RULE-MAKING ORDER

CR-103P (May 2009)
(Implements RCW 34.05.360)

Agency: Health Care Authority (HCA), Public Employees Benefits Board (PEBB) Admin # 2016-01

Permanent Rule Only

Effective date of rule:

Permanent Rules

☐ 31 days after filing.

☒ Other (specify) January 1, 2017 **(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: See "Attachment"

Citation of existing rules affected by this order:

Repealed:

Amended: Chapters 182-08, 182-12, and 182-16

Suspended:

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Other authority: SB 6475 (2016 Regular Session) and Public Employees Benefits Board Policy Resolutions

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 16-17-115 on August 22, 2016.

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: phone ( ) _____

Address: fax ( ) _____

e-mail _____

Date adopted: October 4, 2016

NAME (TYPE OR PRINT)
Wendy Barcus

SIGNATURE

TITLE
HCA Rules Coordinator

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: October 04, 2016
TIME: 10:58 AM

WSR 16-20-080

(COMPLETE REVERSE SIDE)

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Federal statute:	New		Amended		Repealed	
Federal rules or standards:	New		Amended		Repealed	
Recently enacted state statutes:	New		Amended	14	Repealed	

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

	New		Amended		Repealed	

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

	New		Amended		Repealed	

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

	New	2	Amended	50	Repealed	0

The number of sections adopted using:

Negotiated rule making:	New		Amended		Repealed	
Pilot rule making:	New		Amended		Repealed	
Other alternative rule making:	New	2	Amended	64	Repealed	0

Health Care Authority - Public Employees Benefits Board – Attachment to CR-103

Amends existing rules in Title 182 WAC specific to the PEBB Program with the following effect:

1. Implement PEB Board policy resolutions to amend the definition of Tobacco Products and amend Domestic Partner eligibility requirements.

2. Makes technical amendments to:

   - Amend WAC 182-08-180 to specifically state that failure to pay premiums will result in termination of PEBB benefits.

   - Amend WAC 182-08-197 to state that elections not submitted in a timely manner will result in default elections; add clarity to describe when optional life and long-term disability insurance begins for an employee who regains eligibility, and changing the number of days for an employee to submit a life insurance form from 60 to 31 days.

   - Amend WAC 182-08-199(3)(a)(xi) to state “or enrolls in or terminates enrollment in a Medicare Part D plan”.

   - Amend WAC 182-08-220(1)(c) to replace the word “employees” with the word “enrollees”.

   - Amend rules in Chapters 182-08 WAC and 182-12 WAC to more clearly distinguish school districts and educational service districts from all the other employer groups that may contract with the PEBB program. Clarify that applications submitted by employer groups must clearly identify all bargaining units within their organization and which bargaining units are applying for PEBB benefits. Clarify when enrollment will begin following approval of an application.

   - Clarify within WAC 182-08-237 that a local government or tribal government must make the decision to include or not include existing retirees at the time the entity submits an application for the bargaining unit to participate in PEBB benefits.

   - Amend WAC 182-08-240 to clarify what data is used to evaluate employer group applications.

   - Amend WAC 182-12-131(3) to ensure that the references to WAC 182-12-114 are clear.

   - Amend WAC 182-12-133(2) to say employees may continue medical, dental, or both for the remaining months allowed under COBRA.

   - Amend WAC 182-12-148 to state that premiums must be paid or coverage will be terminated.

   - Amend Chapters 182-08, 12, 16 WAC to clarify the meaning of employer-paid coverage versus employer-based coverage.

   - Amend references to RCW 41.05.011, to include medical only employer groups in which an employee has waived PEBB program medical coverage.

   - Amend Chapters 182-08 WAC and 182-12 WAC to address under payment of premiums.

   - Amend WAC 182-12-260(3) to say “Children are eligible through the last day of the month in which their twenty-sixth birthday occurred”.

   - Amend WAC 182-16-010 to state that the definitions within WAC 182-16-020 apply throughout this chapter.

   - Amend WAC 182-16-020 to add new definitions for “Appellant,” “Filling,” and “Service” and to amend definitions for “PEBB program,” “Denial or denial notice,” “Documents,” and “Hearing.”

   - Amend all sections within Chapter 182-16 WAC to account for the new and amended definitions contained within WAC 182-16-020.

   - Clarify within WAC 182-16-050(2) that a written request must be received within 30 calendar days after the date of the written decision letter from the PEBB appeals committee.

- Amend WAC 182-16-052 so that an appellant may act on their own behalf or have someone else represent them.
- Clarify within WAC 182-16-061(3) that a petition request can also be denied.
- Add new sections to Chapter 182-16 WAC regarding how to serve documents and the use of subpoenas within the appeals process.
- Clarify within WAC 182-16-071 that a presiding officer's office must serve notice 21 calendar days before a hearing, not 14 calendar days.
- Clarify within WAC 182-16-081(4)(d) that a schedule will be established for: the exchange and filling of briefs, providing a proposed witnesses list, and providing exhibit lists prior to the hearing.
- Amend WAC 182-16-105(1) to include a timeline when a reconsideration request may be made to the presiding officer.
- Global change across Chapters 182-08, 12, 16 WAC to incorporate the correct use of "PEBB insurance coverage" vs "insurance coverage".
- Global change across Chapters 182-08, 12, 16 WAC to incorporate the correct use of "employer" as used in RCW 41.05.011.
- Amend WAC 182-12-205 to require a request to terminate coverage to be made in writing and to allow coverage to be terminate the last day of the previous month if a written request to voluntary terminate coverage is received on the first day of the month.
- Global change across Chapters 182-08, 12, 16 WAC to include "and regulations" along with every reference to Internal Revenue Code (IRC).
- Amend WAC 182-12-114 so that employee's eligibility for benefits is in alignment with RCW 41.05.065.
- Amending the special open enrollment provision for a "change in employment status" to add clarity.

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

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

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

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

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

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

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

"Continuation coverage" means the temporary continuation of PEBB health plan coverage available to enrollees after a qualifying event occurs as administered under Title XXII of the Public Health Service (PHS) Act, 42 U.S.C. Secs. 300bb-1 through 300bb-8.

"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 eligible survivor.

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

"Dependent care assistance program" or "DCAP" means a benefit plan whereby state and public employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan authorized in chapter 41.05 RCW.

"Director" means the director of the authority.

"Documents" means papers, letters, writings, ((~~e-mails~~)) electronic mail, electronic files, or other printed or written items.

"Employee" 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 ((~~seeks and receives the approval of~~)) submits application materials to the authority to provide any of its insurance programs by contract

with the authority, as provided in RCW 41.04.205 and 41.05.021 (1)(g); (b) employees of employee organizations representing state civil service employees, at the option of each such employee organization, and, effective October 1, 1995, employees of employee organizations currently pooled with employees of school districts for the purpose of purchasing insurance benefits, at the option of each such employee organization; (c) employees of a school district if the authority agrees to provide any of the school districts' insurance programs by contract with the authority as provided in RCW 28A.400.350; (d) employees of a tribal government, if the governing body of the tribal government seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(f) and (g); (e) employees of the Washington health benefit exchange if the governing board of the exchange established in RCW 43.71.020 seeks and receives approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(g) and (n); and (f) employees of a charter school established under chapter 28A.710 RCW. "Employee" does not include: Adult family home providers; unpaid volunteers; patients of state hospitals; inmates; employees of the Washington state convention and trade center as provided in RCW 41.05.110; students of institutions of higher education as determined by their institution; and any others not expressly defined as employees under this chapter or by the authority under this chapter.

"Employer" means the state of Washington as defined in RCW 41.05.011.

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

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

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

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

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

"Employing agency" means a division, department, or separate agency of state government, including an institution of higher education; a county, municipality, school district, educational service

district, or other political subdivision; charter school; or a tribal government covered by chapter 41.05 RCW.

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

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

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

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

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

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

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

"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" includes basic life insurance paid for by the employing agency, life insurance offered to employees on an optional basis, and retiree life insurance.

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

((~~"Mail" or "mailing" means placing a document in the United States Postal system, commercial delivery service, or Washington state consolidated mail services properly addressed.~~))

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby state and public employees may reduce their salary before taxes to pay for medical expenses not reimbursed by insurance as provided in the salary reduction plan authorized in chapter 41.05 RCW.

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

"PEBB" means the public employees benefits board.

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

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

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

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

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

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

• Premiums are less than ninety-five percent of Uniform Medical Plan (UMP) Classic premiums; and

• The actuarial value of benefits is at least ninety-five percent of the actuarial value of UMP Classic benefits.

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

"Salary reduction plan" means a benefit plan whereby state and public employees may agree to a reduction of salary on a pretax basis to participate in the DCAP, medical FSA, or premium payment plan as authorized in chapter 41.05 RCW.

((~~"School district" means public schools as defined in RCW 28A.150.010 which includes charter schools established under chapter 28A.710 RCW.~~

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

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

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

"Subscriber" means the employee, retiree, COBRA beneficiary, or eligible survivor who has been designated by the HCA as the individual to whom the HCA and contracted vendors will issue all notices, information, requests and premium bills on behalf of enrollees.

"Tobacco products" means any product made with or derived from tobacco that is intended for human consumption, including any compo-

nent, 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 ((~~or e-cigarettes until their tobacco related status is determined by the FDA~~)).

