agency must perform a complete review of the denial by one or more staff who did not take part in the decision resulting in the denial.

(b) The state agency must render a written decision within (~~(thirty)~~) 30 days of receiving the written request for administrative review. The written decision must be sent to the employee who submitted the written request for review and must include a description of appeal rights. The state agency must also send a copy of the state agency's written decision to the state agency's administrator (or designee) and to the PEBB appeals unit. If a state agency fails to render a written decision within (~~(thirty)~~) 30 days of receiving the written request for administrative review, the request for administrative review may be considered denied as of the (~~(thirty-first)~~) 31st day and the original underlying state agency decision may be appealed to the PEBB appeals unit by following the process in this section.

(2) Any employee who disagrees with the state agency's decision in response to a written request for administrative review, as described in this section, may request a brief adjudicative proceeding to be conducted by the authority by submitting a written request to the PEBB appeals unit.

(a) The PEBB appeals unit must receive the request for a brief adjudicative proceeding no later than (~~(thirty)~~) 30 days after the date of the state agency's written decision on the request for administrative review. If a state agency fails to render a written decision within (~~(thirty)~~) 30 days of receiving a written request for administrative review, the PEBB appeals unit must receive the request for a brief adjudicative proceeding no later than (~~(thirty)~~) 30 days after the date the request for administrative review was deemed denied. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(i) The PEBB appeals unit must notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(ii) Once the PEBB appeals unit receives a request for a brief adjudicative proceeding, the PEBB appeals unit will send a request for documentation and information to the applicable state agency. The state agency will then have two business days to respond to the request and provide the documentation and information requested. The state agency will also send a copy of the documentation and information to the employee.

(iii) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(b) If an employee fails to timely request a brief adjudicative proceeding, the state agency's prior written decision becomes the authority's final order without further action.

(3) Any employee aggrieved by a decision regarding a claim for benefits under the medical flexible spending arrangement or limited purpose flexible spending arrangement (FSA) or dependent care assistance program (DCAP) offered under the salary reduction plan may appeal that decision to the authority's contracted vendor by following the appeal process of that contracted vendor.

(a) Any employee who disagrees with a decision in response to an appeal filed with the contracted vendor that administers the medical FSA, limited purpose FSA, and DCAP under the salary reduction plan may

request a brief adjudicative proceeding by submitting a written request to the PEBB appeals unit. The PEBB appeals unit must receive the request for a brief adjudicative proceeding no later than (~~(thirty)~~) 30 days after the date of the contracted vendor's appeal decision. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(i) The PEBB appeals unit must notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(ii) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(b) If an employee fails to timely request a brief adjudicative proceeding, the contracted vendor's prior written decision becomes the authority's final order without further action.

(4) Any employee aggrieved by a decision regarding the administration of the premium payment plan offered under the salary reduction plan may request a brief adjudicative proceeding to be conducted by the authority by submitting a written request to the PEBB appeals unit for a brief adjudicative proceeding.

(a) The PEBB appeals unit must receive the request for a brief adjudicative proceeding no later than (~~(thirty)~~) 30 days after the date of the denial notice by the PEBB program. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(i) The PEBB appeals unit must notify the appellant in writing when the notice of appeal has been received.

(ii) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(b) If an employee fails to timely request a brief adjudicative proceeding, the PEBB program's prior written decision becomes the authority's final order without further action.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-2080 Who can appeal or represent a party in a brief adjudicative proceeding? (1) The appellant may act as their own representative or may choose to be represented by another person, except that employees of the health care authority (HCA) or HCA's authorized agents may not represent an appellant, unless approved by a presiding officer or (~~(review)~~) reviewing officer.

(2) If the appellant is represented by a person who is not an attorney admitted to practice in Washington state, the representative must provide the presiding officer and other parties with the representative's name, address, and telephone number. In cases involving confidential information, the nonattorney representative must provide the PEBB appeals unit and other parties with a signed, written consent permitting release to the nonattorney representative of the appellant's health information protected by state or federal law.

