# RULE-MAKING ORDER
## PERMANENT RULE ONLY

## CR-103P (December 2017)
## (Implements RCW 34.05.360)

**CODE REVISER USE ONLY**

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STATE OF WASHINGTON
FILED

DATE: August 20, 2019
TIME: 11:07 AM

WSR 19-17-073

**Agency:** Health Care Authority Public Employees Benefits Board (PEBB) Admin #2019-01

**Effective date of rule:**

**Permanent Rules**

☐ 31 days after filing.

☒ Other (specify) January 1, 2020 **(If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)**

**Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?**

☐ Yes ☒ No If Yes, explain:

**Purpose:** The purpose is to create new rules and to amend some of the existing rules to support the Public Employees Benefits Board (PEBB) Program.

**1. Implement Public Employees Benefits (PEB) Board policy resolutions:**

- Amended WAC 182-08-187 to allow an error correction if an employing agency provides incorrect information regarding PEBB Program benefits to the employee that they relied upon, and at a minimum the error will be corrected prospectively with enrollment in benefits effective the first day of the month following the date the error is identified;
- Amended WAC 182-12-205 to clarify a subscriber may defer PEBB retiree insurance coverage due to enrollment in CHAMPVA;
- Amended WAC 182-12-209 to include PEBB retiree term life insurance eligibility for an eligible school employee who participates in the SEBB Program's life insurance;
- Amended WAC 182-12-300 to include new deadlines for completing wellness activities.

**2. Make technical amendments:**

- Amended WAC 182-08-190, 182-12-131, and 182-12-138 to include requirements for the paid family and medical leave program;
- Amended WAC 182-08-198 to include a special open enrollment event must be an event other than an employee gaining initial eligibility, and to include an exception related to the availability of a dental plan, and to explain the consequences of a subscriber not making a new health plan selection when moving to a new location, and to clarify the disruption of care life events;
- Amended WAC 182-08-199 to include the requirement that the change in residence results in the dependent losing their health insurance when the dependent moves into or out of the United States, to include the requirement that the change in residence results in the dependent losing their health insurance, and to clarify the disruption of care life events;
- Amended WAC 182-12-111 to remove references related to school districts and charter schools, and amended to include educational service districts for their non-represented employees through December 31, 2023;
- Amended WAC 182-12-116 to remove charter school;
- Amended WAC 182-12-171, 182-12-200, 182-12-205, 182-12-211, and 182-12-265 to include retiring school employee and to remove school district and charter school;
- Amended WAC 182-12-262 to change notification requirements for removing a dependent who loses eligibility, to adjust the amount of time for subscribers to provide notice from 12 months to no more than 60 days for adding a newborn or a child based on adoption, to clarify when a dependent's PEBB insurance coverage will begin and end, and to add corresponding WAC references for different types of enrollees;
- Amended WAC 182-16-055 to replace existing WACs with WAC 182-08-191;
- Amended WAC 182-16-064 to include that an employing agency must follow PEBB program rules and instructions from the HCA;
- Amended WAC 182-16-066 to include that the appellant has the burden of proof in a brief adjudicative proceeding or a formal administrative hearing;
- Amended WAC 182-16-120 to clarify that the time prescribed is ten days or less;
- Amended WAC 182-16-2000 and 182-16-3000 with the correct RCW citation;
- Amended WAC 182-16-2010 to correct PEBB benefits' and PEBB appeals unit's descriptions;

- Amended WAC 182-16-2020 to require the state agency to perform a complete review of the denial, removed the language that the state agency may hold a formal meeting or formal administrative hearing, included when the request for administrative review may be considered denied, and removed language related to the state agency may reverse eligibility, premium surcharges, or enrollment decisions based on circumstances with a WAC reference;
- Amended WAC 182-16-2085 and 182-16-2090 to increase readability;
- Amended WAC 182-16-2100 to include the written or oral request for review of the initial order must be made by using the contact information included in the initial order and to clarify the authority may review an order resulting from a brief adjudicative proceeding on its own motion if the appellant has not requested review;
- Amended WAC 182-16-2160 with the correct RCW citation and to clarify the director designates a hearing officer to conduct the formal administrative hearing;
- Amended WAC 182-16-3080 and 182-16-3100 to correct notice requirements and rescheduling requirement references;
- Amended WAC 182-16-3130 to detail who may request the hearing officer quash or change a subpoena request at any time before the deadline given in the subpoena;
- Amended WAC 182-16-3190 to correct a WAC reference and to clarify if the request for reconsideration is granted issuing a new written final order;
- Amended WAC 182-16-3200 with the correct RCW citations.

**3. Amend rules to improve administration of the PEBB Program:**

- Within the definitions sections of chapters 182-08, 182-12, and 182-16 WAC:
  - Amended the definition of “life insurance” to remove the reference to accidental death and dismemberment (AD&D) insurance and created a new definition for “AD&D;”
  - Amended the definition of “Calendar days or days” to include all legal state holidays as described in RCW 1.16.050;
  - Amended the definition of “Dependent care assistance program or DCAP” to reflect the correct statute and to incorporate who may participate;
  - Amended the definition of “Employee” to include non-represented educational service districts’ employees and to remove employees of employee organizations currently pooled with employees of school districts;
  - Amended the definition of “Employer group” to clarify school districts and charter schools could enter in contractual agreement through December 31, 2019; and educational service districts could enter in contractual agreement through December 31, 2023 with the HCA;
  - Amended the definition of “Employing agency” to remove school district and educational service district;
  - Amended the definition of “Long-term disability insurance or LTD insurance” to clarify supplemental long-term disability insurance offered to and paid for by the employee;
  - Amended the definition of “Medical flexible spending arrangement or medical FSA” to correct statute reference and to match with statute;
  - Amended the definition of “PEBB insurance coverage” to include accidental death and dismemberment insurance;
  - Amended the definition of “Premium payment plan” to include state statute’s and federal regulations’ references;
  - Amended the definition of “Premium surcharge” to clarify that it is the PEBB Uniform Medical Plan;
  - Created new definitions of “Forms or form”, “Public employee”, and “State registered domestic partner;”
  - Amended the definition of “Salary reduction plan” to match with statute;
  - Amended the definition of “State agency” for an error correction;
  - Amended the definition of “Subscriber” to clarify a subscriber is enrolled in PEBB benefits;

- Within the definitions sections of chapters 182-08 and 182-12 WAC:
  - Amended the definitions of “Annual open enrollment” and “Continuation coverage” for clarity;
  - Amended the definition of “Employer contribution” to remove charter school;
  - Amended the definition of “Employer-paid coverage” to remove charter school and include SEBB insurance coverage for which an employer contribution is made by a SEBB organization;
  - Created a new definition of “Supplemental coverage;
  - Amended the definition of “Waive” to clarify an eligible employee affirmatively declining enrollment in a PEBB health plan;”

- Amended the following definitions in WAC 182-12-109:
  - Amended the definition of “Seasonal employee” to match with statute;
  - Created new definitions of “school employee,” “SEBB,” “ SEBB insurance coverage,” and “SEBB organization;”

- Amended the following definitions in WAC 182-16-020:
  - Amended the definition of “Appellant” to clarify it is a person who requests a brief adjudicative proceeding with the PEBB appeals unit;
  - Amended the definition of “Brief adjudicative proceeding” to include WAC references;
  - Amended the definition of “Denial” or “denial notice” to include contracted vendor;
  - Created a new definition of “Dispositive motion;”
  - Amended the definition of “Final order” to clarify an order that is the final Health Care Authority’s decision;
  - Amended the definition of “Formal administrative hearing” to include statute and WAC references;

- Amended WAC 182-08-180 to clarify that the PEBB insurance coverage premiums and applicable premium surcharges are due for all subscriber, to include HCA may develop a reasonable payment plan of up to 12 months in duration upon subscriber or subscriber’s legal representative’s request, to clarify under what circumstances the PEBB director, the PEBB director’s designee, or the PEBB appeals unit may approve a premium refund, to add the PEBB director, the PEBB director’s designee, or the PEBB appeals unit may approve an enrollment change that was originally requested and which forms the basis for a refund, and to clarify employing agency errors will be corrected with corresponding WAC references;
- Amended WAC 182-08-185 to clarify premium surcharge is in addition to the medical premium, to clarify Medicare risk pool by adding a corresponding statute, and to clarify when an employee or a subscriber may attest for the spousal premium surcharge;
- Amended WAC 182-08-187 to clarify an enrollment error for failure to enroll an employee and their dependents in PEBB insurance coverage;
- Amended WAC 182-08-190 to remove charter school and to clarify the employer contributions must be paid to the HCA;
- Created WAC 182-08-191 to include employees and subscribers’ address requirements;
- Amended WAC 182-08-196 to clarify when a subscriber must elect a new health plan when their previously selected health plan becomes unavailable and when they submit the required forms and consequences of not making a new election;
- Amended WAC 182-08-197 to clarify when an employee may enroll in supplemental coverage and what coverage an employee may be defaulted to when the employing agency or contracted vendor did not receive the required forms within thirty-one days;
- Amended WAC 182-08-200 to clarify which employing agency is responsible for employer contribution when an employee changes employment;
- Amended WAC 182-08-235 and 182-08-245 to remove charter school and school districts, and to include educational service districts as employer groups applying for their non-represented employees;
- Amended WAC 182-12-113 to include state agencies must determine employee’s dependents eligibility for PEBB benefits and to clarify state agencies must inform the employee their right to appeal when they are ineligible for benefits and the employer contribution due to a change in work patterns;
- Amended WAC 182-12-114 to clarify when employees, seasonal employees, and faculty are eligible for PEBB benefits through stacking;
- Amended WAC 182-12-123 to include public employees benefits board in the title for clarity, to include a WAC reference when the PEBB Program will terminate the employee’s enrollment as a dependent, and to remove health plan sponsored by school district and charter school and replace them with SEBB;
- Amended WAC 182-12-128 to clarify a special enrollment event must be an event other than an employee gaining initial eligibility for PEBB benefits, to clarify if an employee waives PEBB medical the employee may not enroll dependents into PEBB medical, to include WAC 182-12-262 reference when referring to the dependents’ effective date of PEBB medical, and to include the requirement that the change in residence results in the dependent losing their health insurance when the dependent moves into or out of the United States;
- Amended WAC 182-12-133 to change references from PEBB insurance coverage to PEBB benefits;
- Amended WAC 182-12-146 to restructure this section for clarity, to include additional WAC references when clarifying COBRA eligibility for a retiree or a retiree’s dependent, to make a technical correction from an employee’s to a subscriber’s state registered domestic partner in the note section of subsection (6), to clarify when COBRA coverage will end, and to clarify a COBRA-eligible employee can continue Medical FSA if they have a greater amount in remaining benefits than remaining contribution payments for the current year;
- Amended WAC 182-12-148 to clarify HCA will refund premiums and applicable premium surcharges the employee paid when the employer contribution is reinstated;
- Amended WAC 182-12-171 to include PEBB retiree insurance coverage enrollment when referencing first premium payment;
- Amended WAC 182-12-211 to include defer enrollment in the title, to clarify the date of enrollment or deferment in PEBB retiree insurance coverage must be indicated on the form, to add a new subsection to indicate premiums and applicable premium surcharges are due from the effective date of enrollment;
- Amended WAC 182-12-260 to include notice requirements for an employee when a dependent is no longer eligible, to include WAC references for retirees, survivors, and PEBB continuation coverage enrollees, to clarify when PEBB insurance coverage will end, to include when enrollment of an extended dependent or a dependent with a disability

will begin, and to make a technical correction and replace health plan references with PEBB benefits;
- Amended WAC 182-12-263 to clarify subscribers on continuation coverage or PEBB retiree insurance coverage submit the required forms to the PEBB program;
- Amended WAC 182-12-265 to include survivors of school employee and a note regarding a spouse, state registered domestic partner, or child of an eligible school employee enrolled in SEBB insurance coverage may continue health plan enrollment as described in WAC 182-31-090;
- Amended WAC 182-12-270 to make error corrections and moved existing language to a new subsection (3) for clarity;
- Amended WAC 182-12-300 to include a statute when describing Medicare risk pool and to make an error correction;
- Amended WAC 182-16-2030, 182-16-2040, 182-16-2050, 182-16-2060 regarding PEBB appeals unit's notification;
- Amended WAC 182-16-2050 regarding state agency's requirements when handling a salary reduction plan's appeal;
- Amended WAC 182-16-2080 and 182-16-3010 to clarify when HCA employees may represent an appellant;
- Amended WAC 182-16-2100 to clarify that when requesting for reconsideration, the request can be made written or orally and is subject to be granted in a written final order;
- Amended WAC 182-16-2105 to clarify procedures after a withdrawal request is received;
- Amended WAC 182-16-2120 to clarify the exception when no evidence may be offered in support of a motion for reconsideration;
- Amended WAC 182-16-2130 to clarify the RCW references when filing a written petition for judicial review and to include the PEBB Program and the employing agency may not request judicial review;
- Amended WAC 182-16-3010 to clarify employees of the HCA or HCA's authorized agents may not represent an appellant unless approved by the hearing officer;
- Amended WAC 182-16-3030 to remove de novo (anew);
- Amended WAC 182-16-3120 about entering an order dismissing the dispositive motion;
- Amended WAC 182-16-3140 to clarify if no request is received the deadline, the dismissal order becomes the HCA's final decision without further action;
- Amended WAC 182-16-3160 to clarify which hearing representative an appellant may contact to withdraw a formal administrative hearing;
- Amended WAC 182-16-3180 to clarify the party filing the request for reconsideration must serve copies of the request on all other parties on the same day the request is served on the hearing officer, and to clarify the exception when no evidence may be offered in support of a motion for reconsideration;
- Amended WAC 182-16-3190 to clarify a new written final order is issued if the request is granted and to correct a WAC citation reference.

**Citation of rules affected by this order:**

New: 182-08-191

Repealed:

Amended: 182-08-015, 182-08-120, 182-08-180, 182-08-185,182-08-187, 182-08-190, 182-08-196, 182-08-197, 182-08-198, 182-08-199, 182-08-200, 182-08-235, 182-08-245, 182-12-109, 182-12-111, 182-12-113, 182-12-114, 182-12-116, 182-12-123, 182-12-128, 182-12-131, 182-12-133, 182-12-138, 182-12-141, 182-12-142, 182-12-146, 182-12-148, 182-12-171, 182-12-180, 182-12-200, 182-12-205, 182-12-207, 182-12-209, 182-12-211, 182-12-260, 182-12-262, 182-12-263, 182-12-265, 182-12-270, 182-12-300, 182-16-010, 182-16-020, 182-16-055, 182-16-064, 182-16-066, 182-16-120, 182-16-130, 182-16-2000, 182-16-2010, 182-16-2020, 182-16-2030, 182-16-2040, 182-16-2050, 182-16-2060, 182-16-2080, 182-16-2085, 182-16-2090, 182-16-2100, 182-16-2105, 182-16-2120, 182-16-2130, 182-16-2140, 182-16-2150, 182-16-2160, 182-16-3000, 182-16-3010, 182-16-3030, 182-16-3080, 182-16-3100, 182-16-3120, 182-16-3130, 182-16-3140, 182-16-3160, 182-16-3170, 182-16-3180, 182-16-3190, 182-16-3200

Suspended:

**Statutory authority for adoption:** RCW 41.05.021, 41.05.160

**Other authority:** Public Employees Benefits Board Policy Resolutions

**PERMANENT RULE (Including Expedited Rule Making)**

Adopted under notice filed as WSR 19-14-095 on July 1, 2019 (date).