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

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

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

AMENDATORY SECTION (Amending WSR 13-22-019, filed 10/28/13, effective 1/1/14)

WAC 182-08-120 Employer contribution. The employer contribution must be used to provide public employees benefits board (PEBB) insurance coverage for the basic life insurance benefit, the basic long-term disability insurance benefit, medical((~~,~~)) and dental, 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 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-08-180 Premium payments and premium refunds. Premiums are due as described in this section, except when an employing agency is correcting its enrollment error as described in WAC 182-08-187 (2) or (3).

(1) **Premium payments.** Public employees benefits board (PEBB) insurance coverage premiums become due the first of the month in which insurance coverage is effective.

Premium is due from the subscriber for the entire month of insurance coverage and will not be prorated during any month.

(a) If an employee elects optional coverage as described in WAC 182-08-197 (1)(a) or (3)(a), the employee is responsible for payment of premiums from the month that the optional coverage begins.

(b) Unpaid or underpaid ((~~accounts~~)) premiums must be paid, and are due from the employing agency, subscriber, or ((~~beneficiary~~)) a subscriber's legal representative to the health care authority (HCA). ((~~If a subscriber's account is past due and~~)) A subscriber's monthly

premium or premium surcharge that remains unpaid for thirty days will be considered delinquent. A subscriber is allowed a grace period of thirty days from the date the monthly premium or premium surcharge becomes delinquent to pay the unpaid premium balance or surcharge. If a subscriber's monthly premium or premium surcharge remains unpaid for sixty days, the subscriber's PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and any premium surcharge was paid. If it is determined by the authority that ((~~full~~)) payment of the unpaid balance in a lump sum would be considered a hardship, the authority may develop a reasonable repayment plan with the subscriber or ((~~beneficiary~~)) the subscriber's legal representative upon request.

(c) A monthly premium 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 premium or premium surcharge is received by the authority and the monthly premium remains unpaid for thirty days; or

(ii) A premium payment or premium surcharge received by the authority is underpaid by an amount greater than an insignificant shortfall and the monthly premium remains underpaid for thirty days past the date the monthly premium was due.

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

(a) When a subscriber submits an enrollment change affecting subscriber or dependent eligibility, HCA may allow up to three months of accounting adjustments. HCA will refund to the individual or the employing agency any excess premium paid during the three month adjustment period, except as indicated in WAC 182-12-148((~~(4)~~)) (5).

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

(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 all premiums paid during the time he or she was enrolled under the federal program if approved by the PEBB ((~~deputy~~)) division director or designee.

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

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

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

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

(a) A subscriber must attest to whether any enrollee, thirteen years and older, enrolled in his or her public employees benefits

board (PEBB) medical engages in tobacco use. The subscriber must attest as described in (a)(i) through (vii) of this subsection:

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

(ii) If there is a change in the tobacco use status of any enrollee, thirteen years and older on the subscriber's PEBB medical, the subscriber must update his or her attestation on the required form. An employee must submit the updated attestation to his or her employing agency. Any other subscriber must submit his or her updated attestation to the PEBB program.

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

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

(iii) If a subscriber submits the required form to enroll a dependent, thirteen years and older, in PEBB medical as described in WAC 182-12-262, the subscriber must update his or her attestation on the required form. An employee must submit the updated attestation to his or her employing agency. Any other subscriber must submit his or her updated attestation 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 182-12-146, must provide an attestation on the required form if he or she has not previously attested as described in (a) of this subsection. The enrollee must submit his or her updated attestation 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), 182-12-200 (3)(a) and (b), or 182-12-205 (6)(a), (b), (c), (d), and (e), must provide an attestation on the required form if he or she has not previously attested as described in (a) of this subsection. The employee or retiree must submit his or her updated attestation 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 182-12-250(5) or 182-12-265, must provide an attestation on the required form to the PEBB program if he or she has not previously attested as described in (a) of this subsection. An attestation that results in a premium surcharge will take effect the same date as PEBB medical begins.

(vii) An employee who previously waived PEBB medical must complete the required form to enroll in PEBB medical as described in WAC 182-12-128(3). The employee must include his or her attestation on that form. An employee must submit the attestation to his or her em-

ploying agency. An attestation that results in a premium surcharge will take effect the same date as PEBB medical begins.

Exception: (1) A subscriber enrolled in both medicare parts A and B and in the medicare risk pool is not required to provide an attestation and no premium surcharge will be imposed on the subscriber's account.
(2) An employee who waives PEBB medical according to WAC 182-12-128 is not required to provide an attestation and no premium surcharge will be applied to his or her account as long as the employee enrollment remains in waived status.

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

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

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

(ii) An enrollee who is thirteen through seventeen years old and uses tobacco products may access the information and resources aimed at teens on the Washington state department of health's web site at http://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 if an enrolled spouse or state registered domestic partner elected not to enroll in employer-based group medical ((~~insurance~~)) that has premiums less than ninety-five percent of the Uniform Medical Plan (UMP) Classic's premiums and benefits with an actuarial value of at least ninety-five percent of the actuarial value of the UMP Classic's benefits.

(a) A subscriber who enrolled a spouse or state registered domestic partner under his or her 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 as described in WAC 182-12-262 (1)(a). A subscriber must complete the required form to enroll his or her spouse or state registered domestic partner. The subscriber must include his or her attestation on that form. The employee must submit the attestation to his or her employing agency. Any other subscriber must submit an attestation to the PEBB program. If the subscriber's attestation results in a premium surcharge it will take effect the same date as PEBB medical begins;

(ii) When a special open enrollment (SOE) event occurs as described in WAC 182-12-262 (1)(c). A subscriber must submit the required form to enroll a spouse or state registered domestic partner in PEBB medical. The subscriber must include his or her updated attestation on that form. An employee must submit an updated attestation to his or her employing agency. Any other subscriber must submit an updated attestation to the PEBB program. If the subscriber's attestation results in a premium surcharge it will take effect the first day of the month following receipt of the attestation. If that day is the first day of the month, the change to the surcharge begins on that day;

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

- Incurring the surcharge;

• Not incurring the surcharge because the spouse's or state registered domestic partner's share of the medical premium through his or her employer-based group medical ((~~insurance~~)) was more than ninety-five percent of the UMP Classic's premiums; 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 ((~~insurance~~)) was less than ninety-five percent of the UMP Classic's actuarial value.

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

(iv) When there is a change in the spouse's or state registered domestic partner's employer-based group medical ((~~insurance~~)). An employee must submit an updated attestation to his or her employing agency within sixty days of when the spouse's or state registered domestic partner's employer-based group medical ((~~insurance~~)) status changes. Any other subscriber must submit an updated attestation to the PEBB program no later than sixty days after the spouse's or state registered domestic partner's employer-based group medical ((~~insurance~~)) 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.

Exception:
(1) A subscriber enrolled in both medicare parts A and B and in the medicare risk pool is not required to provide an attestation and no premium surcharge will be imposed on the subscriber's account.
(2) An employee who waives PEBB medical according to WAC 182-12-128 is not required to provide an attestation and no premium surcharge will be applied to his or her account as long as the employee remains in waived status.
(3) An employee who covers his or her spouse or state registered domestic partner who has waived his or her own PEBB medical must attest, but a premium surcharge will not be applied.
(4) A subscriber who covers his or her spouse or state registered domestic partner who elected not to enroll in TRICARE must attest, but a premium surcharge will not be applied.

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

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

WAC 182-08-187 How do employing agencies correct enrollment errors and is there a limit on retroactive enrollment? An employing agency that fails to timely enroll an employee, or his or her dependent, in public employees benefits board (PEBB) benefits must correct the error as described in this section. An agency must correct a failure to notify an employee timely of his or her eligibility for PEBB benefits and the employer contribution; or a failure to accurately enroll PEBB insurance coverage; or a failure to accurately enroll PEBB

insurance coverage as ((~~required by~~)) described in WAC 182-08-197 (1)(b); or a failure to accurately reflect premium surcharge status.

The employing agency or the PEBB program's designee must enroll the employee and the employee's dependent, as elected, in PEBB benefits as described in subsection (1) of this section, reconcile premium payments and premium surcharges as described in subsection (2) of this section, and provide recourse as described in subsection (3) 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. Employees who do not return the required enrollment forms default to enrollment according to WAC 182-08-197 (1)(b).

(1) **Enrollment.**

(a) PEBB medical and dental enrollment is effective the first day of the month following the date the enrollment error is identified, unless the authority determines additional recourse is warranted, as described in subsection (3) of this section. If the enrollment error is identified on the first day of the month, the enrollment correction is effective that day;

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

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

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

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

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

(d) If the employee is eligible and elects (or elected) to enroll in the medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP), enrollment is limited to three months prior to the date enrollment is processed, but not earlier than the current plan year. If an employee was not enrolled in an FSA or DCAP as elected, the employee may adjust his or her election. The employee may either participate at the amount originally elected with a corresponding increase in contributions for the balance of the plan year, or partic-

ipate at a reduced amount for the plan year by maintaining the per-pay period contribution in effect.