(3) An attorney admitted to practice law in Washington state representing the appellant must file a written notice of appearance containing the attorney's name, address, and telephone number with the presiding officer's office and serve all parties with the notice. In cases involving confidential information, the attorney must provide

the PEBB appeals unit and other parties with a signed, written consent permitting release to the attorney of the appellant's health information protected by state or federal law. If the appellant's attorney representative no longer represents the appellant, then the attorney must file a written notice of withdrawal of representation with the presiding officer or (~~review~~) reviewing officer or officers' office and serve all parties with the notice.

AMENDATORY SECTION (Amending WSR 20-16-062, filed 7/28/20, effective 1/1/21)

WAC 182-16-2085 Continuances. The presiding officer or (~~review~~) reviewing officer or officers may grant, in their sole discretion, a request for a continuance on motion of the appellant, the authority, or on their own. The continuance may be up to (~~thirty~~) 30 calendar days.

AMENDATORY SECTION (Amending WSR 20-16-062, filed 7/28/20, effective 1/1/21)

WAC 182-16-2100 How to request a review of an initial order resulting from a brief adjudicative proceeding. (1) Both the appellant and the authority may request review of an initial order. An appellant who has received an initial order upholding an employing agency decision, public employees benefits board (PEBB) program decision, or a decision made by a PEBB program contracted vendor, may request review of the initial order by the authority. The appellant (~~must file~~) may request review of the initial order by filing a written request for review of the initial order or (~~make~~) making an oral request (~~for review of the initial order~~) with the PEBB appeals unit within (~~twenty-one~~) 21 days after service of the initial order. The written or oral request for review of the initial order must be made by using the contact information included in the initial order. If the appellant fails to request review of the initial order within (~~twenty-one~~) 21 days, the initial order becomes the authority's final order without further action.

(2) Upon timely request by the appellant, a review of an initial order will be performed by one or more (~~review~~) reviewing officers designated by the director of the authority.

(3) If the appellant has not requested review, the authority may review an order resulting from a brief adjudicative proceeding on its own, and without notice to the parties, but it may not take action on review less favorable to any party than the initial order without giving that party notice and an opportunity to explain that party's view of the matter.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-2105 Withdrawing the request for a brief adjudicative proceeding or review of an initial order. (1) The appellant may withdraw the request for a brief adjudicative proceeding or review of an initial order for any reason, and at any time, by contacting the public employees benefits board (PEBB) appeals unit. The PEBB appeals unit will present the withdrawal request to the presiding officer or (~~review~~) reviewing officer or officers.

(2) The request for withdrawal must be made in writing.

(3) After a withdrawal request is received, the presiding officer or (~~review~~) reviewing officer or officers must enter and serve a written order dismissing the brief adjudicative proceeding or review of an initial order.

(4) If an appellant withdraws a request for a brief adjudicative proceeding or review of an initial order, the appellant may not restate the request for a brief adjudicative proceeding or review of an initial order unless time remains on their original appeal period.

AMENDATORY SECTION (Amending WSR 20-16-062, filed 7/28/20, effective 1/1/21)

WAC 182-16-2110 Final order. (1) A final order issued by the (~~review~~) reviewing officer or officers will be in writing and include a brief statement of the reasons for the decision.

(2) The final order must be served within (~~twenty~~) 20 days of the date of the initial order or of the date the request for review of the initial order was received by the PEBB appeals unit, whichever is later.

(3) The final order will include a notice that reconsideration and judicial review may be available.

(4) A request for review of the initial order is deemed denied if the authority does not issue a final order within (~~twenty~~) 20 days after the request for review of the initial order is filed.

AMENDATORY SECTION (Amending WSR 20-16-062, filed 7/28/20, effective 1/1/21)

WAC 182-16-2120 Request for reconsideration. (1) A request for reconsideration asks the (~~review~~) reviewing officer or officers to reconsider the final order because the party believes the (~~review~~) reviewing officer or officers made a mistake of law, mistake of fact, or clerical error.

(2) A request for reconsideration must state in writing why the party wants the final order to be reconsidered.

(3) Requests for reconsideration must be filed with the (~~review~~) reviewing officer or officers who entered the final order.