Describe any changes other than editing from proposed to adopted version: None

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

Name:

Address:

Phone:

Fax:

TTY:

Email:

Web site:
Other:

**Note: If any category is left blank, it will be calculated as zero. No descriptive text.**

**Count by whole WAC sections only, from the WAC number through the history note. A section may be counted in more than one category.**

**The number of sections adopted in order to comply with:**

| | | | | | | |
|---|---|---|---|---|---|---|
| Federal statute: | New | ____ | Amended | ____ | Repealed | ____ |
| Federal rules or standards: | New | ____ | Amended | ____ | Repealed | ____ |
| Recently enacted state statutes: | New | ____ | Amended | ____ | Repealed | ____ |

**The number of sections adopted at the request of a nongovernmental entity:**

| | | | | | | |
|---|---|---|---|---|---|---|
| | New | ____ | Amended | ____ | Repealed | ____ |

**The number of sections adopted on the agency's own initiative:**

| | | | | | | |
|---|---|---|---|---|---|---|
| | New | | Amended | | Repealed | ____ |

**The number of sections adopted in order to clarify, streamline, or reform agency procedures:**

| | | | | | | |
|---|---|---|---|---|---|---|
| | New | 1 | Amended | 77 | Repealed | ____ |

**The number of sections adopted using:**

| | | | | | | |
|---|---|---|---|---|---|---|
| Negotiated rule making: | New | ____ | Amended | ____ | Repealed | ____ |
| Pilot rule making: | New | ____ | Amended | ____ | Repealed | ____ |
| Other alternative rule making: | New | 1 | Amended | 77 | Repealed | ____ |

**Date Adopted:** August 20, 2019

**Name:** Wendy Barcus

**Title:** HCA Rules Coordinator

**Signature:**

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

**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, ((~~or~~)) enroll in coverage, or waive enrollment in PEBB medical. Employees eligible to participate in the salary reduction plan may enroll in or change their election under the dependent care assistance program (DCAP) ((~~and~~)) or the medical flexible spending arrangement (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 ((~~and~~)), Sundays, and all legal state 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 health plan coverage available to enrollees ((~~after a qualifying event occurs as administered~~)) 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 ((~~PEBB insurance coverage extended by~~)) the public employees benefits ((~~board under WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, and 182-12-270~~)) 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 a PEBB health plan by a retiree or an eligible survivor.

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

"Dependent care assistance program" or "DCAP" means a benefit plan whereby ((~~state and public~~)) employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan under ((~~this~~)) 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((~~, and, effective October 1, 1995, employees of employee organizations currently pooled with employees of school districts for the purpose of purchasing insurance benefits, at the option of each such employee organization~~)); (c) 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); ((~~and~~)) (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 ((~~authority~~)) HCA by a state agency((~~,~~)) or employer group((~~, or charter school~~)) for its eligible employees as described ((~~in~~)) under WAC 182-12-114 and 182-12-131.

"Employer group" means those counties, municipalities, political subdivisions, the Washington health benefit exchange, tribal governments, ((~~school districts, educational service districts, and~~)) employee organizations representing state civil service employees, 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((~~, or charter school~~)) 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 ((~~school districts or~~)) an educational service district.

"Employing agency" for the public employees benefits board program means a division, department, or separate agency of state government, including an institution of higher education; a county, municipality, ((~~school district, educational service district,~~)) or other political subdivision; 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 ((~~public employees benefits board~~)) PEBB and provided by a contracted vendor or self-insured plans administered by the HCA.

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

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

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

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

"Life insurance" ((~~for eligible employees includes~~)) means basic life insurance ((~~and accidental death and dismemberment (AD&D) insurance~~)) paid for by the employing agency, as well as ((~~optional~~)) supplemental life insurance ((~~and optional AD&D 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.

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

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby eligible state ((~~and public~~)) employees may reduce their salary before taxes to pay for medical expenses not reimbursed by insurance as provided in the salary reduction plan established under ((~~this~~)) 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 and 182-12-180), eligible survivors (as described in WAC 182-12-180, 182-12-250, and 182-12-265), eligible dependents (as described in WAC 182-12-250 and 182-12-260) and others as defined in RCW 41.05.011.

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

"Premium payment plan" means a benefit plan whereby ((~~state and~~)) public employees may pay their share of group health plan premiums with pretax dollars as provided in the salary reduction plan 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 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 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 ((~~state and~~)) public employees may agree to a reduction of salary on a pretax basis to participate in the dependent care assistance program ((~~(DCAP)~~)), medical flexible spending arrangement ((~~(FSA)~~)), or premium payment plan offered pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

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

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

"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, ((~~or charter school~~)) 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((~~s~~)).

"Supplemental coverage" means any life insurance, accidental death and dismemberment (AD&D) insurance coverage, or long-term disability 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 ((~~to interrupt~~)) an eligible ((~~employee's~~)) employee affirmatively declining enrollment in a PEBB health plan because the employee is enrolled in other employer-based group medical, TRICARE plans, or medicare as allowed under WAC 182-12-128, or is on approved educational leave and obtains another employer-based group health plan as allowed under WAC 182-12-136.

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

**WAC 182-08-120 Employer contribution for the public employees benefits board (PEBB) benefits.** The employer contribution must be used to provide public employees benefits board (PEBB) insurance coverage for the basic life insurance benefit, basic accidental death and dismemberment insurance benefit (AD&D), the basic long-term disability (LTD) insurance benefit, medical ((~~and~~)) insurance, dental insurance, and to establish a reserve for any remaining balance. There is no employer contribution available for any other insurance coverage for employees employed by state agencies.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

**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 ((~~(3)~~)) (4) or ((~~(4)~~)) (5).

(1) **Premium payments.** ((~~Public employees benefits board (~~))PEBB((~~)~~)) insurance coverage premiums and applicable premium surcharges for all subscribers become due the first of the month in which 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)(a) through (f), 182-12-211, and 182-12-265; or electing to enroll in continuation coverage as described in WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, and 182-12-270, the first premium payment and applicable premium surcharges are due to the health care authority (HCA) no later than forty-five days after the election period ends as described within the Washington Administrative Code applicable to the subscriber. Premiums

and applicable premium surcharges associated with continuing PEBB medical must be made to the HCA as well as premiums associated with continuing PEBB dental or long-term disability insurance coverage. Premiums associated with life insurance and accidental death and dismemberment insurance coverage must be made to the contracted vendor. Following the first premium payment, premiums and applicable premium surcharges must be paid as premiums become due.

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

(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. For subscribers not eligible for the employer contribution or employees eligible for the employer contribution as described in WAC 182-12-138, monthly premiums or applicable premium surcharges that remain unpaid for thirty days will be considered delinquent. A subscriber is allowed a grace period of thirty days from the date the monthly premiums or applicable premium surcharges become 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 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 months in duration with the subscriber or the subscriber's legal representative upon request.

(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 and the monthly premiums or applicable premium surcharges remain unpaid for thirty days; or

(ii) Premium payments or applicable premium surcharges received by the HCA are underpaid by an amount greater than an insignificant shortfall and the monthly premiums or applicable premium surcharges remain underpaid for thirty 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 three month adjustment period, except as indicated in WAC 182-12-148(5).

(b) If a PEBB subscriber, dependent, or beneficiary submits a written appeal as described in WAC 182-16-2010, ((~~showing proof~~)) and provides clear and convincing evidence of extraordinary circumstances ((~~beyond their control~~)), such that ((~~it was effectively impossible to~~)) the subscriber could not timely submit the necessary information to accomplish an allowable enrollment change within sixty 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 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 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 18-20-117, filed 10/3/18, effective 1/1/19)

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

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

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

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

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

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

(iii) If a subscriber submits the required form to enroll a dependent, thirteen years and older, in PEBB medical as described in WAC 182-12-262, the subscriber must attest for their dependent on the required form. An employee must submit the form to their employing agen-

cy. Any other subscriber must submit their form to the PEBB program. A change that results in a premium surcharge will take effect the same date as PEBB medical begins.

(iv) An enrollee, thirteen years and older, who elects to continue medical coverage as described in WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, or 182-12-270, must provide an attestation on the required form if they have not previously attested as described in (a) of this subsection. The enrollee must submit their form to the PEBB program. An attestation that results in a premium surcharge will take effect the same date as PEBB medical begins.

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

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

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

**Exceptions:** (1) A subscriber enrolled in both medicare Parts A and B and in the medicare risk pool as described in RCW 41.05.080(3) is not required to provide an attestation and no premium surcharge will be imposed on the subscriber's account.
(2) An employee who waives PEBB medical ((~~according to~~)) as described in WAC 182-12-128 is not required to provide an attestation and no premium surcharge will be applied to their account as long as the employee remains in waived status.

(b) A subscriber's account will incur a premium surcharge when a subscriber fails to attest to the tobacco use status of all enrollees as described in subsection (1)(a) of this section.

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

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

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

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

(2) A subscriber will incur a premium surcharge in addition to the subscriber's monthly medical premium, if an enrolled spouse or state registered domestic partner ((~~elected~~)) has chosen not to enroll

in another employer-based group medical where the spouse's or state registered domestic partner's share of the medical premium is less than ninety-five percent of the additional cost an employee would be required to pay to enroll a spouse or state registered domestic partner in the PEBB Uniform Medical Plan (UMP) Classic and the benefits have an actuarial value of at least ninety-five percent of the actuarial value of the PEBB UMP Classic's benefits.

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

(i) When a subscriber becomes eligible to enroll a spouse or state registered domestic partner in PEBB medical ((~~or during the annual open enrollment~~)) as described in WAC 182-12-262 ((~~(1)(a) or (b). A~~)). The subscriber must complete the required form to enroll their spouse or state registered domestic partner((~~. The subscriber must~~)), and include their attestation on that form. The employee must submit the form to their employing agency. Any other subscriber must submit the form to the PEBB program. If the subscriber's attestation results in a premium surcharge it will take effect the same date as PEBB medical begins;

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

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

- Incurring the surcharge;
- Not incurring the surcharge because the spouse's or state registered domestic partner's share of the medical premium through their employer-based group medical was more than ninety-five percent of the additional cost an employee would be required to pay to enroll a spouse or state registered domestic partner in the PEBB UMP Classic; or
- Not incurring the surcharge because the actuarial value of benefits provided through the spouse's or state registered domestic partner's employer-based group medical was less than ninety-five percent of the actuarial value of the PEBB UMP Classic's benefits.

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

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

spouse's or state registered domestic partner's employer-based group medical status changes.

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

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

**Exceptions:**
(1) A subscriber enrolled in both medicare Parts A and B and in the medicare risk pool as described in RCW 41.05.080(3) is not required to provide an attestation and no premium surcharge will be imposed on the subscriber's account.
(2) An employee who waives PEBB medical ((~~according to~~)) as described in WAC 182-12-128 is not required to provide an attestation and no premium surcharge will be applied to their account as long as the employee remains in waived status.
(3) An employee who covers their spouse or state registered domestic partner who has waived their own PEBB medical must attest as described in this subsection, but will not incur a premium surcharge ((~~will not be applied~~)) if the employee provides an attestation that their spouse or state registered domestic partner is eligible for PEBB coverage.
(4) A subscriber who covers their spouse or state registered domestic partner who elected not to enroll in a TRICARE plan must attest as described in this subsection, but will not incur a premium surcharge ((~~will not be applied~~)) if the subscriber provides an attestation that their spouse or state registered domestic partner is eligible for a TRICARE plan.

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

**WAC 182-08-187 How do employing agencies and contracted vendors correct enrollment errors and is there a limit on retroactive enrollment?** (1) An employing agency or contracted vendor that makes one or more of the following enrollment errors must correct the error as described in subsections (2) through (4) of this section.

(a) Failure to timely notify an employee of 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 insurance coverage as elected by the employee, if the elections were timely;

(c) Failure to enroll an employee and their dependents in PEBB insurance coverage 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; ((~~or~~))

(e) Enrolling an employee or their dependent((~~s~~)) 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 ((~~(2)~~)) (3) of this section, reconcile premium payments and applicable premium surcharges as described in subsection ((~~(3)~~)) (4) of this section, and provide recourse as described in subsection ((~~(4)~~)) (5) of this section.

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

((~~(2)~~)) (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 ((~~(4)~~)) (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), and basic long-term disability (LTD) insurance enrollment is retroactive to the first day of the month following the day the employee became newly eligible, or the first day of the month the employee regained eligibility, as described in WAC 182-08-197. If the employee became newly eligible on the first working day of a month, basic life, basic AD&D, and basic LTD insurance begins on that date;

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

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

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

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

(d) If the employee is eligible and elects (or elected) to enroll in the medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP), enrollment is limited to three months prior to the date enrollment is processed, but not earlier than the current plan year. If an employee was not enrolled in a medical 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 insurance coverage will be terminated prospectively effective as of the last day of the month.

((~~(3)~~)) (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 basic LTD ((~~from~~)) starting the date PEBB insurance coverage begins as described in subsections ((~~(2)~~)) (3) and ((~~(4)~~)) (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 months following notification of a new enrollment period.

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

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

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

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

((~~(4)~~)) (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 ((~~(2)~~)) (3) of this section, the employing agency must work with the employee, and receive approval from the authority, to implement retroactive PEBB insurance coverage within the following parameters:

(i) Retroactive enrollment in a PEBB health plan;

(ii) Reimbursement of claims paid;

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

(iv) Other legal remedy received or offered; or

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

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

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

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

the employer contributions to the health care authority (HCA) for PEBB insurance coverage for all eligible employees and their dependents.

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

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

(3) Each employee of a state agency eligible under WAC 182-12-131 or each eligible employee of a state agency on leave under the federal Family and Medical Leave Act (FMLA) or the paid family and medical leave program is eligible for the employer contribution as described in WAC 182-12-138. The entire employer contribution is due and payable to HCA even if PEBB medical is waived as described in WAC 182-12-128.

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

(5) The entire employer contribution is due and payable to the HCA even if PEBB medical is waived as described in WAC 182-12-128.

((~~(5)~~)) (6) Washington state patrol officers disabled while performing their duties as determined by the chief of the Washington state patrol are eligible for the employer contribution for PEBB medical as authorized in RCW 43.43.040. No other retiree or disabled employee is eligible for the employer contribution for PEBB benefits unless they are an eligible employee as described in WAC 182-12-114 or 182-12-131.

((~~(6)~~)) (7) The terms of payment to HCA for employer groups ((~~and charter schools~~)) shall be stipulated under contract with the HCA.

NEW SECTION

**WAC 182-08-191 Subscriber address requirements.** (1) All employees must provide their employing agency with their correct address and update their address if it changes. A subscriber on PEBB retiree insurance coverage or continuation coverage must provide the PEBB program with their correct address and updates to their address if it changes.