(2) **Premium payments.**

(a) The employing agency must remit to the authority the employer contribution and the employee contribution for health plan premiums, premium surcharges, basic life, and basic LTD from the date insurance coverage begins as described in subsections (1) and (3)(a)(i) of this section. If a state agency failed to notify a newly eligible employee of his or her eligibility for PEBB benefits, the state agency may only collect the employee contribution for health plan premiums and 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 life insurance or optional LTD insurance ((~~coverage~~)) 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 life insurance or optional LTD insurance vendor is responsible for premium refunds for the most recent twenty-four months of coverage. The employing agency is responsible for additional months of premium refunds.

(3) **Recourse.**

(a) Employee eligibility for PEBB benefits begins on the first day of the month following the date eligibility is established as described in WAC 182-12-114. Dependent eligibility is described in WAC 182-12-260, and dependent enrollment is described in WAC 182-12-262. When retroactive correction of an enrollment error is limited as described in subsection (1) of this section, the employing agency must work with the employee, and 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 medical and dental premiums; or

(iv) 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 15-22-099, filed 11/4/15, effective 1/1/16)

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 contributions to the HCA for PEBB insurance coverage for all eligible employees and their dependents.

(1) Employer contributions for state agencies set by the HCA 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) 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. 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) 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) The terms of payment to HCA for employer groups and charter schools shall be stipulated under contract with the HCA.

AMENDATORY SECTION (Amending WSR 11-22-036, filed 10/26/11, effective 1/1/12)

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

(a) Employees must notify their employing agency of their new health plan ((~~choice~~)) election.

(b) All other subscribers must notify the PEBB program of their new health plan ((~~choice~~)) election.

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

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

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

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

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

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

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

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

(a) An employee must complete the required forms indicating his or her 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. Forms must be received by his or her employing agency no later than thirty-one days ((~~(sixty days for life insurance)~~)) after the employee becomes eligible for PEBB benefits under WAC 182-12-114.

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

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

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

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

(i) Uniform Medical Plan Classic;

(ii) Uniform Dental Plan;

(iii) Basic life insurance;

(iv) Basic long-term disability insurance;

(v) Dependents will not be enrolled; and

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

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

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

(a) The employee must complete the required forms indicating his or her 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 no later than thirty-one days after the employee regains eligibility, except as described in subsection (3)(b) of this section:

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

(ii) An employee who was eligible to continue optional life under continuation coverage but discontinued that insurance coverage must submit evidence of insurability;

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

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

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

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

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

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

(4) If an employee who is eligible to participate in the state's salary reduction plan (see WAC 182-12-116) is hired into a new position that is eligible for PEBB benefits in the same year, the employee may not resume participation in DCAP or medical FSA until the beginning of the next plan year, unless the time between employments is less than thirty days and the employee notifies the new state agency

and the DCAP or FSA administrator of his or her employment transfer within the current plan year.

(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 coverage. This includes movement of an employee between any entities described in WAC 182-12-111 and participating in PEBB benefits. PEBB insurance coverage elections also remain the same when an employee has a break in employment that does not interrupt his or her employer contribution toward PEBB insurance coverage.

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

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

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

(2) **During a special open enrollment:** Subscribers may change health plans outside of the annual open enrollment if a special open enrollment event occurs. The change in enrollment must be allowable under Internal Revenue Code (IRC) and Treasury regulations, and correspond to and be consistent with the event that creates the special open enrollment for the subscriber, the subscriber's dependent, or both. To make a health plan change, the subscriber must submit the required enrollment forms (and a completed disenrollment form, if required). The forms must be received no later than sixty days after the event occurs. An employee((s)) submits the enrollment forms to ((their)) his or her employing agency. All other subscribers submit the enrollment forms to the PEBB program. Subscribers must provide evidence of the event that created the special open enrollment. New health plan coverage will begin the first day of the month following the later of the event date or the date the form is received. If that day is the first of the month, the change in enrollment begins on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, health plan coverage will begin the month in which the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption occurs. Any one of the following events may create a special open enrollment:

(a) Subscriber acquires a new dependent due to:

(i) Marriage or registering a domestic partnership;

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

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

(iv) A child becoming eligible as a dependent with a disability;

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

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

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

(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. If the subscriber does not select a new health plan, the PEBB program may change the subscriber's health plan as described in WAC 182-08-196(2);

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

((~~(f)~~)) (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;

((~~(g)~~)) (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);

((~~(h)~~)) (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 ((~~cancels~~)) 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);

((~~(i)~~)) (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;

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

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

(ii) Transplant within the last twelve months; or

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

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

(v) Third trimester of pregnancy.

If the employee is having premiums taken from payroll on a pretax basis, a 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 15-22-099, filed 11/4/15, effective 1/1/16)

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

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

(2) **During annual open enrollment:** An eligible employee may enroll in or change his or her election under the state's premium payment plan, medical FSA, or DCAP during the annual open enrollment. For the state's premium payment plan, the required form must be submitted to his or her employing agency. To enroll or reenroll in medical FSA or DCAP the employee must submit the required form to his or her employing agency or the public employees benefits board (PEBB) program's designee. All required forms must be received no later than the last day of the annual open enrollment. The enrollment or new election ((~~will be~~)) becomes effective January 1st of the following year.

(3) **During a special open enrollment:** An employee may enroll or change his or her 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 forms as instructed on the forms. The required forms must be received no later than sixty days after the event occurs. The employee must provide evidence of the event that created the special open enrollment.

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

(a) **Premium payment plan.** An employee may enroll or change his or her election under the premium payment plan when any of the following special open enrollment events occur, if the requested change corre-

sponds to and is consistent with the event. The enrollment or change in election will be effective the first day of the month following the later of the event date or the date the required form is received. If that day is the first of the month, the enrollment or change in election begins on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, the enrollment or change in election will begin the first of the month in which the event occurs.

(i) Employee acquires a new dependent due to:

• Marriage;

• Registering a domestic partnership when the dependent is a tax dependent of the subscriber;

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

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

• A child becoming eligible as a dependent with a disability.

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

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

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

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

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

((~~(vii)~~)) (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;

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

((~~(ix)~~)) (x) Employee or an employee's dependent becomes entitled to coverage under medicaid or a state children's health insurance pro-

gram (CHIP), or the subscriber or a subscriber's dependent loses eligibility for coverage under medicaid or CHIP;

((~~(x)~~)) (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);

((~~(xi)~~)) (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((~~, or enrolls in or terminates enrollment in a medicare Part D plan~~));

((~~(xii)~~)) (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) may require evidence that the employee or employee's dependent is no longer eligible for an HSA;

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

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

• Transplant within the last twelve months; or

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

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

• Third trimester of pregnancy.

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

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

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

(i) Employee acquires a new dependent due to:

• Marriage;

• Registering a domestic partnership if the domestic partner qualifies as a tax dependent of the subscriber;

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

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

• A child becoming eligible as a dependent with a disability.

(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 FSA;

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

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

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

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

(i) Employee acquires a new dependent due to:

• Marriage;

• Registering a domestic partnership if the domestic partner qualifies as a tax dependent of the subscriber;

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

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

• A child becoming eligible as a dependent with a disability.

(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 ((~~another~~)) an employer-based group health ((~~insurance~~))

plan during its annual open enrollment that does not align with the PEBB program's annual open enrollment;

(iv) Employee changes dependent care provider; the change to DCAP 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 Section 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 to reflect the new cost if the dependent care provider is not a qualifying relative of the employee as defined in Internal Revenue Code Section 152.

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

WAC 182-08-220 Advertising or promotion of public employees benefits board (PEBB) benefit plans. (1) In order to assure equal and unbiased representation of public employees benefits board (PEBB) benefits, contracted vendors must comply with all of the following:

(a) All materials describing PEBB benefits must be prepared by or approved by the health care authority (HCA) before use.

(b) Distribution or mailing of all benefit descriptions must be performed by or under the direction of the HCA.

(c) All media announcements or advertising by a contracted vendor which includes any mention of the "public employees benefits board," "PEBB," "health care authority," "HCA," any reference to benefits for "state employees," or "retirees," or any group of ((~~employees~~)) enrollees covered by PEBB benefits, must receive the advance written approval of the HCA.

(2) Failure to comply with any or all of these requirements by a PEBB contracted vendor or subcontractor may result in contract termination by the HCA, refusal to continue or renew a contract with the noncomplying party, or both.

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

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). ((~~With the exception of school districts and educational service districts, the authority will approve or deny applications through the evaluation criteria described in WAC 182-08-240. To apply, employer groups must submit the documents and information described in this rule to the public employees benefits board (PEBB) program~~))

(1) Employer groups and charter schools with less than five thousand employees must apply at least sixty days before the requested coverage effective date. ((~~School districts and educational service districts are only~~)) Employer groups and charter schools with five

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

(a) School districts, educational service districts, and charter schools are required to provide the documents described in subsections ((~~(1), (2), and (3)~~)) (2)(a) through (c) of this section((~~. If school districts or educational service districts are required by the superintendent of public instruction to purchase insurance coverage provided by the authority, they are required to submit documents and information described in subsections (1)(c), (2), and (3) of this section.~~ ~~(1)~~));

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 ((~~(d)~~)) (iv) of this subsection:

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

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

((~~(c)~~)) (iii) Employer tax ID number (TIN); and

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

((~~(2)~~)) (b) A resolution from the ((~~employer~~)) group's governing body authorizing the purchase of PEBB insurance coverage.

((~~(3)~~)) (c) A signed governmental function attestation document that attests to the fact that employees for whom the ((~~employer~~)) group is applying are governmental employees whose services are substantially all in the performance of essential governmental functions.