(4) If a party files a request for reconsideration:

(a) The ((~~review~~)) reviewing officer or officers must receive the request for reconsideration on or before the tenth business day after the service date of the final order;

(b) The party filing the request must send copies of the request to all other parties; and

(c) Within five business days of receiving a request for reconsideration, the ((~~review~~)) reviewing officer or officers must serve all parties a notice that provides the date the request for reconsideration was received.

(5) The other parties may respond to the request for reconsideration. The response must state in writing why the final order should stand. Responses are optional. If a party chooses not to respond, that party will not be prejudiced because of that choice.

(a) Responses to a request for reconsideration must be received by the ((~~review~~)) reviewing officer or officers no later than seven business days after the service date of the ((~~review~~)) reviewing officer or officers' notice as described in subsection (4)(c) of this section, or the response will not be considered.

(b) Service of responses to a request for reconsideration must be made to all parties.

(6) If a party needs more time to file a request for reconsideration or respond to a request for reconsideration, the ((~~review~~)) reviewing officer or officers may extend the required time frame if the party makes a written request providing a good reason for the request within the required time frame.

(7) Unless the request for reconsideration is denied as untimely filed under subsection (4)(a) of this section, the same ((~~review~~)) reviewing officer or officers who entered the final order, if reasonably available, will also consider the request as well as any responses received.

(8) The decision on the request for reconsideration must be in the form of a written order denying the request, granting the request in whole or in part and issuing a new written final order, or granting the request and setting the matter for further hearing.

(9) If the ((~~review~~)) reviewing officer or officers do not send an order on the request for reconsideration within ((~~twenty~~)) 20 calendar days of the date of the notice described in subsection (4)(c) of this section, the request is deemed denied.

(10) If any party files a request for reconsideration of the final order, the reconsideration process must be completed before any judicial review may be requested. However, the filing of a request for reconsideration is not required before requesting judicial review.

(11) An order denying a request for reconsideration is not subject to judicial review.

(12) No evidence may be offered in support of a motion for reconsideration, except newly discovered evidence that is material for the party moving for reconsideration and that the party could not with reasonable diligence have discovered and produced prior to the final order being issued.

NEW SECTION

WAC 182-16-2135 Petitions for judicial review—Service on the authority. Delivery pursuant to RCW 34.05.542(4) shall be deemed to have been made when a copy of the petition for judicial review has been received by the public employees benefits board (PEBB) appeals unit at Cherry Street Plaza, 626 8th Avenue S.E., Olympia, WA 98501 or received by mail at the PEBB appeals unit, P.O. Box 45504, Olympia, WA 98504-5504.

AMENDATORY SECTION (Amending WSR 20-16-062, filed 7/28/20, effective 1/1/21)

WAC 182-16-2150 ((Review)) Reviewing officer or officers—Designation and authority. (1) The designation of a ((~~review~~)) reviewing officer or officers must be consistent with the requirements of RCW 34.05.491 and the ((~~review~~)) reviewing officer or officers must not have personally participated in the decision made by the employing agency or PEBB program.

(2) The ((~~review~~)) reviewing officer or officers must review the initial order and the record to determine if the initial order was correctly decided and make any inquiries necessary to ascertain whether the proceeding must be converted to a formal administrative hearing.

(3) The ((~~review~~)) reviewing officer or officers will issue a final order that will either:

- (a) Affirm the initial order in whole or in part; or
- (b) Reverse the initial order in whole or in part; or
- (c) ~~((Convert the matter to a formal administrative hearing; or~~
- ~~(d))~~ Remand to the presiding officer in whole or in part.

(4) A ((~~review~~)) reviewing officer or officers are limited to those powers granted by the state constitution, statutes, rules, or applicable case law.

(5) A ((~~review~~)) reviewing officer or officers may not decide that a rule is invalid or unenforceable.

(6) In addition to the record, the ((~~review~~)) reviewing officer or officers may employ the authority's expertise as a basis for the decision.

AMENDATORY SECTION (Amending WSR 20-16-062, filed 7/28/20, effective 1/1/21)

WAC 182-16-2160 Conversion of a brief adjudicative proceeding to a formal administrative hearing. (1) The presiding officer or the ((~~review~~)) reviewing officer or officers, in their sole discretion, may convert a brief adjudicative proceeding to a formal administrative hearing at any time before the final order is issued on motion by ~~((the subscriber or enrollee or their))~~:

- (a) The appellant;

(b) The representative (~~(, the)~~) of the appellant;

(c) The authority (~~(, or on the)~~); or

(d) The presiding officer or (~~(review)~~) reviewing officer or (~~(officers' own)~~) officers.