(2) Employees who are appealing a decision to the public employees benefits board (PEBB) program must update their address as required in WAC 182-16-055.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

**WAC 182-08-196 What happens if my health plan becomes unavailable due to a change in contracted service area or eligibility for medicare?** (1) A subscriber((~~s~~)) must ((~~select~~)) elect a new health plan ((~~within sixty days of~~)) when their ((~~chosen~~)) previously selected health plan ((~~becoming~~)) becomes unavailable due to a change in con-

tracting service area ((~~or the subscriber or subscriber's dependent ceasing to be eligible for their current plan because of their enrollment in medicare.~~

~~(a) Employees~~)) as described below:

(a) When a health plan becomes unavailable during the plan year, a subscriber must elect a new health plan no later than sixty days after the date their previously selected health plan becomes unavailable.

(i) An employee must submit the required forms to their employing agency electing their new health plan.

((~~(b) All~~)) (ii) Any other subscriber((~~s~~)) must submit the required forms to ((~~notify~~)) the PEBB program electing their new health plan.

((~~(c)~~)) (iii) The effective date of the change in health plan will be the first day of the month following the later of the date the health plan becomes unavailable or the date the form is received. ((~~(2) The PEBB program will change health plan enrollment as follows if the~~)) If that day is the first of the month, the change in health plan begins on that day.

(b) When a health plan becomes unavailable at the beginning of the next plan year, a subscriber must elect a new health plan no later than the last day of the public employees benefits board (PEBB) annual open enrollment.

(i) An employee must submit the required forms to their employing agency electing their new health plan.

(ii) Any other subscriber must submit the required forms to the PEBB program electing their new health plan.

(iii) The effective date of the change in health plan will be January 1st of the following year.

(c) A subscriber who fails to ((~~select~~)) elect a new health plan ((~~as required under subsection (1) of this section:~~

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

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

~~(3) Any~~)) (2) A subscriber ((~~enrolled in a~~)) must elect a new health plan ((~~as described in subsection (2) of this section may not change~~)) when their previously selected health ((~~plans except as allowed in WAC 182-08-198~~)) plan becomes unavailable due to the subscriber or subscriber's dependent ceasing to be eligible for their current health plan because of enrollment in medicare as described below:

(a) The required forms electing a new health plan must be received no later than sixty days after the date their previously selected health plan becomes unavailable.

(b) An employee must submit the required forms to their employing agency electing their new health plan.

(c) Any other subscriber must submit the required forms to the PEBB program electing their new health plan.

(d) The effective date of the change in health plan will be the first day of the month following the later of the date the health plan becomes unavailable or the date the form is received. If that day is the first of the month, the change in health plan begins on that day.

(e) A subscriber who is enrolled in a consumer directed health plan (CDHP) with a health savings account (HSA), who fails to elect a new health plan within the required time period as required in this subsection, will not be eligible to receive contributions to the HSA. A subscriber will be liable for any tax penalties resulting from contributions made when they are no longer eligible.

(3) A subscriber enrolled in a health plan as described in subsection (1)(c) or (2) of this section may not change health plans except as allowed in WAC 182-08-198.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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

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

(a) An employee must complete the required forms indicating their enrollment elections, including an election to waive PEBB medical ((~~if~~)) provided the employee is eligible to waive PEBB medical and elects to waive ((~~PEBB medical~~)) as described in WAC 182-12-128. The required forms must be returned to the employee's employing agency. ((~~Forms~~)) Their employing agency must ((~~be received by their employing agency~~)) receive the forms no later than thirty-one days after the employee becomes eligible for PEBB benefits under WAC 182-12-114.

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

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

(iii) If an employee is eligible to participate in the ((~~state's~~)) salary reduction plan (see WAC 182-12-116), the employee may enroll in the state's medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP) or both, except as limited by subsection (4) of this section. To enroll in these ((~~optional~~)) supplemental PEBB benefits, the employee must return the required form to their state agency. The form must be received by the state agency

no later than thirty-one days after the employee becomes eligible for PEBB benefits.

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

(i) Uniform Medical Plan Classic;

(ii) Uniform Dental Plan;

(iii) Basic life insurance;

(iv) Basic AD&D insurance;

(v) Basic long-term disability insurance;

((~~(v)~~)) (vi) Dependents will not be enrolled; and

((~~(vi)~~)) (vii) A tobacco use surcharge will be incurred as described in WAC 182-08-185 (1)(b).

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

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

(a) The employee must complete the required forms indicating their enrollment elections, including an election to waive PEBB medical if the employee chooses to waive PEBB medical as described in WAC 182-12-128. The required forms must be returned to the employee's employing agency except as described in (d) of this subsection. Forms must be received by the employing agency, ((~~or~~)) life insurance contracted vendor, or AD&D contracted vendor, if required, no later than thirty-one days after the employee regains eligibility, except as described in subsection (3)(b) of this section:

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

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

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

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

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

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

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

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

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

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

**WAC 182-08-198 When may a subscriber change health plans?** A subscriber((~~s~~)) may change health plans at the following times:

(1) **During the annual open enrollment:** A subscriber((~~s~~)) may change health plans during the public employees benefits board (PEBB) annual open enrollment period. ((~~The~~)) A subscriber must submit the required enrollment forms to change their health plan. An employee submits the enrollment forms to their employing agency. ((~~All~~)) Any other subscriber((~~s~~)) 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 s~~s~~ubscriber((~~s~~)) 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. The change in enrollment must be allowable under Internal Revenue Code ((~~(IRC)~~)) and Treasury regulations, and correspond to and be consistent with the event that creates the special open enrollment for the subscriber, the subscriber's dependent, or both. To make a health plan change, ((~~the~~)) a subscriber must submit the required enrollment forms (and a completed disenrollment form, if required). The forms must be received no later than sixty days after the event occurs, except as described in (i) of this subsection. An employee submits the enrollment forms to their employing agency. ((~~All~~)) Any other subscriber((~~s~~)) submits the enrollment forms to the PEBB program. In addition to the required forms, a subscriber((~~s~~)) must provide evidence of the event that created the special open enrollment. New health plan coverage will begin the first day of the month following the later of the event date or the date the form is received. If that day is the first of the month, the change in enrollment begins on that day.

**Exception:** When a subscriber or their dependent is enrolled in a medicare advantage plan, the new health plan coverage will begin the first day of the month following the date the medicare advantage plan disenrollment form is received.

If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, health plan coverage will begin the month in which the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption occurs. Any one of the following events may create a special open enrollment:

(a) Subscriber acquires a new dependent due to:

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

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

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

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

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

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

((**~~Exception:~~**)) **Note:** ((~~For the purposes of special open enrollment~~)) 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 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 becomes entitled to coverage under medicaid or a state children's health insurance program (CHIP), or the subscriber or a subscriber's dependent loses eligibility for coverage under medicaid or CHIP;

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

(i) Subscriber or a subscriber's dependent becomes entitled to coverage under medicare, or the subscriber or a subscriber's dependent loses eligibility for coverage under medicare, or enrolls in or terminates enrollment in a medicare Part D plan. If the subscriber's current health plan becomes unavailable due to the subscriber's or a subscriber's dependent's entitlement to medicare, the subscriber must select a new health plan as described in WAC 182-08-196((~~(1)~~)) (2). A subscriber has six months from the date of their or their dependent's enrollment in medicare Part B to enroll in a PEBB medicare supplement plan for which they or their dependent is eligible. The forms must be received by the PEBB program no later than six months after the enrollment in medicare Part B for either the subscriber or the subscriber's dependent;

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

(k) Subscriber or a subscriber's dependent experiences a disruption of care for active and ongoing treatment, that could function as a reduction in benefits for the subscriber or the subscriber's dependent ((~~for a specific condition or ongoing course of treatment. The~~)). 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 ((~~for up to ninety days or until medically stable; or~~

~~(ii) Transplant within the last twelve months; or~~

~~(iii) Scheduled surgery within the next sixty days (elective procedures within the next sixty days do not qualify for continuity of care); or~~));

(ii) Treatment following a recent organ transplant;

(iii) A scheduled surgery;

(iv) Recent major surgery still within the postoperative period ((~~of up to eight weeks~~)); or

(v) ((~~Third trimester of~~)) Treatment for a high-risk pregnancy.

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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

(1) When newly eligible under WAC 182-12-114((~~,~~)) 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 ((~~state's~~)) premium payment plan during the annual open enrollment by submitting the required form to their employing agency. An eligible employee may elect to enroll or reenroll in the medical FSA, DCAP, or both during the annual open enrollment 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.

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

(3) **During a special open enrollment:** An employee who is eligible to participate in the salary reduction plan may enroll or revoke their election and make a new election under the ((~~state's~~)) premium payment plan, medical FSA, or DCAP outside of the annual open enrollment if a special open enrollment event occurs. The enrollment or change in election must be allowable under Internal Revenue Code (IRC) and Treasury regulations, and correspond to and be consistent with the event that creates the special open enrollment. To make a change or enroll, the employee must submit the required form 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 days after the event occurs.

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

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

(i) Employee acquires a new dependent due to:

• Marriage;

• Registering a state registered domestic partnership when the dependent is a tax dependent of the ((~~subscriber~~)) employee;

• Birth, adoption, or when the ((~~subscriber~~)) 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 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 for the employer contribution under their employer-based group health plan;

((**~~Exception:~~**)) **Note:** ((~~For the purposes of special open enrollment~~)) 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 subscriber (a former spouse or former state registered domestic partner is not an eligible dependent);

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

(xi) Employee or an employee's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from medicaid or ((~~a state children's health insurance program~~ ~~(~~))CHIP((~~)~~));

(xii) Employee or an employee's dependent becomes entitled to coverage under medicare or the employee or an employee's dependent loses eligibility for coverage under medicare;

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

authority (HCA) requires evidence that the employee or employee's dependent is no longer eligible for an HSA;

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

• Active cancer treatment such as chemotherapy or radiation therapy ((~~for up to ninety days or until medically stable; or~~

~~• Transplant within the last twelve months; or~~

~~• Scheduled surgery within the next sixty days (elective procedures within the next sixty days do not qualify for continuity of care); or~~));

• Treatment following a recent organ transplant;

• A scheduled surgery;

• Recent major surgery still within the postoperative period ((~~of up to eight weeks~~)); or

• ((~~Third trimester of~~)) 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 plan change will not be approved if it would conflict with provisions of the salary reduction plan authorized under RCW 41.05.300.

(b) **Medical ((~~flexible spending arrangement ~~))FSA((~~)~~)).** An employee may enroll or revoke their election and make a new election under the medical FSA when any one of the following special open enrollment events occur, if the requested change corresponds to and is consistent with the event. The enrollment or 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 ((~~subscriber~~)) employee;

• Birth, adoption, or when the ((~~subscriber~~)) 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 or otherwise does not meet dependent child eligibility criteria;

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

• An eligible dependent dies.

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

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

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

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

(vii) Employee or an employee's dependent becomes entitled to coverage under medicare.

(c) **((~~Dependent care assistance program (~~))DCAP((~~)~~))**. An employee may enroll or 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 ((~~subscriber~~)) 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 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 18-20-117, filed 10/3/18, effective 1/1/19)

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

(1) **For eligible employees changing agencies:** When an eligible employee's employment relationship terminates with an employing agency at any time during the month for which a premium contribution is due and that employee transfers to another agency, the ((~~losing~~)) agency losing the employee is responsible for the payment of the employer contribution for ((~~that~~)) the employee for that month. The receiving agency is liable for any employer contribution for the eligible employee beginning the first day of the month following the transfer.

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

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

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

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

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

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

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

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

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

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

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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

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

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

(a) ((~~School districts,~~)) Educational service districts((~~, and charter schools~~)) applying for its nonrepresented employees are required to provide the documents described in subsections (2)(a) through (c) of this section;

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

(b) Counties, municipalities, political subdivisions, and tribal governments with fewer than five thousand employees are required to provide the documents and information described in subsection (2)(a) through (f) of this section;

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

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

(2) Documents and information required with application:

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

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

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

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

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

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

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

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

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

(ii) Age;

(iii) Gender;

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

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

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

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

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

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

(iii) Summary of historical plan costs; and

(iv) The director or the director's designee may make an exception to the claims and cost information requirements based on the size of the group, except that the current health plan does not have a case management program, then the primary diagnosis code designated by the authority must be reported for each large claimant. If the code indicates a condition which is expected to continue into the next quarter, the claim is counted as an ongoing large claim. If historical claims and cost information as described in (e)(i) through (iii) of this subsection are unavailable, the director or the director's designee may make an exception to allow all of the following alternative requirements:

• A letter from their carrier indicating they will not or cannot provide claims data.

• Provide information about the health plan most employees are enrolled in by completing the actuarial calculator authorized by the PEBB program.

• Current premiums for the health plan.

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

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

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

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

(iii) Executive summary of benefits;

(iv) Summary of benefits and certificate of coverage; and

(v) Summary of historical plan costs.

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

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

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

**WAC 182-08-245 Employer group ((~~and charter school~~)) participation requirements.** This section applies to an employer group as defined in WAC 182-08-015 ((~~or a charter school~~)) that is approved to purchase insurance for its employees through a contract with the health care authority (HCA).

(1) Prior to enrollment of employees in public employees benefits board (PEBB) insurance coverage, the employer group ((~~or charter school~~)) must:

(a) Remit to the authority the required start-up fee in the amount publicized by the PEBB program;

(b) Sign a contract with the authority;

(c) Determine employee and dependent eligibility and terms of enrollment for PEBB insurance coverage by the criteria outlined in this chapter and chapter 182-12 WAC unless otherwise approved by the authority in the employer group's ((~~or charter school's~~)) contract with the authority;

(d) Determine eligibility in order to ensure the PEBB program's continued status as a governmental plan under Section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA) as amended. This means the employer group ((~~or charter school~~)) may only consider employees whose services are substantially all in the performance of es-

sential governmental functions, but not in the performance of commercial activities, whether or not those activities qualify as essential governmental functions to be eligible; and

(e) Ensure PEBB insurance coverage is the only employer-sponsored coverage available to groups of employees eligible for PEBB insurance coverage under the contract.

(2) Pay premiums under its contract with the authority based on the following premium structure:

(a) The premium rate structure for ((~~school districts,~~)) educational service districts((~~, and charter schools~~)) purchasing PEBB insurance coverage for nonrepresented employees will be a composite rate equal to the rate charged to state agencies plus an amount equal to the employee premium based on health plan election and family enrollment. ((~~School districts and~~)) Educational service districts must collect an amount equal to the premium surcharges applied to an employee's account by the authority from their nonrepresented employees and include the funds in their payment to the authority.

**Exception:** The authority will allow educational service districts that enrolled prior to September 1, 2002, to continue participation based on a tiered rate structure. The authority may require the district to change to a composite rate structure with ninety days advance written notice.

(b) The premium rate structure for employer groups other than educational service districts ((~~and charter schools~~)) described in (a) of this subsection will be a tiered rate based on health plan election and family enrollment. Employer groups must collect an amount equal to the premium surcharges applied to an employee's account by the authority from their employees and include the funds in their payment to the authority.

**Exception:** The authority will allow employer groups that enrolled prior to January 1, 1996, to continue to participate based on a composite rate structure. The authority may require the employer group to change to a tiered rate structure with ninety days advance written notice.

(3) Counties, municipalities, political subdivisions, and tribal governments must pay the monthly employer group rate surcharge in the amount invoiced by the authority.