((~~(4)~~)) (d) A member level census file for all of the employees for whom the ((~~employer~~)) group is applying. The file must be provided in the format required by the authority and contain the following dem-

ographic data, by member, with each member classified as employee, spouse or state registered domestic partner, or child:

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

((~~(b)~~)) (ii) Age;

((~~(c)~~)) (iii) Gender;

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

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

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

((~~(5)~~)) (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 designee may make an exception to the claims and cost information requirements based on the size of the group.

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

(f) If the application is for a subset of the ((~~employer~~)) group's employees (e.g., bargaining unit), the ((~~employer~~)) 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 ((~~(4) of this section~~)). This includes retired employees participating under the ((~~employer~~)) group's current health plan. The file must include the same demographic data by member.

((~~(6) In addition to the requirements of subsections (1) through (5) of this section, additional information is required based upon the total number of employees that the employer group employs who are eligible under their current health plan:~~

~~(a) Employer groups with fewer than eleven eligible employees must provide proof of current coverage or proof of prior coverage within the last twelve months.~~

~~(b) Employer groups with three hundred one to two thousand five hundred eligible employees must provide the following:~~

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

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

~~(c)~~)) (g) Employer groups ((~~with greater than two thousand five hundred eligible employees~~)) 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 ((~~employer~~)) group must pay for the cost of the evaluation. This cost is nonrefundable. ((~~An employer~~)) 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.

((~~(d) The following definitions apply for purposes of this section:~~

~~(i) "Large claim" is defined as a member that received more than twenty-five thousand dollars in allowed cost for services in a quarter; and~~

~~(ii) An "ongoing large claim" is 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 twenty-five thousand dollars in the quarter.~~

~~(e) 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 and if the code indicates a condition which is expected to continue into the next quarter, the claim is counted as an ongoing large claim.~~))

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 12-20-022, filed 9/25/12, effective 11/1/12)

WAC 182-08-237 May a local government entity or tribal government entity applying for participation in public employees benefits board (PEBB) insurance coverage include their retirees? A local government or tribal government that applies for participation in public employees benefits board (PEBB) insurance coverage under WAC 182-08-235 ((~~may~~)) will have a one-time opportunity to request inclusion of retired employees who are covered under its retiree health plan at the time of application.

(1) The authority will use the following criteria to approve or deny a request to include retirees:

(a) The local government or tribal government retiree health plan must have existed at least three years before the date of the employer group application;

(b) Eligibility for coverage under the local government's or tribal government's retiree health plan must have required immediate enrollment in retiree health plan coverage upon termination of employee coverage; and

(c) The retirees must have maintained continuous enrollment in the local government or tribal government retiree health plan.

(2) If the local government's or tribal government's application is for a subset of their employees (e.g., bargaining unit) only retirees previously within the bargaining unit may be included in the transfer.

(3) Retirees and dependents included in the transfer unit are subject to the enrollment and eligibility rules outlined in chapters 182-08, 182-12 and 182-16 WAC.

((~~(3)~~)) (4) Employees eligible for retirement subsequent to the local government or tribal government transferring to PEBB health plan coverage must meet retiree eligibility as outlined in chapter 182-12 WAC.

((~~(4)~~)) (5) To protect the integrity of the risk pool, if total local government or tribal government retiree enrollment exceeds ten percent of the total PEBB retiree population, the PEBB program may:

(a) Stop approving inclusion of retirees with local government or tribal government unit transfers; or

(b) Adopt a new rating methodology reflective of the cost of covering local government or tribal government retirees.

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

WAC 182-08-240 How will the health care authority (HCA) decide to approve or deny ((~~an employer~~)) a group application? ((~~Employer~~)) This section only applies to employee organizations representing state civil service employees and the Washington health benefit exchange, regardless of the number of employees, counties, municipalities, political subdivisions, and tribal governments with five thousand or more employees. Group applications for participation in public employees benefits board (PEBB) insurance coverage provided through the ((~~public employees benefits board (~~))PEBB((~~)~~)) program are approved or denied by the health care authority (HCA) based upon the information and documents submitted by the ((~~employer~~)) group and the employer group evaluation (EGE) criteria described in this rule. ((~~The authority may automatically deny an employer group application if the employer group fails to provide the required information and documents described in WAC 182-08-235.~~))

(1) ((~~Employer~~)) Groups are evaluated as a single unit. To support this requirement the ((~~employer~~)) group must provide a census file, as described in WAC 182-08-235 ((~~(1) through (5)~~)) (2)(d), and additional information as described in WAC 182-08-235((~~(6)~~)) (2)(g) for all employees eligible to participate under the ((~~employer~~)) group's current health plan. If the ((~~employer~~)) group's application is for both employees and retirees, the census file data and additional information for retired employees participating under the ((~~employer~~)) group's current health plan must also be included.

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

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

(2) ((~~An employer~~)) A group must pass the EGE criteria or the actuarial evaluation required in subsection (3) of this section as a single unit before the application can be approved. For purposes of this section a single unit includes all employees eligible under the

((~~employer~~)) group's current health plan. If the application is only for a bargaining unit, then the bargaining unit must be evaluated using the EGE criteria in addition to all eligible employees of ((~~employer~~)) the group as a single unit. If the ((~~employer~~)) group passes the EGE criteria as a single unit, but an individual bargaining unit does not, the ((~~employer~~)) group may only participate if all eligible employees of the entity participate.

(3) The authority will ((~~determine which of the criteria in (a) though (d) of this subsection is used to evaluate the employer group based upon the total number of eligible employees in the single unit.~~

~~(a) **Micro groups** (a single unit of one to ten employees) must meet the following criteria in order to pass the EGE evaluation:~~

~~(i) Provide proof of current coverage or proof of prior coverage within the last twelve months; and~~

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

~~(b) **Small and medium groups** (a single unit of eleven to three hundred employees) must meet the following criterion in order to pass the EGE evaluation: The member level census file demographic data must indicate a relative underwriting factor that is equal to or better than the relative underwriting factor as determined by the authority for the like population within the nonmedicare PEBB risk pool as described in subsection (1) of this section.~~

~~(c) **Large groups** (a single unit of three hundred one to two thousand five hundred employees) must meet the following criteria in order to pass the EGE evaluation:~~

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

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

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

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

~~(d) **Jumbo groups** (a single unit of two thousand five hundred one or more employees) must meet the following criteria in order to pass the actuarial evaluation:~~

~~(i)~~)) use the following criteria to evaluate the group.

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

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

((~~•~~)) (i) The frequency of large claims must be less than or equal to the PEBB historical benchmark frequency for the PEBB like

population within the nonmedicare population as described in subsection (1) of this section;

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

((~~(iii)~~)) (c) Provide an executive summary of benefits;

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

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

((~~(vi)~~)) (f) The evaluation of criteria in ((~~(d)(iii), (iv) and (v)~~)) (c), (d), and (e) of this subsection must indicate that the historical cost of benefits for the ((~~employer~~)) group is equal to or less than the historical cost of the PEBB like population within the nonmedicare population as described in subsection (1) of this section for a comparable plan design.

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

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

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

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

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 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 essential 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 ((~~and~~)), educational service districts, and charter schools 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 ((~~surcharge(s)~~)) 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 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 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 ((~~surcharge(s)~~)) 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.

((~~(4)~~)) (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.

((~~(5)~~)) (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 ((~~medical and dental~~)) health plan as COBRA ((~~enrollees~~)) subscribers for the remainder of the months available to them based on their qualifying event.

((~~(6)~~)) (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 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 15-22-099, filed 11/4/15, effective 1/1/16)

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

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

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

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

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

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

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

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

"Continuation coverage" means the temporary continuation of PEBB health plan coverage available to enrollees after a qualifying event occurs as administered under Title XXII of the Public Health Service (PHS) Act, 42 U.S.C. Secs. 300bb-1 through 300bb-8.

"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 eligible survivor.

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

"Dependent care assistance program" or "DCAP" means a benefit plan whereby state and public employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan authorized in chapter 41.05 RCW.

"Director" means the director of the authority.

"Documents" means papers, letters, writings, ((~~e-mails~~)) 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" 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 authori-

ty, "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 ((~~seeks and receives the approval of~~)) submits application materials to the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.04.205 and 41.05.021 (1)(g); (b) employees of employee organizations representing state civil service employees, at the option of each such employee organization, and, effective October 1, 1995, employees of employee organizations currently pooled with employees of school districts for the purpose of purchasing insurance benefits, at the option of each such employee organization; (c) employees of a school district if the authority agrees to provide any of the school districts' insurance programs by contract with the authority as provided in RCW 28A.400.350; (d) employees of a tribal government, if the governing body of the tribal government seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(f) and (g); (e) employees of the Washington health benefit exchange if the governing board of the exchange established in RCW 43.71.020 seeks and receives approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(g) and (n); and (f) employees of a charter school established under chapter 28A.710 RCW. "Employee" does not include: Adult family home providers; unpaid volunteers; patients of state hospitals; inmates; employees of the Washington state convention and trade center as provided in RCW 41.05.110; students of institutions of higher education as determined by their institution; and any others not expressly defined as employees under this chapter or by the authority under this chapter.

"Employer" means the state of Washington as defined by RCW 41.05.011.