(2) The presiding officer or (~~(review)~~) reviewing officer or officers must convert the brief adjudicative proceeding to a formal administrative hearing when it is found that the use of the brief adjudicative proceeding violates any provision of law, when the protection of the public interest requires the authority to give notice and an opportunity to participate to persons other than the parties, or when the issues and interests involved in the controversy warrant the use of the procedures or RCW 34.05.413 through 34.05.476 that govern formal administrative hearings.

(3) When a brief adjudicative proceeding is converted to a formal administrative hearing, the director designates a hearing officer to conduct the formal administrative hearing upon notice to the (~~(subscriber or enrollee)~~) appellant and the authority.

(4) When a brief adjudicative proceeding is converted to a formal administrative hearing, WAC 182-16-010 through 182-16-130 and 182-16-3000 through 182-16-3200 apply to the formal administrative hearing.

AMENDATORY SECTION (Amending WSR 20-16-062, filed 7/28/20, effective 1/1/21)

WAC 182-16-3170 Office of administrative hearings—Initial or final order (~~(deadline)~~)—Required information. (1) (~~(Within ninety days after the formal administrative hearing record is closed, the hearing officer must serve a copy of the final order to all parties)~~)

Initial order: When the office of administrative hearings is holding a formal administrative hearing on behalf of the authority, the hearing officer must render a written initial order that addresses the issue or issues raised by the appellant in their appeal. The hearing officer must serve a copy of the initial order on all parties and the initial order must contain information on how the appellant may request review of the initial order.

(2) **Final order:** The final order will only be issued by the authority. After the reviewing officer or officers receives a request for review, the reviewing officer or officers has 20 calendar days to enter and serve a final order to all parties unless the reviewing officer serves notice allowing more time.

~~((2))~~ (3) In the written final order, the hearing officer must:

(a) Identify the order as a final order of the public employees benefits board (PEBB) program;

(b) List the name and docket number of the case and the names of all parties and representatives;

(c) Enter findings of fact used to resolve the dispute based on the evidence admitted in the record;

(d) Explain why evidence is, or is not, credible when describing the weight given to evidence related to disputed facts;

(e) State the law that applies to the dispute;

(f) Apply the law to the facts of the case in the conclusions of law;

- (g) Discuss the reasons for the decision based on the facts and the law;
- (h) State the result and remedy ordered; and
- (i) Include any other information required by law or program rules.

NEW SECTION

WAC 182-16-3175 How to request a review of an initial order by the office of administrative hearings. (1) Both the appellant and the authority may request review of an initial order. An appellant who has received an initial order upholding an employing agency decision, a public employees benefits board (PEBB) program decision, or a decision made by a PEBB program contracted vendor, may request review of the initial order or an oral request with the PEBB appeals unit within 20 days after service of the initial order. The written or oral request for review of the initial order must be made by using the contact information included in the initial order. If such review is requested, the hearing officer or their designee from the authority, shall issue a final order in accordance with WAC 182-16-3030. If the appellant fails to request review of the initial order within 20 days, the initial order becomes the authority's final order without further action.

(2) Upon timely request by the appellant, a review of an initial order will be performed by one or more reviewing officers designated by the director of the authority.

(3) If the appellant has not requested review of the initial order, the authority may review an initial order issued by the office of administrative hearings on its own, and without notice to the parties, but it may not take action on review less favorable to any party than the initial order without giving that party notice and an opportunity to explain that party's view of the matter.

NEW SECTION

WAC 182-16-3210 Petitions for judicial review—Service on the authority. Delivery pursuant to RCW 34.05.542(4) shall be deemed to have been made when a copy of the petition for judicial review has been received by the public employees benefits board (PEBB) appeals unit at Cherry Street Plaza, 626 8th Avenue S.E., Olympia, WA 98501 or received by mail at the PEBB appeals unit, P.O. Box 45504, Olympia, WA 98504-5504.