(4) If an employer group ((~~or charter school~~)) wants to make subsequent changes to the contract, the changes must be submitted to the authority for approval.

(5) The employer group ((~~or charter school~~)) must maintain participation in PEBB insurance coverage for at least one full year. An employer group ((~~or charter school~~)) may only end participation at the end of a plan year unless the authority approves a mid-year termination. To end participation, an employer group ((~~or charter school~~)) must provide written notice to the PEBB program at least sixty days before the requested termination date.

(6) Upon approval to purchase insurance through a contract with the authority, the employer group ((~~or charter school~~)) must provide a list of employees and dependents that are enrolled in Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage and the remaining number of months available to them based on their qualifying event. These employees and dependents may enroll in a PEBB health plan as COBRA subscribers for the remainder of the months available to them based on their qualifying event.

(7) Enrollees in PEBB insurance coverage under one of the continuation of coverage provisions allowed under chapter 182-12 WAC or retirees included in the transfer unit as allowed under WAC 182-08-237 cease to be eligible as of the last day of the contract and may not continue enrollment beyond the end of the month in which the contract is terminated.

**Exception:** If an employer group, other than ((~~a school district or~~)) an educational service district, ends participation, retired and disabled employees who began participation before September 15, 1991, are eligible to continue enrollment in PEBB insurance coverage if the employee continues to meet the procedural and eligibility requirements of WAC 182-12-171. Employees who enrolled after September 15, 1991, who are enrolled in PEBB retiree insurance coverage cease to be eligible under WAC 182-12-171, but may continue health plan enrollment under COBRA (see WAC 182-12-146).

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

**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 agencies, 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, ((~~or~~)) enroll in coverage, or waive enrollment in PEBB medical. Employees eligible to participate in the salary reduction plan may enroll in or change their election under the dependent care assistance program (DCAP) or the medical flexible spending arrangement (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 ((~~and~~)), Sundays, and all legal state 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 health plan coverage available to enrollees ((~~after a qualifying event occurs as administered~~)) 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 ((~~PEBB insurance coverage extended by~~)) the public employees benefits ((~~board under WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, and 182-12-270~~)) 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 a PEBB health plan by a retiree or an eligible survivor.

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

"Dependent care assistance program" or "DCAP" means a benefit plan whereby ((~~state and public~~)) employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan under ((~~this~~)) 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((~~, and, effective October 1, 1995, employees of employee organizations currently pooled with employees of school districts for the purpose of purchasing insurance benefits, at the option of each such employee organization~~)); (c) 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); ((~~and~~)) (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 edu-

cation as determined by their institution; and any others not expressly defined as employees under RCW 41.05.011 or by the authority under this chapter.

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

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

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

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

"Employer contribution" means the funding amount paid to the ((~~authority~~)) HCA by a state agency((~~,~~)) or employer group((~~, or charter school~~)) 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, ((~~school districts, educational service districts, and~~)) 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 ((~~or charter school~~)) 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 ((~~school districts or~~)) an educational service district.

"Employing agency" for the public employees benefits board means a division, department, or separate agency of state government, including an institution of higher education; a county, municipality, ((~~school district, educational service district,~~)) or other political subdivision; 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 ((~~public employees benefits board~~)) PEBB and provided by a contracted vendor or self-insured plans administered by the HCA.

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

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

"Life insurance" ((~~for eligible employees includes~~)) means basic life insurance ((~~and accidental death and dismemberment (AD&D) insurance~~)) paid for by the employing agency, as well as ((~~optional~~)) supplemental life insurance ((~~and optional AD&D 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.

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

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby eligible state ((~~and public~~)) employees may reduce their salary before taxes to pay for medical expenses not reimbursed by insurance as provided in the salary reduction plan established under ((~~this~~)) 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 and 182-12-180), eligible survivors (as described in WAC 182-12-180, 182-12-250, and 182-12-265), eligible dependents (as described in WAC 182-12-250 and 182-12-260) and others as defined in RCW 41.05.011.

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

"Premium payment plan" means a benefit plan whereby ((~~state and~~)) public employees may pay their share of group health plan premiums with pretax dollars as provided in the salary reduction plan 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 ((~~a~~)) 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 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 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 ((~~(DCAP)~~)), medical flexible spending arrangement ((~~(FSA)~~)), 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 school employees benefits board established in RCW 41.05.740.

"SEBB insurance coverage" means any health plan, 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 consecutive months.

"Seasonal employee" means ((~~an~~)) 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 in PEBB medical. Employees eligible to participate in the salary reductions plan may enroll in or revoke their election under the DCAP, medical FSA, or the premium payment plan and make a new election. For special open enrollment events related to specific PEBB benefits, see WAC 182-08-198, 182-08-199, 182-12-128, and 182-12-262.

"State agency" means an office, department, board, commission, institution, or other separate unit or division, however designated, of the state government ((~~and all personnel thereof~~)). It includes the legislature, executive branch, and agencies or courts within the judi-

cial 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, ((~~or charter school~~)) 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((~~s~~)).

"Supplemental coverage" means any life insurance, accidental death and dismemberment (AD&D) insurance coverage, or long-term disability 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 ((~~to interrupt~~)) an eligible ((~~employee's~~)) employee affirmatively declining enrollment in a PEBB health plan because the employee is enrolled in other employer-based group medical, TRICARE plans, or medicare as allowed under WAC 182-12-128, or is on approved educational leave and obtains another employer-based group health plan as allowed under WAC 182-12-136.

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

**WAC 182-12-111 Which entities and individuals are eligible for public employees benefits board (PEBB) benefits?** The following entities and individuals shall be eligible for public employees benefits board (PEBB) benefits subject to the terms and conditions set forth below:

(1) **State agencies.** State agencies, as defined in WAC 182-12-109, are required to participate in all PEBB benefits. Insurance and health care contributions for ferry employees shall be governed by RCW 47.64.270.

(2) **Employer groups.** Employer groups may apply to participate in PEBB insurance coverage for groups of employees described in (a)(i) of this subsection and for members of the group's governing authority as described in (a)(i), (ii), and (iii) of this subsection at the option of each employer group:

(a) All eligible employees of the entity must transfer as a unit with the following exceptions:

(i) Bargaining units may elect to participate separately from the whole group;

(ii) Nonrepresented employees may elect to participate separately from the whole group provided all nonrepresented employees join as a group; and

(iii) Members of the employer group's governing authority may participate as described in the employer group's governing statutes and RCW 41.04.205.

(b) Employer groups must apply through the process described in WAC 182-08-235. Applications from employees of employee organizations representing state civil service employees, the Washington health benefit exchange, and employer groups with five thousand or more employees, except for ((~~school districts and~~)) educational service districts are subject to review and approval by the health care authority (HCA) based on the employer group evaluation criteria described in WAC 182-08-240.

(c) Employer groups ((~~and charter schools~~)) participate through a contract with the authority as described in WAC 182-08-245.

(3) **((~~School districts,~~)) Washington state educational service districts((~~, and charter schools~~)).** In addition to subsection (2) of this section, the following applies to ((~~school districts,~~)) Washington state educational service districts((~~, and charter schools~~)) enrolling in PEBB insurance coverage for its nonrepresented employees until December 31, 2023:

(a) The HCA will collect an amount equal to the composite rate charged to state agencies, plus an amount equal to the employee premium by health plan and family size and an amount equal to any applicable premium surcharge as would be charged to state employees for each participating ((~~school district,~~)) educational service district((~~, or charter school~~)).

(b) The HCA may collect these amounts in accordance with the district fiscal year, as described in RCW 28A.505.030.

(4) **The Washington health benefit exchange.** In addition to subsection (2) of this section, the following provisions apply:

(a) The Washington health benefit exchange is subject to the same rules as an employing agency in chapters 182-08, 182-12, and 182-16 WAC.

(b) Employees of the Washington health benefit exchange are subject to the same rules as employees of an employing agency in chapters 182-08, 182-12 and 182-16 WAC.

(5) **Eligible nonemployees.**

(a) Blind vendors actively operating a business enterprise program facility in the state of Washington and deemed eligible by the department of services for the blind (DSB) may voluntarily participate in PEBB medical. Dependents of blind vendors are eligible as described in WAC 182-12-260. Eligible blind vendors and their dependents may enroll during the following times:

(i) When newly eligible: The DSB will notify eligible blind vendors of their eligibility in advance of the date they are eligible for enrollment in PEBB medical.

To enroll, blind vendors must submit the required forms to the DSB. The forms must be received by the DSB no later than thirty-one days after the blind vendor becomes eligible for PEBB medical.

(ii) During the annual open enrollment: Blind vendors may enroll during the annual open enrollment. The required form must be received

by the DSB before the end of the annual open enrollment. Enrollment will begin January 1st of the following year.

(iii) Following loss of other medical insurance coverage: Blind vendors may enroll following loss of other medical insurance coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA). To enroll, blind vendors must submit the required forms to the DSB. The forms must be received by the DSB no later than sixty days after the loss of other medical insurance coverage. In addition to the required forms, the DSB will require blind vendors to provide evidence of loss of other medical insurance coverage.

(iv) Blind vendors who cease to actively operate a facility become ineligible to participate in PEBB medical as described in (a) of this subsection. Enrollees who lose eligibility for coverage may continue enrollment in PEBB medical on a self-pay basis under COBRA coverage as described in WAC 182-12-146(5).

(v) Blind vendors are not eligible for PEBB retiree insurance coverage.

(b) Dislocated forest products workers enrolled in the employment and career orientation program pursuant to chapter 50.70 RCW shall be eligible for PEBB health plans while enrolled in that program.

(c) School board members or students eligible to participate under RCW 28A.400.350 may participate in PEBB insurance coverage as long as they remain eligible under that section.

(6) **Individuals and entities not eligible as employees include:**

(a) Adult family home providers as defined in RCW 70.128.010;

(b) Unpaid volunteers;

(c) Patients of state hospitals;

(d) Inmates in work programs offered by the Washington state department of corrections as described in RCW 72.09.100 or an equivalent program administered by a local government;

(e) Employees of the Washington state convention and trade center as provided in RCW 41.05.110;

(f) Students of institutions of higher education as determined by their institutions; and

(g) Any others not expressly defined as an employee.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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

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

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

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

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

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

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

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

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

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

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

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

(3) State agencies must determine employee's dependents eligibility for PEBB benefits according to the criteria in WAC 182-12-260.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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

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

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

(a) **Eligibility.** An employee is eligible if they are anticipated to work an average of at least eighty 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 insurance coverage. 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 insurance coverage as described in WAC 182-12-131(1).

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

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

(a) **Eligibility.** A seasonal employee is eligible if they are anticipated to work an average of at least eighty 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 cri-

teria in (a) of this subsection, the employee becomes eligible when the revision is made.

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

(c) **Stacking of hours.** As long as the work is within one state agency, employees may "stack" or combine hours worked in more than one position or job to establish eligibility and maintain the employer contribution toward PEBB insurance coverage. Employees 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 insurance coverage as described in WAC 182-12-131(1).

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

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

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

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

(ii) **For faculty hired on quarter/semester to quarter/semester basis:** Faculty who the employing agency anticipates will not work for the entire instructional year, or equivalent nine-month period, are eligible at the beginning of the second consecutive quarter or semester of employment in which they are anticipated to work, or has actually worked, half-time or more. Spring and fall are considered consecutive quarters/semesters when first establishing eligibility for faculty that work less than half-time during the summer quarter/semester.

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

(b) **Stacking.** Faculty may establish eligibility and maintain the employer contribution toward PEBB insurance coverage by working as faculty for more than one institution of higher education. Faculty workloads may only be stacked with other faculty workloads to estab-

lish 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 insurance coverage begins.**

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

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

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

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

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

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

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

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

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

**WAC 182-12-116 Who is eligible to participate in the ((~~state's~~)) salary reduction plan?** (1) Employees of state agencies are eligible to participate in the state's salary reduction plan provided they are eligible for public employees benefits board (PEBB) benefits as described in WAC 182-12-114 and they elect to participate within the time frames described in WAC 182-08-197, 182-08-187, or 182-08-199.

(2) Employees of employer groups, as defined in WAC 182-12-109, ((~~and charter schools~~)) are not eligible to participate in the state's salary reduction plan.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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

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

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

(3) A dependent enrolled in a PEBB health plan who becomes eligible for PEBB benefits as an employee must elect to enroll in PEBB benefits as described in WAC 182-08-197 (1) or (3). This includes making an election to enroll in or waive enrollment in PEBB medical as described in WAC 182-12-128.

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

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

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

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

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

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

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

(b) If the employee loses eligibility under the employing agency, they ((~~may choose to enroll as described in (a) of this subsection, the employee~~)) must notify their other employing agency no later than sixty days from the date PEBB coverage ends through the employing agency described in (a) of this subsection to transfer coverage.

(c) The employee's PEBB insurance coverage elections remain the same when an employee transfers their enrollment ((~~from enrollment~~))

under one employing agency to another employing agency without a break in PEBB insurance coverage for one month or more, as described in (b) of this subsection.

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

**WAC 182-12-128 When may an employee waive enrollment in public employees benefits board (PEBB) medical and when may they enroll in PEBB medical after having waived enrollment?** An employee may waive enrollment in public employees benefits board (PEBB) medical if they are enrolled in other employer-based group medical, a TRICARE plan, or medicare as described in subsection (1)(a) through (c) of this section. A special open enrollment event must be an event other than an employee gaining initial eligibility for PEBB benefits. An employee who waives enrollment in PEBB medical must enroll in dental, basic life insurance, basic accidental death and dismemberment insurance, and basic long-term disability (LTD) insurance (unless the employing agency does not participate in these PEBB insurance coverages).

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

(a) **When the employee becomes eligible:** An employee ((~~enrolled in other employer-based group medical, a TRICARE plan, or medicare~~)) may waive PEBB medical when 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 days after the date the employee becomes eligible for 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 as described in subsection (4) of this section.

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

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

(2) If an employee waives PEBB medical, the ((~~employee's eligible~~)) employee may not enroll dependents ((~~may not be enrolled~~)) 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 days after the event that creates the special open enrollment. In addition to the required form, the employee must provide evidence of the event that creates the special open enrollment to the employing agency.

PEBB medical will begin the first day of the month following the later of the event date or the date the required form is received. If that day is the first of the month, coverage is effective on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, PEBB medical will begin ((~~as follows:~~

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

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

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

~~(iv) For the spouse or state registered domestic partner of an employee, PEBB medical will begin the first day of the month in which the event occurs~~)) (see WAC 182-12-262 for the PEBB medical effective date of a newly born child, newly adopted child, spouse, or state registered domestic partner).

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

(a) Employee acquires a new dependent due to:

(i) Marriage or registering ((~~for~~)) a state 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 for the employer contribution under their employer-based group medical;

((~~**Exception:**~~)) **Note:** ((~~For the purposes of special open enrollment~~)) 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 ((~~subscriber~~)) employee (a former spouse or former state registered domestic partner is not an eligible dependent);

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

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

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

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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

(1) **Maintaining the employer contribution.** Except as described in subsections (2), (3), and (4) of this section, employees who have established eligibility for benefits as described in WAC 182-12-114 are

eligible for the employer contribution each month in which they are in pay status eight or more hours per month.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Employees on authorized leave without pay;

(ii) Employees on approved educational leave;

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

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

(v) Employees applying for disability retirement.