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

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

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

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

"Employing agency" means a division, department, or separate agency of state government, including an institution of higher education; a county, municipality, school district, educational service district, or other political subdivision; charter school; or 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 which are not employer-based group medical ((~~insurance~~)).

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

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

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

"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" includes basic life insurance paid for by the employing agency, life insurance offered to employees on an optional basis, and retiree life insurance.

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

((~~"Mail" or "mailing" means placing a document in the United States Postal system, commercial delivery service, or Washington state consolidated mail services properly addressed.~~))

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby state and public employees may reduce their salary before taxes to pay for medical expenses not reimbursed by insurance as provided in the salary reduction plan authorized in chapter 41.05 RCW.

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

"PEBB" means the public employees benefits board.

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

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

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

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

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

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

• Premiums are less than ninety-five percent of Uniform Medical Plan (UMP) Classic premiums; and

• The actuarial value of benefits is at least ninety-five percent of the actuarial value of UMP Classic benefits.

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

"Salary reduction plan" means a benefit plan whereby state and public employees may agree to a reduction of salary on a pretax basis to participate in the DCAP, medical FSA, or premium payment plan as authorized in chapter 41.05 RCW.

((~~"School district" means public schools as defined in RCW 28A.150.010 which includes charter schools established under chapter 28A.710 RCW.~~))

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

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

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

"Subscriber" means the employee, retiree, COBRA beneficiary, or eligible survivor who has been designated by the HCA as the individual

to whom the HCA and contracted vendors will issue all notices, information, requests and premium bills on behalf of enrollees.

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

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

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

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

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

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. ((~~School district and educational service district ap-~~

~~plications must provide the documents described in WAC 182-08-235 (1), (2), and (3). If a school district or educational service district is required by the superintendent of public instruction to purchase insurance coverage provided by the authority, the school district or educational service district is required to submit documents and information described in WAC 182-08-235 (1)(c), (2), and (3). Employer group~~)) 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)((~~. With the exception of a school district or educational service district, the authority will approve or deny an employer group's application~~)) 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 ((~~and~~)), educational service districts, and charter schools.** In addition to subsection (2) of this section, the following applies to school districts ((~~and~~)), educational service districts, and charter schools:

(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 ((~~or~~)), 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 de-

fined 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 12-20-022, filed 9/25/12, effective 11/1/12)

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

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

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

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

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

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

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

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

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

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

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

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

AMENDATORY SECTION (Amending WSR 13-22-019, filed 10/28/13, effective 1/1/14)

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 ((~~provided~~)) described in subsections (2) through (5) of this section:

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

(b) **Determining eligibility.**

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

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

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

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

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

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

(iii) The employee combines hours from a seasonal position ((~~to~~)) 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 ((~~under~~)) as described in WAC 182-12-131(1).

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

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

(a) **Eligibility.** A seasonal employee is eligible if he or she ((~~works~~)) is anticipated to work an average of at least eighty hours per month and ((~~works~~)) is anticipated to work for at least eight hours in each month of at least three consecutive months of the season. A season is any recurring, cyclical period of work at a specific time of year that lasts three to eleven months.

(b) **Determining eligibility.**

(i) **Upon employment:** A seasonal employee is eligible from the date of employment if the employing agency anticipates that he or she 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 such that the employee meets the eligibility criteria in (a) of this subsection, the employee becomes eligible when the revision is made.

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

(c) **Stacking of hours.** As long as the work is within one state agency, employees may "stack" or combine hours worked in more than one

position or job to establish eligibility and maintain the employer contribution toward PEBB insurance coverage. Employees must notify their employing agency if they believe they are eligible through stacking. Stacking includes work situations in which:

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

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

(iii) The employee combines hours from a seasonal position or job ((~~to~~)) 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 ((~~under~~)) as described in WAC 182-12-131(1).

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

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

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

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

(ii) **For faculty hired on quarter/semester to quarter/semester basis:** Faculty who the employing agency anticipates will not work for the entire instructional year, or equivalent nine-month period, are eligible at the beginning of the second consecutive quarter or semester of employment in which he or she is 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 ((~~of~~)) as described in (a)(i) or (ii) of this subsection become eligible when the revision is made.

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

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

(i) Medical ((~~and~~)), dental ((~~insurance coverage and~~)), basic life insurance, and basic long-term disability insurance ((~~coverage~~)) begin on the first day of the month following the day the faculty be-

comes 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 ((~~and~~)), dental ((~~insurance coverage and~~)), basic life insurance, and basic long-term disability insurance ((~~coverage~~)) begin the first day of the month following the beginning of the second consecutive quarter/semester of half-time or more employment. If the first day of the second consecutive quarter/semester is the first working day of the month, then PEBB insurance coverage begins at the beginning of the second consecutive quarter/semester.

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

(a) **Eligibility.** A legislator is eligible for PEBB benefits on the date his or her 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 ((~~and~~)), dental ((~~insurance coverage and~~)), basic life insurance, and basic long-term disability insurance ((~~coverage for an eligible employee~~)) begin on the first day of the month following the day ((~~he or she~~)) 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 ((~~and~~)), dental ((~~insurance coverage and~~)), basic life insurance, and basic long-term disability insurance ((~~coverage for an eligible employee~~)) begin on the first day of the month following the day ((~~he or she~~)) 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 13-22-019, filed 10/28/13, effective 1/1/14)

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 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 15-22-099, filed 11/4/15, effective 1/1/16)

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

(1) ((~~Effective January 1, 2002,~~)) An individual who has more than one source of eligibility for enrollment in PEBB health plan coverage (called "dual eligibility") is limited to one enrollment.

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

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

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

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

(b) If the employee elects to waive his or her enrollment in PEBB medical, the employee will remain enrolled in PEBB medical under his or her 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 ((~~under~~)) as described in WAC 182-12-114(3) with two or more state institutions of higher education will be enrolled under the employing agency responsible to pay the employer contribution according to WAC 182-08-200(2).

(b) If the employee loses eligibility under the employing agency he or she chose to enroll under as described in ((~~subsection (5)~~)) (a) of this ((~~section~~)) subsection, the employee must notify his or her 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 from enrollment under one employing agency to another employing agency without a break in PEBB insurance coverage, 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,

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

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

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

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

(a) **When the employee becomes eligible:** An employee may waive PEBB medical when he or she becomes eligible for PEBB benefits. The employee must indicate his or her election to waive enrollment in PEBB medical on the required form and submit the form to his or her employing agency. The form must be received by the employing agency no later than thirty-one days after the date the employee becomes eligible (see WAC 182-08-197). PEBB medical will be waived as of the date the employee becomes eligible for PEBB benefits.

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

(c) **During a special open enrollment:** An employee may waive PEBB medical during a special open enrollment as described in subsection (4) of this section.

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

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

(2) If an employee waives PEBB medical, the employee's eligible dependents may not be enrolled in medical.

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

(a) During the annual open enrollment. The required form must be received by the employee's employing agency before the end of the an-

nual open enrollment. PEBB medical will begin January 1st of the following year.

(b) During a special open enrollment. A special open enrollment allows an employee to change his or her enrollment outside of the annual open enrollment. A special open enrollment may be created when one of the events described in subsection (4) of this section occurs.

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

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 the first of the month in which the event occurs.

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

(a) Employee acquires a new dependent due to:

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

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

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

(iv) A child becoming eligible as a dependent with a disability;

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

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

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

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

((~~(e)~~)) (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;

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

((~~(g)~~)) (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;

((~~(h)~~)) (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);

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

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

AMENDATORY SECTION (Amending WSR 13-22-019, filed 10/28/13, effective 1/1/14)

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

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

• Be hired into a position with a state agency within twenty-four months of the original eligible position ending; and

• Upon hire, notify the employing state agency that he or she is potentially eligible to use this section.

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

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

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

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 ((~~public employees benefits board (~~))PEBB((~~)~~)) benefits begin ((~~under~~)) 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 ((~~under~~)) 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 ((~~under~~)) 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 ((~~under~~)) 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 ((~~under~~)) 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 ((~~under~~)) 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 ((~~under~~)) 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 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 insurance coverage after the employee was no longer eligible for the employer contribution, insurance coverage ends the last day of the month for which employee premiums were deducted.

(d) Two-year averaging: All benefits-eligible faculty (eligible ((~~under~~)) 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 ((~~to~~)) toward PEBB insurance coverage. "Academic year" means summer, fall, winter, and spring quarters or summer, fall, and spring semesters and begins with summer quarter/semester. In order to be eligible for the employer contribution through two-year averaging, the faculty must provide written notification of his or her potential eligibility to his or her 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 ((~~under~~)) as described in WAC 182-12-114 (3)(a) and (b)) who lose eligibility for the employer contribution will regain it if they return to a faculty position where it is anticipated that they will work half-time or more for the quarter/semester no later than the twelfth month after the month in which they lost eligibility for the employer contribution. The employer contribution begins on the first day of the month in which the quarter/semester begins.

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

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

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

(i) Employees on authorized leave without pay;

(ii) Employees on approved educational leave;

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

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

(v) Employees applying for disability retirement.

(5) **Maintaining the employer contribution - Employees who move from an eligible to an otherwise ineligible position due to a layoff** maintain the employer contribution toward PEBB insurance coverage ((~~under the criteria~~)) 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 ((~~under~~)) 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 ((~~under~~)) 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 ((~~full~~)) premium set by the health care authority (HCA). These options are available ((~~according to~~)) 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 15-22-099, filed 11/4/15, effective 1/1/16)

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 ((~~under~~)) as described in WAC 182-12-114 may continue coverage for themselves and their dependents during certain types of leave or when their employment ends due to a layoff.