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

(6) **Employees who are in pay status less than eight hours in a month.** Unless otherwise indicated in this section, when there is a month in which employees are not in pay status for at least eight hours, employees:

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

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

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

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

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

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

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

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

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

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

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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

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

(a) Employees may continue any combination of medical, dental, ((~~and~~)) life insurance, and accidental death and dismemberment (AD&D) insurance; however, only employees on approved educational leave or called in to active duty in the uniformed services as defined under the Uniformed Services Employment and Reemployment Rights Act (USERRA) may continue either basic or both basic and ((~~optional~~)) supplemental long-term disability (LTD) insurance.

(b) Employees in the following circumstances who lose their eligibility for the employer contribution toward PEBB benefits qualify to continue coverage under this subsection:

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

(ii) Employees who are on approved educational leave;

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

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

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

(vi) Employees who are applying for disability retirement.

(c) The employee's election must be received by the PEBB program no later than sixty days from the date the employee's PEBB health plan

coverage ended or from the postmark date on the election notice sent by the PEBB program, whichever is later((~~.~~));

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

Premiums and applicable premium surcharges associated with continuing PEBB medical, must be made to the HCA as well as premiums associated with continuing PEBB dental or LTD insurance coverage. Premiums associated with continuing life insurance and AD&D insurance coverage must be made to the contracted vendor. Following the employee's first premium payment, the employee must pay the premium amounts for PEBB insurance coverage and applicable premium surcharges as premiums become due((~~.~~)); and

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

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

**WAC 182-12-138 What options are available if an employee is approved for the federal Family and Medical Leave Act (FMLA) or the paid family and medical leave program?** (1) An employee on approved leave under the federal Family and Medical Leave Act (FMLA) or the family and medical leave insurance program under chapter 50A.04 RCW (paid family and medical leave program) may continue to receive the employer contribution toward public employees benefits board (PEBB) insurance coverage in accordance with the federal FMLA or RCW 50A.04.245. The employee may also continue current ((~~optional~~)) supplemental life, supplemental accidental death and dismemberment (AD&D), and ((~~optional~~)) supplemental long-term disability ((~~(LTD)~~)) insurance. The employee's employing agency is responsible for determining if the employee is eligible for leave under FMLA and the duration of such leave. The employment security department is responsible for determining if the employee is eligible for leave under the paid family and medical leave program.

(2) If an employee's monthly premium or applicable premium surcharges remain((~~s~~)) unpaid for sixty days from the original due date, the employee's PEBB insurance coverage will be terminated retroactive

to the last day of the month for which the monthly premium and applicable premium surcharges ((~~was~~)) were paid.

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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

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

(b) The employee's first premium payment and applicable premium surcharges ((~~is~~)) are due to the HCA no later than forty-five days after the election period ends as described in (a) of this subsection. Premiums and applicable premium surcharges associated with continuing PEBB medical must be made to the HCA as well as premiums associated with continuing PEBB dental. Premiums associated with continuing life insurance and accidental death and dismemberment insurance coverage must be made to the contracted vendor;

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

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

(2) If an employee is reverted due to a layoff, the employee may be eligible for the employer contribution toward PEBB insurance coverage under the criteria of WAC 182-12-129. If determined not to be eligible under WAC 182-12-129, the employee may continue PEBB insurance coverage by self-paying the premium and applicable premium surcharges set by the HCA under WAC 182-12-133.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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

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

(b) The employee's first premium payment and applicable premium surcharges ((~~is~~)) are due to the HCA no later than forty-five days after the election period ends as described in (a) of this subsection. Premiums and applicable premium surcharges associated with continuing PEBB medical must be made to the HCA as well as premiums associated with continuing PEBB dental. Premiums associated with continuing life insurance and AD&D insurance coverage must be made to the contracted vendor;

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

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

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

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

(b) The employee's first premium payment and applicable premium surcharges ((~~is~~)) are due to the HCA no later than forty-five days after the election period ends as described in (a) of this subsection. Premiums and applicable premium surcharges associated with continuing PEBB medical must be made to the HCA as well as premiums associated with continuing PEBB dental. Premiums associated with continuing life insurance and AD&D insurance coverage must be made to the contracted vendor;

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

(d) If the employee's monthly premium or applicable premium surcharges remain((~~s~~)) unpaid for sixty days from the original due date, the employee's PEBB insurance coverage will be terminated retroactive

to the last day of the month for which the monthly premium and applicable premium surcharges ((~~was~~)) were paid as described in WAC 182-08-180 (1)(c).

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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

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

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

~~(b) The enrollee's first premium payment and applicable premium surcharge is due to the HCA no later than forty-five days after the 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) Enrollees who request to voluntarily terminate their COBRA coverage must do so in writing. The written termination request must be received by the PEBB program. Enrollees who terminate their COBRA coverage will not be eligible to reenroll in COBRA coverage unless they regain eligibility. COBRA coverage will end on the last day of the month in which the PEBB program receives the termination request. If the termination request is received on the first day of the month, COBRA coverage will end on the last day of the previous month; and~~

~~(d) Medical flexible spending arrangement (FSA) enrollees who on the date of the qualifying event, have a greater number of remaining benefits than remaining contribution payments for the current year, will have an opportunity to continue making contributions to their medical FSA by electing COBRA. The enrollee's first premium payment is due to the contracted vendor no later than forty-five days after the election period ends as described below. The enrollee's election must be received by the contracted vendor no later than sixty days from the date the enrollee's PEBB health plan coverage ended or from the post-~~

~~mark date on the election notice sent by the contracted vendor, whichever is later.~~

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

~~(3)~~)) An employee or an employee's dependent who loses eligibility for 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 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 medical, dental, or both for the remaining difference in months.

((~~(4)~~)) (3) A retired employee who loses eligibility for PEBB retiree insurance because an employer group, with the exception of ((~~school districts,~~)) educational service districts, ((~~and charter schools~~)) ceases participation in PEBB insurance coverage may continue medical, dental, or both.

((~~(5) A retired employee,~~)) (4) A retiree or a dependent of a ((~~retired employee~~)) retiree, who is no longer eligible ((~~to continue coverage~~)) as described in WAC 182-12-171, 182-12-180, or 182-12-260 may continue medical, dental, or both.

((~~(6)~~)) (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.

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

(6) An enrollee may continue PEBB health plan coverage under COBRA by self-paying the premium and applicable premium surcharges set by the health care authority (HCA):

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

(a) The election must be received by the PEBB program no later than sixty days from the date the enrollee's PEBB health plan coverage ended or from the postmark date on the election notice sent by the 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 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) and the employee's dependents will have an opportunity to continue making contributions to their medical 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 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 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 days after the election period ends as described above.

(7) 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 18-20-117, filed 10/3/18, effective 1/1/19)

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

(a) The personnel resources board;

(b) An arbitrator; or

(c) A grievance or appeals committee established under a collective bargaining agreement for union represented employees.

(2) The employee must pay premium amounts and applicable premium surcharges associated with PEBB insurance coverage as premiums and applicable premium surcharges become due. If the monthly premium or applicable premium surcharges remain((~~s~~)) unpaid for sixty days from the original due date, PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharges ((~~was~~)) were paid as described in WAC 182-08-180 (1)(c).

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

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

(5) If the board, arbitrator, committee, or court sustains the employee in the appeal and directs reinstatement of employer paid PEBB

insurance coverage retroactively, the employing agency must forward to HCA the full employer contribution for the period directed by the board, arbitrator, committee, or court and collect from the employee the employee's share of premiums due, if any.

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

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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

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

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

(b) The employee's or the school employee's first premium payment for PEBB retiree insurance coverage enrollment and applicable premium surcharges ((~~is~~)) are due to the health care authority (HCA) no later than forty-five days after the election period ends as described in (a) of this subsection. Following the employee's or the school employee's first premium payment, premiums and applicable premium surcharges must be paid as described in WAC 182-08-180 (1)(c); and

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

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

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

(2) **Substantive eligibility requirements.**

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

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

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

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

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

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

(d) A retiring employee of an employer group participating in PEBB insurance coverage under contractual agreement with the authority must be eligible to retire as described in (i) or (ii) of this subsection to be eligible to continue PEBB insurance coverage as a retiree, except for ((~~a school district,~~)) an educational service district((~~, or charter school~~)) employee who must meet the requirements as described in subsection (2)(e) of this section.

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

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

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

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

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

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

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

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

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

(3) A retiring employee or a retiring school employee and their enrolled dependents who are entitled to medicare must enroll and maintain enrollment in both medicare Parts A and B if the employee or the school employee retired after July 1, 1991. If a retiree or an enrolled dependent becomes entitled to medicare after enrollment in PEBB retiree insurance coverage, they must enroll and maintain enrollment in medicare Parts A and B to remain enrolled in a PEBB retiree health plan. If an enrollee who is entitled to medicare does not meet this procedural requirement, the enrollee is no longer eligible for enrollment in a PEBB retiree health plan. The enrollee may continue PEBB health plan enrollment as described in WAC 182-12-146.

(4) Washington state-sponsored retirement plans include:

(a) Higher education retirement plans;

(b) Law enforcement officers' and firefighters' retirement system;

(c) Public employees' retirement system;

(d) Public safety employees' retirement system;

(e) School employees' retirement system;

(f) State judges/judicial retirement system;

(g) Teachers' retirement system; and

(h) State patrol retirement system.

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

**WAC 182-12-180 When is an elected and full-time appointed official of the legislative and executive branch of state government, or their survivor eligible to continue enrollment in public employees benefits board (PEBB) retiree insurance coverage?** (1) An elected and full-time appointed official of the legislative and executive branch of state government is eligible to continue enrollment or defer enrollment in public employees benefits board (PEBB) retiree insurance coverage under the same terms as an outgoing legislator, when they voluntarily or involuntarily leave public office. The following officials are eligible if they meet the procedural requirements as described in subsection (3) of this section:

(a) A member of the state legislature;

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

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

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

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

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

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

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

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

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

the date of the official's death or the first day of the month after the survivor's PEBB insurance coverage ends;

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

(c) If an official or a survivor elects to enroll a dependent in PEBB health plan coverage, the dependent must be enrolled in the same PEBB medical and PEBB dental plan as the official or survivor;

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

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

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

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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

(2) A retiree who defers enrollment in medical must defer enrollment in dental. Retirees must be enrolled in medical to enroll in den-

tal. A retiree who defers enrollment in a PEBB health plan also defers enrollment for all eligible dependents.

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

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

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

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

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

**WAC 182-12-205 May a retiree or a survivor defer or voluntarily terminate public employees benefits board (PEBB) health plan enrollment under PEBB retiree insurance coverage?** (1) The following individuals may defer enrollment in a public employees benefits board (PEBB) health plan:

(a) A retiring employee or a retiring school employee;

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

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

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

(3) A subscriber described in subsection (1) of this section who defers enrollment in a PEBB health plan must maintain continuous enrollment in other medical as described in this section or WAC 182-12-200. A subscriber who defers enrollment in medical must defer enrollment in dental. A subscriber must be enrolled in medical to enroll in dental.

(a) Beginning January 1, 2001, enrollment in a PEBB health plan may be deferred when the subscriber is enrolled in employer-based group medical as an employee or the dependent of an employee, or such

medical insurance continued under Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage or continuation coverage.

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

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

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

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

(4) To defer PEBB health plan enrollment, the required forms must be submitted to the PEBB program.

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

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

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

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

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

(ii) For a survivor of an official who meets the requirements as described in WAC 182-12-180(2), enrollment will be deferred the first of the month following the later of the date of the official's death or the date the survivor's PEBB insurance coverage ends. The forms

must be received by the PEBB program no later than sixty days after the later of the date of the official's death or the date the survivor's PEBB insurance coverage ends.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(f) A subscriber who defers enrollment may enroll in a PEBB health plan if they receive formal notice that the authority has de-

termined it is more cost-effective to enroll them or their eligible dependents in PEBB medical than a medical assistance program.

(g) If a subscriber elects to enroll a dependent in PEBB health plan coverage, the dependent must be enrolled in the same PEBB medical and PEBB dental plan as the subscriber.

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

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

**Exception:** When a subscriber or their dependent is enrolled in a medicare advantage plan, then enrollment in a PEBB health plan will terminate on the last day of the month when the medicare advantage plan disenrollment form is received.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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

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

(2) Knowingly providing false information;

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

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

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

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

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

**WAC 182-12-209 Who is eligible for retiree term life insurance?** Eligible employees who participate in public employees benefits board (PEBB) life insurance as an employee and eligible school employees who participate in school employees benefits board (SEBB) life insurance as an employee and meet qualifications for PEBB retiree insurance coverage as provided in WAC 182-12-171 or 182-12-180, are eligible for retiree term life insurance. They must submit the required forms to the PEBB program. Forms for a retiring employee or a retiring school employee as described in WAC 182-12-171, must be received by the PEBB program no later than sixty days after the date their PEBB or SEBB employee life insurance ends. Forms for an official leaving public office as described in WAC 182-12-180, must be received by the PEBB program no later than sixty days after the official leaves public office.

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

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

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

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

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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

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

(b) The employee's or the school employee's form and a copy of their Washington state-sponsored retirement system's formal determina-

tion letter are received by the PEBB program no later than sixty days after the date on the determination letter; and

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

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

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

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

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

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

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

(3) The director may make an exception to the date of PEBB retiree insurance coverage ((~~begins~~)) described in subsection (2)(a) and (b) of this section; however, such request must demonstrate extraordinary circumstances beyond the control of the retiree.

(4) Premiums and applicable premium surcharges are due from the effective date of enrollment in PEBB retiree insurance coverage.

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

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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

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

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

The following are eligible as dependents:

(1) Legal spouse. A former spouse((~~s are~~)) is not an eligible dependent((~~s~~)) upon finalization of a divorce or annulment, even if a court order requires the subscriber to provide health insurance for the former spouse((~~.~~));

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

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

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

(b) Children of the subscriber's spouse, based on the spouse's establishment of a parent-child relationship, except when parental rights have been terminated. The stepchild's relationship to ((~~a~~)) the subscriber (and eligibility as a dependent) ends on the same date the marriage with the spouse ends through divorce, annulment, dissolution, termination, or death;

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

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

((~~(e)~~)) (d) Children of the subscriber's state registered domestic partner, based on the state registered domestic partner's estab-

lishment of a parent-child relationship, except when parental rights have been terminated. The child's relationship to the subscriber (and eligibility as a dependent) ends on the same date the subscriber's legal relationship with the state registered domestic partner ends through divorce, annulment, dissolution, termination, or death;

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

((~~(g)~~)) (f) Extended dependent in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or subscriber's state registered domestic partner. The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. Extended dependent child does not include a foster child unless the subscriber, the subscriber's spouse, or the subscriber's state registered domestic partner has assumed a legal obligation for total or partial support in anticipation of adoption; and

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

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

(ii) The subscriber must ((~~agree to~~)) notify the PEBB program, in writing, ((~~no later than sixty days after the date that~~)) when the child is no longer eligible under this subsection as described in WAC 182-12-262 (2)(a);

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

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

(v) The PEBB program with input from the applicable contracted vendor will periodically verify the eligibility of a dependent child with a disability beginning at age twenty-six, but no more frequently than annually after the two-year period following the child's twenty-sixth birthday, which may require renewed proof from the subscriber.

(4) Parents.

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

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

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

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

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

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

**WAC 182-12-262 When may subscribers enroll or remove eligible dependents?** (1) **Enrolling dependents in public employees benefits board (PEBB) benefits.** A dependent must be enrolled in the same health plan coverage as the subscriber, and the subscriber must be enrolled to enroll their dependent except as provided in WAC 182-12-205 (3)(c). Subscribers must satisfy the enrollment requirements as described in subsection (4) of this section and may enroll eligible dependents at the following times:

(a) **When the subscriber becomes eligible** and enrolls in ((~~public employees benefits board (~~))PEBB((~~)~~)) benefits. If eligibility is verified and the dependent is enrolled, the dependent's effective date will be the same as the subscriber's effective date, except if the ((~~employee~~)) subscriber enrolls a newborn child in ((~~optional~~)) supplemental dependent life insurance and accidental death and dismemberment (AD&D) insurance. The newborn child's dependent life insurance and AD&D insurance coverage will be effective on the date the child becomes fourteen days old((~~.~~));

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

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

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

(a) **A dependent's eligibility for enrollment in health plan coverage ends the last day of the month the dependent** meets the eligibility criteria as described in WAC 182-12-250 or 182-12-260. ((~~Employees~~)) Subscribers must ((~~notify their employing agency~~)) 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). The notice must be received within sixty days of the last day of the month the dependent loses eligibility for health plan coverage. Employees must notify their employing agency when a dependent is no longer eligible, except as required under WAC 182-12-260 (3)(g)(ii). All other subscribers must notify the PEBB program ((~~when a dependent is no longer eligible~~)). Consequences for not submitting notice within the required sixty days ((~~of the last day of the month the dependent loses eligibility for health plan coverage may~~)) include, but are not limited to:

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

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

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

(c) **Retirees (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 ((~~enrollees with~~)) PEBB continuation coverage ((~~as described in~~)) 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 insurance 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 insurance coverage prospectively. PEBB insurance coverage will end on the last day of the month in which the written notice is received by the PEBB program 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, coverage will end on the last day of the previous month.

(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 ((~~(IRC)~~)) and Treasury Regulations, and correspond to and be consistent with the event that creates the special open enrollment for the subscriber, the subscriber's dependents, or both.

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

(ii) Enrollment of an extended dependent or a dependent with a disability will be the first day of the month following the later of the event date as described in WAC 182-08-198(2) or eligibility certification.

(iii) The dependent will be removed from the subscriber's health plan coverage the last day of the month following the later of the event date or the date the required form 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, ((~~health plan~~)) PEBB benefits coverage will begin or end as follows:

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

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

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

A newly born child must be at least fourteen days old before ((~~optional~~)) supplemental dependent life insurance and AD&D insurance coverage purchased by the employee becomes effective.

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

(b) Subscriber acquires a new dependent due to:

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

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

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

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

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

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

((**Exception:**)) **Note:** ((~~For the purposes of special open enrollment~~)) As used in (e) 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.

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

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

(h) 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);

(i) Subscriber or a subscriber's dependent becomes entitled to coverage under medicaid or a state children's health insurance program (CHIP), or the subscriber or a subscriber's dependent loses eligibility for coverage under medicaid or CHIP;

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

(4) **Enrollment requirements. A subscriber must submit the required forms within the time frames described in this subsection.** ((~~Employees~~)) An employee must submit the required forms to their employing agency((~~. All other~~)), a subscriber((~~s~~)) 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.

(a) If a subscriber wants to enroll their eligible dependents when the subscriber becomes eligible to enroll in PEBB benefits, the subscriber must include the dependent's enrollment information on the required forms ((~~that the subscriber submits~~)) and submit them within the ((~~relevant~~)) 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.

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

(c) If a subscriber wants to enroll newly eligible dependents, the required forms must be received no later than sixty days after the dependent becomes eligible ((~~except as provided in (d) of this subsection~~)).

(d) If a subscriber wants to enroll a newborn or child whom the subscriber has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption, the subscriber should notify the PEBB program by submitting the required 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 ((~~twelve months~~)) sixty 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.

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

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

**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:

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

((~~(2)~~)) (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 ((~~subsection (3)~~)) (c) of this ((~~section~~)) subsection upon request of:

((~~(a)~~)) (i) The child's other parent; or

((~~(b)~~)) (ii) Child support enforcement program.

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

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

((~~(b)~~)) (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;

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

((~~(d)~~)) (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((~~.~~

~~(e)~~)); or

(v) 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.

((~~(4)~~)) (d) Changes to health plan coverage or enrollment as described in ((~~subsection (3)(a)~~)) (c)(i) through ((~~(c)~~)) (iii) of this ((~~section~~)) 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 ((~~subsection (3)(d)~~)) (c)(iv) of this ((~~section~~)) 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.

((~~(5) The subscriber may be eligible to make changes to their health plan enrollment and salary reduction elections related to the NMSN as described in WAC 182-08-198(2), 182-08-199(3), 182-12-128(4), or 182-12-262(3).~~)) (2) When a NMSN requires a spouse, former spouse, or other individual to provide coverage for a dependent enrolled in PEBB coverage and that coverage is in fact provided, the dependent may be removed from the subscriber's PEBB insurance coverage prospectively.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

**WAC 182-12-265 What options for continuing health plan enrollment are available to a surviving spouse, state registered domestic partner, or child, if ((~~the~~)) an employee, a school employee, or a retiree dies?** The survivor of an eligible employee, an eligible school employee, or a retiree who meets the eligibility criteria and submits the required forms as described in subsection (1), (2), or (3) of this section is eligible to enroll or defer enrollment as a survivor under public employees benefits board (PEBB) retiree insurance coverage. If enrolling in PEBB retiree insurance coverage, the survivor's first premium payment and applicable premium surcharges ((~~is~~)) are due to the health care authority (HCA) no later than forty-five days after the election period ends as described in subsection (1), (2), or (3) of this section. Following the survivor's first premium payment, premiums and applicable premium surcharges must be paid as described in WAC 182-08-180 (1)(c).

(1) An employee's spouse, state registered domestic partner, or child who loses eligibility due to the death of an eligible employee may enroll or defer enrollment as a survivor under PEBB retiree insurance coverage provided they immediately begin receiving a monthly retirement benefit from any state of Washington sponsored retirement system. To satisfy the requirement to immediately receive a monthly

retirement benefit they must begin receiving monthly benefit payments no later than one hundred twenty days from the date of death of the employee. The required forms to enroll or defer enrollment must be received by the PEBB program no later than sixty days after the later of the date of the employee's death or the date the survivor's PEBB insurance coverage ends.

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

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

**Notes:** If a spouse, state registered domestic partner, or child of an eligible employee is not eligible for a monthly retirement benefit, they are not eligible to enroll as a survivor under PEBB retiree insurance coverage. However, they may continue health plan enrollment as described in WAC 182-12-146.

Eligibility for the surviving spouse, surviving state registered domestic partner, or surviving child of an employee of a participating employer group will cease at the end of the month in which the group's contract with the authority ends unless the employer group is ((~~a school district,~~)) an educational service district((~~, or charter school~~)).

Eligibility for the surviving spouse, surviving state registered domestic partner, or surviving child of an elected and full-time appointed official of the legislative and executive branches of state government is described in WAC 182-12-180.

(2) A retiree's spouse, state registered domestic partner, or child who loses eligibility due to the death of an eligible retiree may enroll or defer enrollment as a survivor under PEBB retiree insurance coverage. The required forms to enroll or defer enrollment must be received by the PEBB program no later than sixty days after the retiree's death.

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

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

(c) If a spouse, state registered domestic partner, or child of an eligible retiree is not enrolled in a PEBB health plan at the time of the retiree's death, the survivor is eligible to enroll or defer enrollment as a survivor under PEBB retiree insurance coverage. The required forms to enroll or defer enrollment must be received by the PEBB program no later than sixty days after the retiree's death. To enroll in a PEBB health plan, the survivor must provide evidence of continuous enrollment in medical coverage as described in WAC 182-12-205 from the most recent open enrollment for which the survivor was not enrolled in a PEBB medical plan prior to the retiree's death.

**Note:** Eligibility for the surviving spouse, surviving state registered domestic partner, or surviving child of an employer group retiree will cease at the end of the month in which the group's contract with the authority ends unless the employer group is ((~~a school district,~~)) an educational service district((~~, or charter school~~)).

(3) ((~~The~~)) A school employee's spouse, state registered domestic partner, or child ((~~of a deceased school district, educational service district, or a charter school employee is eligible to~~)) who loses eligibility due to the death of an eligible school employee may enroll or defer enrollment as a survivor under PEBB retiree insurance coverage at the time of the school employee's death, provided the employee died on or after October 1, 1993. The survivor must immediately begin receiving a retirement benefit allowance under chapter 41.32, 41.35 or 41.40 RCW. The required forms to enroll or defer enrollment must be received by the PEBB program no later than sixty days after the later of the date of the school employee's death or the date the survivor's ((~~school district coverage,~~)) educational service district coverage, or ((~~charter~~)) school employees benefits board (SEBB) insurance coverage ends.

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

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

**Note:** If a spouse, state registered domestic partner, or child of an eligible school employee is not eligible for a retirement benefit allowance, they are not eligible to enroll as a survivor under PEBB retiree insurance coverage. However, a spouse, state registered domestic partner, or child of an eligible school employee enrolled in SEBB insurance coverage may continue health plan enrollment as described in WAC 182-31-090.

(4) If ((~~a~~)) premiums and applicable premium surcharges received by the HCA ((~~is~~)) are sufficient as described in WAC 182-08-180 (1)(d)(ii) to maintain PEBB health plan enrollment after the ((~~employee's~~)) employee, school employee, or retiree's death, the PEBB program will consider the payment as notice of the survivor's intent to continue enrollment.

If the survivor's enrollment ended due to the death of the employee, school employee, or retiree, the PEBB program will reinstate the survivor's enrollment without a gap subject to payment of premium and applicable premium surcharges.

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

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

(6) In order to avoid duplication of group medical coverage, a survivor may defer enrollment in a PEBB health plan as described in WAC 182-12-200 and 182-12-205.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

**WAC 182-12-270 What options for continuation coverage are available to dependents who cease to meet the eligibility criteria as described in WAC 182-12-260?** If eligible, dependents may continue health plan enrollment under one of the continuation coverage options in subsection (1) or (2) of this section by self-paying the premiums and applicable premium surcharges set by the health care authority (HCA), with no contribution from the employer, following their loss of eligibility under the subscriber's health plan coverage. The dependent's first premium payment and applicable premium surcharges ((~~is~~)) are due to the HCA no later than forty-five days after the election period ends as described in WAC 182-12-146, 182-12-180, 182-12-250, or 182-12-265, whichever applies. Following the ((~~employee's~~)) dependent's first premium payment, the dependent must pay premium and applicable premium surcharge amounts associated with PEBB insurance coverage as premiums and applicable premium surcharges become due. If the monthly premium or applicable premium surcharges remain unpaid for sixty days from the original due date, PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharges ((~~was~~)) were paid as described in WAC 182-08-180 (1)(c). The PEBB program must receive the required forms as outlined in the *PEBB Initial Notice of COBRA and Continuation Coverage Rights*. Options for continuing health plan enrollment are based on the reason that eligibility was lost.

(1) Spouses, state registered domestic partners, or children who lose eligibility due to the death of an employee or retiree may be eligible to continue health plan enrollment as described in WAC 182-12-180, 182-12-250, or 182-12-265; or

(2) Dependents who lose eligibility because they no longer meet the eligibility criteria as described in WAC 182-12-260 are eligible

to continue health plan enrollment under provisions of the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). See WAC 182-12-146 for more information on COBRA.

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

(3) No continuation coverage will be offered unless the PEBB program is notified through hand-delivery or United States Postal Service mail of the qualifying event as outlined in the *PEBB Initial Notice of COBRA and Continuation Coverage Rights*.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

**WAC 182-12-300 Public employees benefits board (PEBB) wellness incentive program eligibility and procedural requirements.** The public employees benefits board (PEBB) annually determines the design of the PEBB wellness incentive program.

(1) All subscribers, except PEBB subscribers who are enrolled in both medicare Parts A and B, and in the medicare risk pool as described in RCW 41.05.080(3), are eligible to participate in the PEBB wellness incentive program.

(2) Effective January 1, ((~~2016~~)) 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 ((~~latest date below~~)) following deadline:

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

(b) ((~~For subscribers enrolling in PEBB medical with an effective date in July or August, the deadline is one hundred twenty days from the subscriber's PEBB medical effective date; or~~

~~(c)~~)) For subscribers enrolling in PEBB medical with an effective date in ((~~September,~~)) October((~~, November, or~~)) 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 ((~~PEBB program~~)) 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) Effective January 1, 2018, an eligible subscriber will receive a separate PEBB wellness incentive for completing the SmartHealth well-being assessment on or before December 31st, of the current plan year. An eligible subscriber may only earn this separate PEBB wellness incentive once per plan year. Once earned, subscribers must claim the incentive on or before December 31st of the same calendar year it was earned.

(5) PEBB wellness incentive will be provided only if:

(a) For the wellness incentive described in subsection (2) of this section the subscriber is still eligible for the PEBB wellness incentive program in the year the incentive applies;

(b) The funding rate provided by the legislature is designed to provide a PEBB wellness incentive program or a PEBB wellness incentive, or both; or

(c) Specific appropriations are provided for wellness incentives.

# Chapter 182-16 WAC
# APPEALS PRACTICE AND PROCEDURE

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

**WAC 182-16-010 Purpose.** This chapter describes the general rules and procedures that apply to the health care authority's brief adjudicative proceedings and formal administrative hearings for the public employees benefits board program.

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

**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 ((~~or entity~~)) who requests a ((~~review by~~)) brief adjudicative proceeding with the PEBB appeals unit ((~~or a formal administrative hearing~~)) about the action of the employing agency, the HCA, or its contracted vendor.

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

"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 legal holidays as set forth in RCW 1.16.050.

"Calendar days" or "days" means all days including Saturdays ((~~and~~)), Sundays, and all legal state 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, ((~~either~~)) 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 ((~~and public~~)) employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan under ((~~this~~)) 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 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((~~, and, effective October 1, 1995, employees of employee organizations currently pooled with employees of school districts for the purpose of purchasing insurance benefits, at the option of each such employee organization~~)); (c) 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); ((~~and~~)) (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 express-

ly 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, ((~~school districts, educational service districts, and~~)) 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, ((~~school district, educational service district,~~)) 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 officer, or hearing officer. A document is considered filed when it is received by the authority or its designee.

"Final order" means an order that is the final ((~~PEBB program~~)) 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 ((~~public employees benefits board~~)) PEBB 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" ((~~for eligible employees includes~~)) means basic life insurance ((~~and accidental death and dismemberment (AD&D) insurance~~)) paid for by the employing agency, as well as ((~~optional~~)) supplemental life insurance ((~~and optional AD&D 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.