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

(a) Employees may self-pay for a maximum of twenty-nine months. The employee must pay the premium amounts for PEBB insurance coverage as premiums become due. If the monthly premium((~~s are more than~~)) or premium surcharge remains unpaid for sixty days ((~~delinquent~~)), PEBB insurance coverage will ((~~end as of~~)) be terminated retroactive to the last day of the month for which ((~~a full~~)) the monthly premium and premium surcharge was paid as described in WAC 182-08-180 (1)(b).

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

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

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

(ii) Employees who are on approved educational leave;

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

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

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

(vi) Employees who are applying for disability retirement.

(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 ((~~and~~)), dental, or both for the remaining difference in months by self-paying the premium as described in WAC 182-12-146.

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

WAC 182-12-136 May employees on approved educational leave waive continuation coverage? In order to avoid duplication of group health plan coverage, the following shall apply to employees during any period of approved educational leave. Employees eligible for continuation coverage provided in WAC 182-12-133 who obtain other employer-based group medical or dental ((~~insurance~~)), or both, may waive continuation of such coverage for each full calendar month in which they maintain coverage under the other ((~~insurance~~)) employer-based medical or dental. These employees have the right to reenroll in a public employees benefits board (PEBB) health plan effective the first day of the month after the date the other employer-based group medical or dental ((~~insurance~~)) ends, provided evidence of such other coverage is provided to the PEBB program upon application for reenrollment.

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

WAC 182-12-138 What options are available if an employee is approved for the federal Family and Medical Leave Act (FMLA)? (1) An employee on approved leave under the federal Family and Medical Leave Act (FMLA) may continue to receive the employer contribution toward public employees benefits board (PEBB) insurance coverage in accordance with the federal FMLA. The employee may also continue current optional life and optional long-term disability. The employee's employing agency is responsible for determining if the employee is eligible for leave under FMLA and the duration of such leave.

(2) If an employee's contribution toward premiums is more than sixty days delinquent, PEBB insurance coverage will end as of the last day of the month for which a ((~~full~~)) premium was paid.

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

AMENDATORY SECTION (Amending WSR 11-22-036, filed 10/26/11, effective 1/1/12)

WAC 182-12-141 If an employee reverts from an eligible position, what happens to his or her public employees benefits board (PEBB) insurance coverage? (1) If an employee reverts for reasons other than a layoff and is not eligible for the employer contribution toward public employees benefits board (PEBB) insurance coverage under this chapter, he or she may continue PEBB insurance coverage by self-paying the ((~~full~~)) premium set by the 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). If the monthly premium or premium surcharge remains unpaid for sixty days, PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and premium surcharge was paid as described in WAC 182-08-180 (1)(b).

(2) If an employee is reverted due to a layoff, the employee may be eligible for the employer contribution toward 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 ((~~full~~)) premium set by the HCA under WAC 182-12-133.

AMENDATORY SECTION (Amending WSR 10-20-147, filed 10/6/10, effective 1/1/11)

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 ((~~coverage~~)) by self-paying the ((~~full~~)) premium set by the HCA, with no contribution from the employer, for a maximum of twelve months between periods of eligibility. The employee must pay the premium amounts associated with public employees benefits board (PEBB) insurance coverage as premiums become due. If the monthly premium((~~s are more than~~)) or premium surcharge remains unpaid for sixty days ((~~delinquent~~)), PEBB insurance coverage will ((~~end as of~~)) be terminated retroactive to the last day of the month for which ((~~a full~~)) the monthly premium or premium surcharge was paid as described in WAC 182-08-180 (1)(b).

(2) **Benefits-eligible seasonal employees** may continue any combination of medical, dental, and life insurance ((~~coverage~~)) by self-paying the ((~~full~~)) premium set by the health care authority (HCA), with no contribution from the employer, for a maximum of twelve months between periods of eligibility. The employee must pay the premium amounts associated with PEBB insurance coverage as premiums become due. If the monthly premium((~~s are more than~~)) or premium surcharge remains unpaid for sixty days ((~~delinquent~~)), PEBB insurance coverage will ((~~end as of~~)) be terminated retroactive to the last day of the month for which ((~~a full~~)) the monthly premium and premium surcharge was paid as described in WAC 182-08-180 (1)(b).

(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 contin-

ue medical and dental for the remaining difference in months by self-paying the ((~~full~~)) premium 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 15-22-099, filed 11/4/15, effective 1/1/16)

WAC 182-12-146 When is an enrollee eligible to continue public employee's benefits board (PEBB) health plan coverage under Consolidated Omnibus Budget Reconciliation Act (COBRA)? 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 ((~~full~~)) premium set by the health care authority (HCA). Premiums must be paid as described in WAC 182-08-180 (1)(b).

(1) 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.

(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.

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

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

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

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

AMENDATORY SECTION (Amending WSR 12-20-022, filed 9/25/12, effective 11/1/12)

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 ((~~full~~)) premium 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 premium surcharges associated with PEBB insurance coverage as premiums and surcharges become due. If the monthly premium or premium surcharge remains unpaid for sixty days, PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and premium surcharge was paid as described in WAC 182-08-180 (1)(b).

(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 ((~~(3)~~)) (4) of this section.

((~~(3)~~)) (4) If the dismissal is upheld and the employee is eligible under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), the employee may continue medical and dental 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.

((~~(4)~~)) (5) If the board, arbitrator, committee, or court sustains the employee in the appeal and directs reinstatement of employer paid PEBB insurance coverage retroactively, the employing agency must forward to HCA the full employer contribution for the period directed by the board, arbitrator, committee, or court and collect from the employee the employee's share of premiums due, if any.

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

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

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

WAC 182-12-171 When is a retiring employee eligible to enroll in public employees benefits board (PEBB) retiree insurance coverage? A retiring employee is eligible to continue enrollment or defer enrollment in public employees benefits board (PEBB) insurance coverage as a retiree if he or she meets procedural and substantive eligibility requirements as described in subsections (1) and (2) of this section.

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

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

(b) To defer enrollment in a PEBB health plan, the employee must defer enrollment as described in WAC 182-12-200 or 182-12-205.

(c) A retiring employee and his or her enrolled dependents who are entitled to medicare must enroll and maintain enrollment in both medicare parts A and B if the employee retired after July 1, 1991. If a retiree or an enrolled dependent becomes entitled to medicare after enrollment in PEBB retiree insurance coverage, he or she must enroll and maintain enrollment in medicare parts A and B to remain enrolled in PEBB retiree insurance coverage.

Note: If an enrollee who is entitled to medicare does not meet this procedural requirement, the enrollee is no longer eligible for enrollment in PEBB retiree insurance coverage. The enrollee may continue PEBB health plan enrollment as described in WAC 182-12-146.

(2) **Substantive eligibility requirements.**

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

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

(ii) A retiring employee who does not meet his or her Washington state-sponsored retirement plan's age requirement when his or her employer-paid coverage or COBRA coverage, or continuation coverage ends, but who meets the age requirement within sixty days of coverage ending, may request an appeal as described in WAC 182-16-032. His or her eligibility will be reviewed by the PEBB appeals committee. An employee must meet PEBB retiree insurance coverage procedural requirements as described in subsection (1) of this section.

(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((~~(20)~~)) (21)), must meet his or her Plan 3 retirement eligibility criteria. The employee does not have to receive a retirement plan payment to enroll in retiree insurance coverage;

(c) A retiring employee of a Washington higher education institution who is a member of a higher education retirement plan (HERP) must immediately begin to receive a monthly retirement plan payment, or

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

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

(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 or educational service district, that ends participation in PEBB insurance coverage is no longer eligible to continue enrollment in PEBB retiree insurance coverage if he or she enrolled after September 15, 1991. Any retiree who loses eligibility for this reason may continue health plan enrollment as described in WAC 182-12-146.

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

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

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

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

(iii) A retiring employee who is a member of a Plan 3 retirement system, also called a separated employee (defined in RCW 41.05.011((~~(20)~~)) (21)), must meet his or her Plan 3 retirement eligibility criteria; or

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

(3) An elected or a full-time appointed state official of the legislative or executive branch of state government who voluntarily or involuntarily leaves public office is eligible to continue PEBB insurance coverage as a retiree if he or she meets procedural requirements of subsection (1) of this section.

(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 15-22-099, filed 11/4/15, effective 1/1/16)

WAC 182-12-200 How does a retiree who is enrolled as a dependent in a health plan sponsored by public employees benefits board (PEBB), a Washington state school district, ((~~or~~)) a Washington state educational service district, or a Washington state charter school defer enrollment under PEBB retiree insurance coverage? (1) A retiree may defer enrollment in a public employees benefits board (PEBB) health plan during the period of time he or she is enrolled as a dependent in a health plan sponsored by PEBB, a Washington state school district, ((~~or~~)) a Washington state education service district, or a Washington state charter school, including such coverage under Consolidated Omnibus Budget Reconciliation Act (COBRA) or continuation coverage.