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

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby eligible state ((~~and public~~)) employees may reduce their salary before taxes to pay for medical expenses not reimbursed by insurance as provided in the salary reduction plan established under ((~~this~~)) 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 and 182-12-180), eligible survivors (as described in WAC 182-12-180, 182-12-250, and 182-12-265), eligible dependents (as described in WAC 182-12-250 and 182-12-260), and others as defined in RCW 41.05.011.

"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 ((~~state and~~)) 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 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 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 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 ((~~state and~~)) public employees may agree to a reduction of salary on a pretax basis to participate in the dependent care assistance program

((~~(DCAP)~~)), medical flexible spending arrangement ((~~(FSA)~~)), or premium payment plan 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((~~, and all personnel thereof~~)). It includes the legislature, executive branch, and agencies or courts within the judicial branch, as well as institutions of higher education, and any unit of state government established by law.

"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, ((~~or charter school~~)) 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((~~s~~)).

"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 18-22-033, filed 10/29/18, effective 1/1/19)

**WAC 182-16-055 Mailing address changes.** (1) During the appeal process if the appellant's mailing address changes, the appellant must notify the public employees benefits board (PEBB) appeals unit as soon as possible.

(2) If the appellant does not notify the PEBB appeals unit of a change in the appellant's mailing address and the PEBB appeals unit continues to serve notices and other important documents to the appellant's last known mailing address, the documents will be deemed served on the appellant.

(3) This requirement to provide notice of an address change is in addition to WAC ((~~182-08-198, 182-08-199, 182-12-128, and 182-12-262~~)) 182-08-191 that require a subscriber to update their address.

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

**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 officer or officers, or hearing officer must first apply the applicable ((~~public employees benefits board (~~))PEBB((~~)~~)) program rules adopted in the ((~~Washington Administrative Code (~~))WAC((~~)~~)). If no PEBB program rule applies, the presiding officer, review 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 18-22-033, filed 10/29/18, effective 1/1/19)

**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 officer or officers, or hearing officer that a position is correct based on the standard of proof. Unless stated otherwise 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 ((~~in a~~)) hearing is a preponderance of the evidence, meaning that something is more likely to be true than not.

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

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

**WAC 182-16-120 Computation of time.** (1) In computing any period of time prescribed by this chapter, the day of the event from which the time begins to run is not included. (For example, if an initial order is served on ((~~Tuesday~~)) Friday and the party has twenty-one days to request a review, start counting the days with ((~~Wednesday.~~)) Saturday.)

(2) ((~~Except~~)) As provided in subsection (3) of this section, the last day of the period so computed is included unless it is a Saturday, Sunday, or legal holiday as defined in RCW 1.16.050, in which case the period extends to the end of the next business day.

(3) When the period of time prescribed or allowed is ((~~less than~~)) ten days or less, intermediate Saturdays, Sundays and legal holidays shall be excluded in the computation.

(4) The deadline is 5:00 p.m. on the last day of the computed period.

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

**WAC 182-16-130 Index of significant decisions.** (1) A final decision may be relied upon, used, or cited as precedent by a party only if the final order has been indexed in the authority's index of significant decisions in accordance with RCW 34.05.473 (1)(b).

(2) An index of significant decisions is available to the public on the health care authority's (HCA) web site. As decisions are indexed they will be available on the web site.

(3) A final decision published in the index of significant decisions may be removed from the index when:

(a) A published decision entered by the court of appeals or the supreme court reverses an indexed final decision; or

(b) HCA determines that the indexed final decision is no longer precedential due to changes in statute, rule, or policy.

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

**WAC 182-16-2000 Brief adjudicative proceedings.** Pursuant to RCW 34.05.482, the authority will 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 ((~~34.05.479~~)) 34.05.476 which govern formal administrative hearings.

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

**WAC 182-16-2010 ((~~Where to appeal~~)) Appealing a decision regarding public employees benefits board (PEBB) eligibility, enrollment, premium payments, premium surcharges, a ((~~public employees benefits board (PEBB)~~)) wellness incentive, or the administration of benefits((~~?~~)).** (1) Any current or former employee of a state agency or their dependent aggrieved by a decision made by the state agency with regard to public employees benefits board (PEBB) eligibility, enrollment, or premium surcharges may appeal that decision to the state agency by the process ((~~outlined~~)) described in WAC 182-16-2020.

**Note:** Eligibility decisions address whether a subscriber or a subscriber's dependent is entitled to PEBB ((~~insurance coverage~~)) benefits, as described in PEBB rules and policies. Enrollment decisions address the application for PEBB benefits as described in PEBB rules and policies including, but not limited to, the submission of proper documentation and meeting enrollment deadlines.

(2) Any current or former employee of an employer group or their dependent who is aggrieved by a decision made by an employer group with regard to PEBB eligibility, enrollment, or premium surcharges may appeal that decision to the employer group through the process established by the employer group.

**Exception:** Any current or former employee of an employer group aggrieved by a decision regarding life insurance, long-term disability (LTD) insurance, eligibility to participate in the PEBB wellness incentive program, or eligibility to receive a PEBB wellness incentive may appeal that decision to the PEBB appeals ((~~committee~~)) unit by the process described in WAC 182-16-2030.

(3) Any subscriber or dependent aggrieved by a decision made by the PEBB program with regard to PEBB eligibility, enrollment, premium payments, premium surcharges, eligibility to participate in the PEBB wellness incentive program, or eligibility to receive a PEBB wellness incentive, may appeal that decision to the PEBB appeals unit by the process described in WAC 182-16-2030.

(4) Any ((~~PEBB~~)) enrollee aggrieved by a decision regarding the administration of a health plan, life insurance, accidental death and dismemberment (AD&D) insurance, or long-term disability insurance may appeal that decision by following the appeal provisions of those plans, with the exception of:

(a) Enrollment decisions;

(b) Premium payment decisions other than life insurance or AD&D insurance premium payment decisions; and

(c) Eligibility decisions.

(5) Any PEBB enrollee aggrieved by a decision regarding the administration of PEBB long-term care insurance or property and casualty insurance may appeal that decision by following the appeal provisions of those plans.

(6) Any PEBB employee aggrieved by a decision regarding the administration of a benefit offered under the state's salary reduction plan may appeal that decision by the process described in WAC 182-16-2050.

(7) Any subscriber aggrieved by a decision made by the PEBB wellness incentive program contracted vendor regarding the completion of the PEBB wellness incentive program requirements, or a request for a reasonable alternative to a wellness incentive program requirement, may appeal that decision by the process described in WAC 182-16-2040.

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

**WAC 182-16-2020 ((~~How can a current or former employee or an employee's dependent appeal~~)) Appealing a decision made by a state agency about eligibility, premium surcharges, or enrollment in benefits((~~?~~)).** (1) An eligibility, premium surcharges, or enrollment decision made by a state agency may be appealed by submitting a written request for administrative review to the state agency. The state agency must receive the request for administrative review no later than thirty days after the date of the denial notice. The contents of the request for administrative review are to be provided as described in WAC 182-16-2070.

(a) Upon receiving the request for administrative review, the state agency ((~~shall~~)) 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. ((~~As part of the administrative review, the state agency may hold a formal meeting or formal administrative hearing, but is not required to do so.~~))

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

(c) The state agency may reverse eligibility, premium surcharges, or enrollment decisions ((~~based only on circumstances that arose due to delays caused by the state agency or errors made by the state agency~~)) as permitted by WAC 182-08-187.

(2) Any current or former employee or employee's dependent who disagrees with the state agency's decision in response to a written request for administrative review, as described in subsection (1) of 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 days after the date of the state agency's written decision on the request for administrative review. 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 ((~~shall~~)) 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 requested documentation and information. The state agency will also send a copy of the documentation and information to the ((~~employee, former employee, or the employee's dependent~~)) appellant.

(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 to appeal the state agency's written decision within thirty days by following the process in (a) of this subsection, the state agency's prior written decision becomes the health care authority's final decision without further action.

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

**WAC 182-16-2030 Appealing a public employees benefits board (PEBB) program decision regarding eligibility, enrollment, premium payments, premium surcharges, a PEBB wellness incentive, or certain decisions made by an employer group((?)).** (1) A decision made by the public employees benefits board (PEBB) program regarding eligibility, enrollment, premium payments, premium surcharges, a PEBB wellness incentive, may be appealed by submitting a request to the PEBB appeals unit for a brief adjudicative proceeding to be conducted by the authority.

(2) A decision made by an employer group regarding life insurance, LTD insurance, eligibility to participate in the PEBB wellness incentive program, or eligibility to receive a PEBB wellness incentive may be appealed by submitting a request to the PEBB appeals unit for a brief adjudicative proceeding to be conducted by the authority.

(3) The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(4) The request for a brief adjudicative proceeding from a current or former employee or employee's dependent must be received by the PEBB appeals unit no later than thirty days after the date of the denial notice.

(5) The request for a brief adjudicative proceeding from a retiree, self-pay enrollee, or dependent of a retiree or self-pay enrollee must be received by the PEBB appeals unit no later than sixty days after the date of the denial notice.

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

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

(8) Failing to timely request a brief adjudicative proceeding to appeal a decision made under this section within the applicable time frame described in subsections (4) and (5) of this section, will result in the prior PEBB program decision becoming the authority's final decision without further ((~~employing agency~~)) action.

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

**WAC 182-16-2040 How can a subscriber appeal a decision regarding the administration of wellness incentive program requirements?** (1) Any subscriber aggrieved by a decision regarding the completion of the wellness incentive program requirements, or request for a reasonable alternative to a wellness incentive program requirement, may appeal that decision to the public employees benefits board (PEBB) wellness incentive program contracted vendor.

(2) Any subscriber who disagrees with a decision in response to an appeal filed with the PEBB wellness incentive program contracted vendor may appeal the decision by submitting a request for a brief adjudicative proceeding to the PEBB appeals unit.

(a) The request for a brief adjudicative proceeding from a current or former employee must be received by the PEBB appeals unit no later than thirty days after the date of the denial notice. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(b) The request for a brief adjudicative proceeding from a retiree or self-pay subscriber must be received by the PEBB appeals unit no later than sixty days after the date of the denial notice. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

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

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

(5) If a subscriber fails to timely request a brief adjudicative proceeding of a decision made under subsection (1) of this section within thirty days by following the process in WAC 182-16-2020(2), the decision of the PEBB wellness incentive program contracted vendor becomes the authority's final decision.

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

**WAC 182-16-2050 How can an employee ((~~who is eligible to participate in the state's salary reduction plan~~)) appeal a decision regarding the administration of benefits offered under the ((~~state's~~)) salary reduction plan?** (1) Any employee who disagrees with a decision that denies eligibility for, or enrollment in, a benefit offered under the ((~~state's~~)) 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 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 ((~~shall~~)) 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 ((~~shall~~)) must render a written decision within thirty days of receiving the request for administrative review. The written decision ((~~shall~~)) must be sent to the employee who submitted the written request for review and must include a description of appeal rights. The state agency ((~~shall~~)) 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 days of receiving the written request for administrative review, the request for administrative review may be considered denied as of the thirty-first 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 days after the date of the state agency's written decision on the request for administrative review. 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 ((~~shall~~)) 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 to appeal a decision made under this section within thirty days by following the process described in this subsection, the state agency's prior written decision becomes the authority's final decision without further ((~~state agency~~)) action.

(3) Any employee aggrieved by a decision regarding a claim for benefits under the medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP) offered under the ((~~state's~~)) 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 and DCAP under the ((~~state's~~)) 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 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 ((~~shall~~)) 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 to appeal a decision made under this section within thirty days by following the process described in this subsection, the contracted vendor's prior written decision becomes the authority's final decision.

(4) Any employee aggrieved by a decision regarding the administration of the premium payment plan offered under the ((~~state's~~)) 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 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 ((~~shall~~)) 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 to appeal a decision made under this section within thirty days by following the process described in this subsection, the PEBB program's prior written decision becomes the authority's final decision.

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

**WAC 182-16-2060 How can an entity or organization appeal a decision of the health care authority to deny an employer group application?** (1) An entity or organization whose employer group application is denied by the authority may appeal the decision by submitting a request for a brief adjudicative proceeding to the public employees benefits board (PEBB) appeals unit. For rules regarding eligible entities, see WAC 182-12-111.

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

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

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

(5) Failing to timely request a brief adjudicative proceeding to appeal a decision made under this section within thirty days by following the process described in subsection (2) of this section, will result in the prior PEBB program decision becoming the authority's final decision.

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

**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 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 ((~~personal~~)) 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 ((~~personal~~)) 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 officer or officers' office and serve all parties with the notice.

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

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

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

**WAC 182-16-2090 Initial order.** Unless a continuance has been granted, within ten days after the PEBB appeals unit receives a request for a brief adjudicative proceeding, the presiding officer shall render a written initial order that addresses the issue or issues raised by the appellant in their appeal. The presiding officer ((~~shall~~)) must serve a copy of the initial order on all parties and the initial order ((~~shall~~)) must contain information on how the appellant may request review of the initial order.

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

**WAC 182-16-2100 How to request a review of an initial order resulting from a brief adjudicative proceeding.** (1) 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 PEBB program contracted vendor, may request review of the initial order by the authority. The appellant must file a written request for review of the initial order or ((~~by making~~)) make an oral request for review of the initial order with the ((~~public employees benefits~~

~~board (~~))PEBB((~~)~~)) appeals unit within twenty-one days after service of the initial order. The written or oral request for review of the initial order must be ((~~provided~~)) 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 days, the order becomes the final order without ((~~any~~)) further action by the authority.

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

(3) If the ((~~parties have~~)) appellant has not requested review, the authority may review an order resulting from a brief adjudicative proceeding on its own motion, 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 18-22-033, filed 10/29/18, effective 1/1/19)

**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 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 officer or officers must enter and serve a written order dismissing the ((~~appeal~~)) 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 reinstate 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 18-22-033, filed 10/29/18, effective 1/1/19)

**WAC 182-16-2120 Request for reconsideration.** (1) A request for reconsideration asks the review officer or officers to reconsider the final order because the party believes the review 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 officer or officers who entered the final order.

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

(a) The review 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.

(c) Within five business days of receiving a request for reconsideration, the review 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 officer or officers no later than seven business days after the service date of the review officer's 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 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 WAC 182-16-2120 (4)(a), the same review 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 petition and setting the matter for further hearing.

(9) If the review officer or officers do not send an order on the request for reconsideration within twenty 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 petition 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 ((~~at the hearing or before the ruling on a dispositive motion~~)) prior to the final order being issued.

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

**WAC 182-16-2130 Judicial review of final order.** (1) Judicial review is the process of appealing a final order to a court.

(2) The appellant may appeal a final order by filing a written petition for judicial review that meets the requirements of RCW

((~~34.05.546. The~~)) 34.05.510 through 34.05.598. Neither the public employees benefits board (PEBB) program nor the employing agency may ((~~not~~)) request judicial review.

((~~(3) The appellant should consult RCW 34.05.510 through 34.05.598 for further details and requirements of the judicial review process.~~))

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

**WAC 182-16-2140 Presiding officer—Designation and authority.** The designation of a presiding officer ((~~shall~~)) must be consistent with the requirements of RCW 34.05.485 and the presiding officer ((~~shall~~)) must not have personally participated in the decision made by the employing agency or PEBB program.