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

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

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

(b) When enrollment in a health plan sponsored by PEBB, a Washington state school district, ((~~or~~)) a Washington state educational service district, or a Washington state charter school ends, or such coverage under COBRA or continuation coverage ends. The retiree must submit the required form to enroll or defer enrollment as described in WAC 182-12-171 (1)(a). The required form 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.

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

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

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

(2) Retirees may defer enrollment in a PEBB health plan at or after retirement if continuously enrolled in other medical as described in this section or WAC 182-12-200. Retirees who defer enrollment in medical must defer enrollment in dental. Retirees must be enrolled in medical to enroll in dental.

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

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

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

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

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

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

(b) If enrolled subscribers submit 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 form is received by the PEBB program. If the form is received on the first day of the month, coverage will end on the last day of the previous month.

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

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

(6) Retirees who defer may later enroll themselves and their dependents in a PEBB health plan as follows:

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

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

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

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

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

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

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

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

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

(iii) No later than the end of the calendar year when their medicaid coverage ends if the retiree 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 form must be received by the PEBB program no later than the last day of the calendar year in which the retiree's medicaid coverage ends.

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

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

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

(e) Retirees who defer enrollment may enroll in a PEBB health plan if the retiree receives formal notice that the authority has determined it is more cost-effective to enroll the retiree or the retiree's eligible dependents in PEBB medical than a medical assistance program.

(7) Retirees who request to voluntarily terminate their PEBB retiree insurance coverage must do so in writing. The written termination request must be received by the PEBB program. Retirees who voluntarily terminate their enrollment in PEBB retiree insurance coverage also terminate enrollment for all eligible dependents. PEBB insurance 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, PEBB insurance coverage will end on the last day of the previous month.

Exception: When a member is enrolled in a medicare advantage plan then PEBB insurance coverage will end on the last day of the month when the medicare advantage form is received.

AMENDATORY SECTION (Amending WSR 09-23-102, filed 11/17/09, effective 1/1/10)

WAC 182-12-207 When can a retiree or eligible dependent's public employees benefits board (PEBB) insurance coverage be canceled by the health care authority (HCA)? A retiree or eligible dependent's public employees benefits board (PEBB) insurance coverage can be ((~~canceled by~~)) 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 premium surcharge when due ((~~or an underpayment of premium~~)) as described in WAC 182-08-180 (1)(b);

(4) Misconduct. If a retiree's PEBB insurance coverage is ((~~canceled~~)) 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 insurance coverage on behalf of the HCA, its employees, or other persons.

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

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

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

(1) A subscriber and his or her dependents enrolling in dental must meet procedural requirements (as described in WAC 182-12-171(1) and 182-12-262) and eligibility requirements (as described in WAC 182-12-171(2) and 182-12-260).

(2) A subscriber and his or her dependents must be enrolled in medical to enroll in dental.

(3) A subscriber enrolling in dental must stay enrolled for at least two years before dental can be dropped unless he or she defers medical and dental coverage as described in WAC 182-12-200 or 182-12-205, or drops dental as described in subsection (4) of this section.

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

(a) A subscriber may enroll in PEBB dental during the PEBB annual open enrollment period. The required form must be received by the PEBB program no later than the last day of the open enrollment period. PEBB dental begins January 1st of the following year.

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

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

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

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

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

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

(a) A lawful spouse;

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

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

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

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

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

(iii) Legally adopted children;

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

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

(vi) Children as defined in RCW 26.26.101.

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

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

(a) The death of the emergency service worker;

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

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

(d) The last day the surviving spouse, state registered domestic partner, or child was covered under the Consolidated Omnibus Budget

Reconciliation Act (COBRA) coverage from the emergency service worker's employer.

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

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

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

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

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

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

(a) Enroll in a PEBB health plan:

(i) Enroll in medical; or

(ii) Enroll in medical and dental.

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

(iv) Dental only is not an option.

(b) Defer enrollment:

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

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

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

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

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

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

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

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

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

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

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

The following are eligible as dependents:

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

(2) State registered domestic partner. State registered domestic partner ((~~is defined to include the following:~~

~~(a) Effective January 1, 2010, a state registered domestic partner, as defined in RCW 26.60.020(1);~~

~~(b) A domestic partner who was qualified under PEBB eligibility criteria as a domestic partner before January 1, 2010, and was continuously enrolled under the subscriber in a PEBB health plan or life insurance; and~~

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

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

(a) Children ((~~as defined~~)) based on establishment of a parent-child relationship as described in RCW 26.26.101 ((~~establishment of parent-child relationship~~));

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

(c) Stepchildren. The stepchild's relationship to a subscriber (and eligibility as a PEBB dependent) ends, for purposes of this rule, on the same date the subscriber's legal relationship with the spouse or state registered domestic partner ends through divorce, annulment, dissolution, termination, or death;

(d) Legally adopted children;

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

(f) Children of the subscriber's state registered domestic partner;

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

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

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

(i) The subscriber must provide evidence of the disability and evidence that the condition occurred before age twenty-six;

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

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

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

(v) The PEBB program will periodically certify 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.

(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 15-22-099, filed 11/4/15, effective 1/1/16)

WAC 182-12-262 When may subscribers enroll or remove eligible dependents? (1) **Enrolling dependents in public employees benefits**

board (PEBB) benefits. A dependent must be enrolled in the same health plan coverage as the subscriber, and the subscriber must be enrolled to enroll his or her dependent except as provided in WAC 182-12-205 (2)(c). Subscribers 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.

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

(c) **During special open enrollment.** Subscribers may enroll dependents during a special open enrollment as described in subsection (3) of this section. The subscriber must satisfy the enrollment requirements as described in subsection (4) of this section.

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

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

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

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

(iii) The subscriber may not be able to recover subscriber-paid insurance premiums for dependents that lost their eligibility; and

(iv) The subscriber may be responsible for premiums paid by the state for the dependent's health plan coverage after the dependent lost eligibility.

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

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

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

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

(3) **Special open enrollment.** Subscribers may enroll or remove their dependents outside of the annual open enrollment if a special open enrollment event occurs. The change in enrollment must be allowable under the Internal Revenue Code (IRC) and Treasury regulations, and correspond to and be consistent with the event that creates the

special open enrollment for the subscriber, the subscriber's dependents, or both.

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

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

• The dependent will be removed from the subscriber's health plan coverage the last day of the month following the later of the event date or the date the required form is received. If that day is the first of the month, the change in enrollment will be made the last day of the previous month.

• If the special open enrollment is due to the birth or adoption of a child, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of a child, health plan coverage will begin or end the month in which the event 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 for a state domestic partnership;

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

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

(iv) A child becoming eligible as a dependent with a disability;

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

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

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

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

((~~(e)~~)) (f) 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;

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

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

(4) **Enrollment requirements. A subscriber must submit the required forms within the time frames described in this subsection.** Employees submit the required forms to their employing agency. All other subscribers submit the required forms to the PEBB program. In addition to the required forms indicating dependent enrollment, the subscriber must provide the required documents as evidence of the dependent's eligibility; or as evidence of the event that created the special open enrollment.

(a) If a subscriber wants to enroll his or her eligible dependents when the subscriber becomes eligible to enroll in PEBB benefits, the subscriber must include the dependent's enrollment information on the required forms that the subscriber submits within the relevant time frame described in WAC 182-08-197, 182-08-187, 182-12-171, or 182-12-250.

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

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

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

(e) If the subscriber wants to enroll a child age twenty-six or older as a child with a disability, the required forms must be received no later than sixty days after the last day of the month in which the child reaches age twenty-six or within the relevant time frame described in WAC 182-12-262 (4)(a), (b), and (f).

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

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

WAC 182-12-265 What options for continuing health plan enrollment are available to widows, widowers and dependent children if the employee or retiree dies? The dependent of an eligible employee or retiree who meets the eligibility criteria in subsection (1), (2), or (3) of this section is eligible to enroll as a survivor under public employees benefits board (PEBB) retiree insurance coverage. An eligible survivor must submit the ((~~appropriate~~)) required forms to enroll or defer enrollment in retiree insurance coverage. The forms must be

received by the PEBB program no later than sixty days after the date of the employee's or retiree's death.

(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 retiree insurance coverage provided they immediately begin receiving a monthly retirement benefit from any state of Washington sponsored retirement system.

(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 ((~~under~~)) as described in WAC 182-12-260.

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

(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 retiree insurance coverage.

(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 ((~~under~~)) as described in WAC 182-12-260.

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

(3) The spouse, state registered domestic partner, or child of a deceased school district ((~~or~~)), educational service district employee, or a charter school is eligible to enroll or defer enrollment as a survivor under PEBB retiree insurance coverage at the time of the employee's death provided the employee died on or after October 1, 1993. The dependent must immediately begin receiving a retirement benefit allowance under chapter 41.32, 41.35 or 41.40 RCW and submit the ((~~appropriate~~)) required form to enroll or defer enrollment in PEBB retiree insurance coverage. The form must be received by the PEBB program no later than sixty days after the date of the employee's death.

(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 ((~~under~~)) as described in WAC 182-12-260.

(4) If a premium or surcharge payment received by the authority is sufficient as described in WAC 180-08-180 (1)(c)(ii) to maintain PEBB health plan enrollment after the employee's or retiree's death, the PEBB program will consider the payment as notice of the survivor's intent to continue enrollment.