(1) The presiding officer will decide the issue based on the information provided by the parties during the presiding officer's review of the appeal.

(2) A presiding officer is limited to those powers granted by the state constitution, statutes, rules, or applicable case law.

(3) A presiding officer may not decide that a rule is invalid or unenforceable.

(4) In addition to the record, the presiding officer may employ ((~~authority~~)) the authority's expertise as a basis for the decision.

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

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

(2) The review officer or officers shall review the initial order and the record to determine if the initial order was correctly decided.

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

(a) Affirm the initial order in whole or in part;

(b) Reverse the initial order in whole or in part; or

(c) Refer the matter for a formal administrative hearing; or

(d) Remand to the presiding officer in whole or in part.

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

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

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

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

**WAC 182-16-2160 Conversion of a brief adjudicative proceeding to a formal administrative hearing.** (1) The presiding officer or the review officer or officers, in their sole discretion, may convert a brief adjudicative proceeding to a formal administrative hearing at any time on motion by the subscriber or enrollee or their representative, the authority, or on the presiding officer or review officer or officers' own motion.

(2) The presiding officer or review 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 ((~~34.05.479~~)) 34.05.476 that govern formal administrative hearings.

(3) When a brief adjudicative proceeding is converted to a formal administrative hearing, the director ((~~may become the hearing officer or may~~)) designates a ((~~replacement~~)) hearing officer to conduct the formal administrative hearing upon notice to the subscriber or enrollee 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 18-22-033, filed 10/29/18, effective 1/1/19)

**WAC 182-16-3000 Formal administrative hearings.** (1) When a brief adjudicative proceeding is converted to a formal administrative hearing consistent with WAC 182-16-2160, the director designates a hearing officer to conduct the formal administrative hearing.

(2) Formal administrative hearings are conducted consistent with the Administrative Procedure Act, RCW 34.05.413 through ((~~34.05.479~~)) 34.05.476.

(3) ((~~This~~)) Part III describes the general rules and procedures that apply to public employees benefits board (PEBB) benefits formal administrative hearings.

(a) ((~~This~~)) Part III supplements the Administrative Procedure Act (APA), chapter 34.05 RCW, and the model rules of procedure in chapter 10-08 WAC. The model rules of procedure adopted by the chief administrative law judge pursuant to RCW 34.05.250, as now or hereafter amended, are hereby adopted for use by the authority in public employees benefits board (PEBB) benefits formal administrative hearings. Other procedural rules adopted in chapters 182-08, 182-12, and 182-16 WAC are supplementary to the model rules of procedure.

(b) In the case of a conflict between the model rules of procedure and this part, the procedural rules adopted in this part ((~~shall~~)) must govern.

(c) If there is a conflict between this part and specific PEBB program rules, the specific PEBB program rules prevail. PEBB program rules are found in chapters 182-08 and 182-12 WAC.

(d) Nothing in this part is intended to affect the constitutional rights of any person or to limit or change additional requirements imposed by statute or other rule. Other laws or rules determine if a hearing right exists, including the APA and program rules or laws.

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

**WAC 182-16-3010 Requirements to appear and represent a party in the formal administrative hearing process.** (1) All parties must provide the hearing officer and all other parties with their name, address, and telephone number.

(2) The appellant may act as their own representative or have another person represent them, except that employees of the health care authority (HCA) or HCA's authorized agents may not represent an appellant, unless approved by a hearing officer.

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

(4) An attorney admitted to practice law in Washington state, who wishes to represent the appellant, must file a written notice of appearance containing the attorney's name, address, and telephone number with the hearing officer's office and serve all parties with the notice. In cases involving confidential information, the attorney representative must provide the HCA hearing representative with a signed, written consent permitting release to the attorney representative of the appellant's ((~~personal~~)) 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 hearing officer's office and serve all parties with the notice.

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

**WAC 182-16-3030 Authority of the hearing officer.** (1) A hearing officer must hear and decide the issues ((~~de novo (anew)~~)) based on the evidence and oral or written arguments presented during a formal administrative hearing and admitted into the record.

(2) A hearing officer has no inherent or common law powers, and is limited to those powers granted by the state constitution, statutes, or rules.

(3) A hearing officer may not decide that a rule is invalid or unenforceable. If the validity of a rule is raised during a formal administrative hearing, the hearing officer may allow only argument to preserve the record for judicial review.

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

**WAC 182-16-3080 Time requirements for service of notices made by the hearing officer.** (1) The hearing officer or their designee must serve a notice of a formal administrative hearing to all parties and their representatives at least twenty-one calendar days before the hearing date. The parties may agree to, but the hearing officer cannot impose, a shorter notice period.

(2) If a prehearing conference or dispositive motion hearing is scheduled, the hearing officer must serve a notice of the prehearing conference or dispositive motion hearing to the parties and their representatives at least seven business days before the date of the prehearing conference or dispositive motion hearing except:

(a) The hearing officer may change any scheduled formal administrative hearing into a prehearing conference or dispositive motion hearing and provide less than seven business days' notice of the prehearing conference or dispositive motion hearing; and

(b) The hearing officer may give less than seven business days' notice if the only purpose of the prehearing conference is to consider whether to grant a continuance.

(3) The hearing officer must reschedule a formal administrative hearing if necessary to comply with the notice requirements in Part III of this ((~~section~~)) chapter.

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

**WAC 182-16-3100 Rescheduling and continuances for formal administrative hearings.** (1) Any party may request the hearing officer to reschedule a formal administrative hearing if a rule requires notice of a hearing and the amount of notice required was not provided.

(a) The hearing officer must reschedule the hearing under circumstances identified in ((~~subsection (1) of~~)) this ((~~section~~)) chapter if requested by any party.

(b) The parties may agree to shorten the amount of notice required by any rule.

(2) Any party may request a continuance of a formal administrative hearing either orally or in writing.

(a) In each formal administrative hearing, the hearing officer must grant each party's first request for a continuance. The continuance may be up to thirty calendar days.

(b) The hearing officer may grant each party up to one additional continuance of up to thirty calendar days because of extraordinary circumstances ((~~established at a proceeding~~)).

(c) After granting a continuance, the hearing officer or their designee must:

(i) Immediately telephone all other parties to inform them the hearing was continued; and

(ii) Serve an order of continuance on the parties no later than fourteen days before the new formal administrative hearing date. All orders of continuance must provide a new deadline for filing documents with the hearing officer. The new filing deadline can be no less than ten calendar days prior to the new formal administrative hearing date. If the continuance is granted pursuant to (b) of this subsection, then the order of continuance must also include findings of fact that state with specificity the extraordinary circumstances for which the hearing officer granted the continuance.

(3) Regardless of whether a party has been granted a continuance as described in subsection ((~~(1)~~)) (2)(b) of this section, the hearing officer must grant a continuance if a new material issue is raised during the formal administrative hearing and a party requests a continuance.

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

**WAC 182-16-3120 Dispositive motions.** (1) A dispositive motion could dispose of one or all the issues in a formal administrative hearing, such as a motion to dismiss or motion for summary judgment.

(2) To request a dispositive motion hearing a party must file a written dispositive motion with the hearing officer and serve a copy of the motion to all other parties. The hearing officer may also set a dispositive motion hearing, and request briefing from the parties, to address any possible dispositive issues the hearing officer believes must be addressed before the hearing.

(3) The deadline to file a timely dispositive motion ((~~shall~~)) must be ten calendar days before the scheduled hearing.

(4) Upon receiving a dispositive motion, a hearing officer:

(a) Must convert the scheduled hearing to a dispositive motion hearing when:

(i) The dispositive motion is timely filed with the hearing officer at least ten calendar days before the date of the hearing; and

(ii) The party filing the dispositive motion has not previously filed a dispositive motion.

(b) May schedule a dispositive motion hearing in all instances other than described in (a) of this subsection.

(5) The hearing officer may conduct the dispositive motion hearing in person or by telephone conference. For dispositive motion hearings scheduled to be held in person, the HCA hearing representative may choose to attend and participate in person or by telephone conference call.

(6) The party requesting the dispositive motion hearing must attend and participate in the dispositive motion hearing in person or by telephone. If the party requesting the motion hearing does not attend and participate in the dispositive motion hearing, the hearing officer will enter an order ((~~of default~~)) dismissing the dispositive motion.

(7) During a dispositive motion hearing, the hearing officer can only consider the filed dispositive motions, any response to the mo-

tions, evidence submitted to support or oppose the motions, and argument on the motions. Prior to rescheduling any necessary hearings, the hearing officer must serve a written order on the dispositive motions.

(8) The hearing officer must serve the written order on the dispositive motions to all parties no later than eighteen calendar days after the dispositive motion hearing is held. Orders on dispositive motions are subject to motions for reconsideration or petitions for judicial review as described in WAC 182-16-2120 and 182-16-2130.

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

**WAC 182-16-3130 Subpoenas.** (1) Hearing officers, the HCA hearing representative, and attorneys for the parties may prepare subpoenas as described in Washington state civil rule 45, unless otherwise prohibited by law. Any party may request the hearing officer prepare a subpoena on their behalf.

(2) The hearing officer may schedule a prehearing conference to decide whether to issue a subpoena.

(3) If a party requests the hearing officer prepare a subpoena on its behalf, the party is responsible for:

(a) Service of the subpoena; and

(b) Any costs associated with:

(i) Compliance with the subpoena; and

(ii) Witness fees as described in RCW 34.05.446(7).

(4) Service of a subpoena must be made by a person who is at least eighteen years old and not a party to the hearing. Service of the subpoena is complete when the person serving the subpoena:

(a) Gives the person or entity named in the subpoena a copy of the subpoena; or

(b) Leaves a copy of the subpoena with a person over the age of eighteen at the residence or place of business of the person or entity named in the subpoena.

(5) To prove service of a subpoena on a witness, the person serving the subpoena must file with the hearing officer's office a signed, written, and dated statement that includes:

(a) The name of the person to whom service of the subpoena occurred;

(b) The date the service of the subpoena occurred;

(c) The address where the service of the subpoena occurred; and

(d) The name, age, and address of the person who provided service of the subpoena.

(6) A ((~~party~~)) person or entity subject to or affected by the subpoena may request the hearing officer quash (set aside) or change a subpoena request at any time before the deadline given in the subpoena.

(7) A hearing officer may quash (set aside) or change a subpoena if it is unreasonable.

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

**WAC 182-16-3140 Orders of dismissal—Reinstating a formal administrative hearing after an order of dismissal.** (1) An order of dismissal is an order from the hearing officer ending the matter. The order is entered because the party who made the appeal withdrew from the proceeding, the appellant is no longer aggrieved, the hearing officer granted a dispositive motion dismissing the matter, or the hearing officer entered an order of default because the party who made the appeal failed to attend or refused to participate in a prehearing conference or the formal administrative hearing.

(2) The order of dismissal becomes a final order if no party files a request to vacate the order as described in subsections (3) through (7) of this section.

(3) If the hearing officer enters and serves an order dismissing the formal administrative hearing, the appellant may file a written request to vacate (set aside) the order of dismissal. Upon receipt of a request to vacate an order of dismissal, the hearing officer must schedule and serve notice of a prehearing conference as described in WAC 182-16-3080. At the prehearing conference, the party asking that the order of dismissal be vacated has the burden to show good cause according to subsection (8) of this section for an order of dismissal to be vacated and the matter to be reinstated.

(4) The request to vacate an order of dismissal must be filed with the hearing officer and the other parties. The party requesting that an order of dismissal be vacated should specify in the request why the order of dismissal should be vacated.

(5) The request to vacate an order of dismissal must be filed with the hearing officer no later than twenty-one calendar days after the date the order of dismissal was entered. If no request is received within that deadline, the dismissal order becomes ((~~a final order and the final order will stand~~)) the health care authority's final decision without further action.

(6) If the hearing officer finds good cause, as described in subsection (8) of this section, for the order of dismissal to be vacated, the hearing officer must enter and serve a written order to the parties setting forth the findings of fact, conclusions of law, and reinstatement of the matter.

(7) If the order of dismissal is vacated, the hearing officer will conduct a formal administrative hearing at which the parties may present argument and evidence about issues raised in the original appeal. The formal administrative hearing may occur immediately following the prehearing conference on the request to vacate only if agreed to by the parties and the hearing officer, otherwise a formal administrative hearing date must be scheduled by the hearing officer.

(8) Good cause is a substantial reason or legal justification for failing to appear, act, or respond to an action using the provisions of Superior Court civil rule 60 as a guideline. This good cause exception applies only to this chapter. This good cause exception does not apply to any other chapter or chapters in Title 182 WAC.

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

**WAC 182-16-3160 Withdrawing a formal administrative hearing.** (1) The appellant may withdraw a formal administrative hearing for any reason, and at any time, by contacting the health care authority (HCA) hearing representative who will coordinate the withdrawal with the hearing officer.

(2) The request for withdrawal must generally be made in writing. An oral withdrawal by the appellant is permitted during a formal administrative hearing when both the hearing officer and HCA hearing representative are present.

(3) After a withdrawal request is received, the hearing officer must cancel any scheduled hearings and enter and serve a written order dismissing the case.

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

**WAC 182-16-3170 Final order deadline—Required information.** (1) Within ninety days after the formal administrative hearing record is closed, the hearing officer ((~~shall~~)) must serve a final order that ((~~shall~~)) must be the final decision of the authority. The hearing officer shall serve a copy of the final order to all parties.

(2) The hearing officer must include the following information in the written final order:

(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.

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

**WAC 182-16-3180 Request for reconsideration and response—Process.** (1) A request for reconsideration asks the hearing officer to

reconsider the final order because the party believes the hearing officer 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 hearing officer who entered the final order.

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

(a) The hearing officer 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 serve copies of the request ((~~to~~)) on all other parties((~~.~~)) on the same day the request is served on the hearing officer; and

(c) Within five business days of receiving a request for reconsideration, the hearing officer must serve to 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 hearing officer no later than seven business days after the service date of the hearing officer's 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 hearing officer 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) No evidence may be offered in support of a motion for re-consideration, except newly discovered evidence that is material for the party moving for reconsideration and that the party could not ((~~with reasonable diligence~~)) have reasonably discovered and produced at the hearing or before the ruling on a dispositive motion.

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

**WAC 182-16-3190 Decisions on requests for reconsideration.** (1) Unless the request for reconsideration is denied as untimely filed under WAC 182-16-3180, the same hearing officer who entered the final order, if reasonably available, will also dispose of the request as well as any responses received.

(2) The decision on the request for reconsideration must be in the form of a written order denying or granting the request in whole or in part and if the request is granted issuing a new written final order.

(3) If the hearing officer does not send an order on the request for reconsideration within twenty calendar days of the date of the notice described in WAC ((~~182-16-2120~~)) 182-16-3180 (4)(c), the request is deemed denied.

(4) 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.

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

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

**WAC 182-16-3200 Judicial review of final order.** (1) Judicial review is the process of appealing a final order to a court.

(2) The appellant may appeal a final order by filing a written petition for judicial review that meets the requirements of RCW ((~~34.05.546~~)) 34.05.510 through 34.05.598. The public employees benefits board (PEBB) program may not request judicial review.

(3) The appellant should consult RCW 34.05.510 through 34.05.598 for further details and requirements of the judicial review process.