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

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

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

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 ((~~full~~)) premiums 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 must pay premium and premium surcharge amounts associated with PEBB insurance coverage as premiums and premium surcharges become due. If the monthly premium or premium surcharge remain unpaid for sixty days, PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and premium surcharge was paid as described in WAC 182-08-180 (1)(b). The public employees benefits board (PEBB) program must receive the ((~~appropriate~~)) 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 ((~~under provisions of~~)) as described in WAC 182-12-250 or 182-12-265; or

(2) Dependents who lose eligibility because they no longer meet the eligibility criteria as described in WAC 182-12-260 are eligible to continue health plan enrollment under provisions of the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). See WAC 182-12-146 for more information on COBRA.

Exception: A dependent who loses eligibility because a state registered domestic partnership or same-sex marriage is dissolved may continue health plan enrollment under an extension of PEBB insurance coverage for a maximum of thirty-six months.

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

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

WAC 182-16-010 Appeals—Purpose and scope. (1) For WAC 182-16-025 through 182-16-040, 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 related proceedings. The model rules of procedure may be found in chapter 10-08 WAC. Other procedural rules adopted in chapters 182-08, 182-12, and 182-16 WAC are supplementary to the model rules of procedure. In the case of a conflict between the model rules of procedure and the procedural rules adopted in WAC 182-16-025 through 182-16-040, the procedural rules adopted shall govern.

(2) WAC 182-16-050 through 182-16-110 describes the general rules and procedures that apply to an administrative hearing, requested under WAC 182-16-050, of a PEBB appeals committee decision.

(a) WAC 182-16-050 through 182-16-110 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 adopted for use in a hearing. In the case of a conflict between the model rules of procedure and the rules adopted in WAC 182-16-050 through 182-16-110, the rules adopted in WAC 182-16-050 through 182-16-110 shall prevail.

(b) If there is a conflict between WAC 182-16-050 through 182-16-110 and specific PEBB program rules, the specific PEBB program rules prevail. PEBB program rules are found in chapters 182-08, 182-12, and 182-16 WAC.

(c) Nothing in WAC 182-16-050 through 182-16-110 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.

(d) The hearing rules for the PEBB program in WAC 182-16-050 through 182-16-110 do not apply to any other health care authority program.

(3) The definitions in WAC 182-16-020 apply throughout this chapter.

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

WAC 182-16-020 Definitions. ((~~As used in~~)) The following definitions apply throughout this chapter ((~~the term~~)):

"Appellant" means a person or entity who requests a review by the PEBB appeals committee or an administrative hearing about the action of the HCA or its designee.

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

"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, Sundays, and all legal holidays as set forth in RCW 1.16.050.

"Continuance" means a change in the date or time of a hearing.

"Denial" or "denial notice" means an action by, or communication from, either an employing agency, or the PEBB program that aggrieves ((~~an employee, or his or her dependent~~)) 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 authorized in chapter 41.05 RCW.

"Director" means the director of the authority.

"Documents" means papers, letters, writings, ((~~e-mails~~)) electronic mail, electronic files, or other printed or written items.

"Employee" 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 ((~~seeks and receives the approval of~~)) submits application materials to the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.04.205 and 41.05.021 (1)(g); (b) employees of employee organizations representing state civil service employees, at the option of each such employee organization, and, effective October 1, 1995, employees of employee organizations currently pooled with employees of school districts for the purpose of purchasing insurance benefits, at the option of each such employee organization; (c) employees of a school district if the authority agrees to provide any of the school districts' insurance programs by contract with the authority as provided in RCW 28A.400.350; (d) employees of a tribal government, if the governing body of the tribal government seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(f) and (g); (e) employees of the Washington health benefit exchange if the governing board of the exchange established in RCW 43.71.020 seeks and receives approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(g) and (n); and (f) employees of a charter school established under chapter 28A.710 RCW. "Employee" does not include: Adult family home providers; unpaid volunteers; patients of state hospitals; inmates; employees of the Washington state convention and trade center as provided in RCW 41.05.110; students of institutions of higher education as determined by their institution; and any others not expressly defined as employees under this chapter or by the authority under this chapter.

"Employer-based group medical ((~~insurance~~))" means employer-based group medical ((~~insurance coverage~~)) related to a current employment relationship. It does not include medical ((~~insurance~~)) coverage available to retired employees, individual market medical ((~~insurance~~)) 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, obtaining employee benefits through a contractual agreement with the authority as described in WAC 182-08-245.

"Employing agency" means a division, department, or separate agency of state government, including an institution of higher education; a county, municipality, school district, educational service district, or other political subdivision; charter school; or 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 presiding officer's office.

"Final order" means an order that is the final PEBB program decision.

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

"Hearing" means a proceeding before a presiding officer that gives ((~~a party~~)) an appellant an opportunity to be heard in a dispute about a decision made by the PEBB appeals committee, including prehearing conferences, dispositive motion hearings, status conferences, and evidentiary hearings.

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

"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.

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

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

((~~"Mail" or "mailing" means placing a document in the United States Postal system, commercial delivery service, or Washington state consolidated mail services properly addressed.~~))

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby state and public employees may reduce their salary before taxes to pay for medical expenses not reimbursed by insurance as provided in the salary reduction plan authorized in chapter 41.05 RCW.

"PEBB" means the public employees benefits board.

"PEBB appeals committee" means the committee that considers appeals relating to the administration of PEBB benefits by the PEBB pro-

gram. The director has delegated the authority to hear appeals at the level below an administrative hearing to the PEBB appeals committee.

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

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

"PEBB program" means the program within the HCA that administers insurance and other benefits for eligible employees (as described in WAC 182-12-114), eligible retired ((~~and disabled~~)) employees (as described in WAC 182-12-171), 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 presiding officer to address issues in preparation for a 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.

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

• Premiums are less than ninety-five percent of Uniform Medical Plan (UMP) Classic premiums; and

• The actuarial value of benefits is at least ninety-five percent of the actuarial value of UMP Classic benefits.

"Presiding officer" means an impartial decision maker who is an attorney, presides at an administrative hearing, and is either a director designated HCA employee or an administrative law judge employed by the office of administrative hearings.

"Record" means the official documentation of the hearing process. The record includes recordings or transcripts, admitted exhibits, decisions, briefs, notices, orders, and other filed documents.

"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 DCAP, medical FSA, or premium payment plan as authorized in chapter 41.05 RCW.

"Service" or "serve" means the delivery of documents as described in WAC 182-16-067.

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

"Subscriber" means the employee, retiree, COBRA beneficiary, or eligible survivor who has been designated by the HCA as the individual to whom the HCA and contracted vendors will issue all notices, information, requests, and premium bills on behalf of enrollees.

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

((~~or e-cigarettes until their tobacco related status is determined by the FDA~~)).

"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 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-16-025 Where do members appeal decisions regarding eligibility, enrollment, premium payments, premium surcharges, a public employees benefits board (PEBB) wellness incentive, or the administration of benefits? (1) Any employee of a state agency or his or her dependent aggrieved by a decision made by the employing state agency with regard to public employees benefits board (PEBB) eligibility, enrollment, or premium surcharge may appeal that decision to the employing state agency by the process outlined in WAC 182-16-030.

Note: Eligibility decisions address whether a subscriber or a subscriber's dependent is entitled to insurance coverage, as described in public employees benefits board (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 employee of an employer group or his or her dependent who is aggrieved by a decision made by an employer group with regard to PEBB eligibility, enrollment, or premium surcharge may appeal that decision to the employer group through the process established by the employer group.

Exception: Any employee of an employer group aggrieved by a decision regarding life insurance, 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 by the process described in WAC 182-16-032.

(3) Any subscriber or dependent aggrieved by a decision made by the PEBB program with regard to PEBB eligibility, enrollment, premium payments, premium surcharge, 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 by the process described in WAC 182-16-032.

(4) Any PEBB enrollee aggrieved by a decision regarding the administration of a ((~~PEBB medical plan, self-insured dental plan, insured dental~~)) health plan, life insurance, or LTD insurance may appeal that decision by following the appeal provisions of those plans, with the exception of eligibility, enrollment, and premium payment determinations.

(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 182-16-036.

(7) Any subscriber aggrieved by a decision made by the third-party administrator contracted to administer the PEBB wellness incentive program 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 182-16-035.

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

WAC 182-16-030 How can an employee or an employee's dependent appeal a decision made by a state agency about eligibility, premium surcharge, or enrollment in benefits? (1) An eligibility, premium surcharge, or enrollment decision made by an employing state agency may be appealed by submitting a written request for review to the employing state agency. The employing state agency must receive the request for review no later than thirty days after the date of the initial denial notice. The contents of the request for review are to be provided ((~~in accordance with~~)) as described in WAC 182-16-040.

(a) Upon receiving the request for review, the employing state agency shall make a complete review of the initial denial by one or more staff who did not take part in the initial denial. As part of the review, the employing state agency may hold a formal meeting or hearing, but is not required to do so.

(b) The employing state agency shall render a written decision within thirty days of receiving the request for review. The written decision shall be sent to the ((~~appellant~~)) employee or employee's dependent who submitted the request for review.

(c) A copy of the employing state agency's written decision shall be sent to the employing state agency's administrator or designee and to the public employees benefits board (PEBB) appeals manager. The employing state agency's written decision shall become the employing state agency's final decision effective fifteen days after the date it is rendered.

(d) The employing state agency may reverse eligibility, premium surcharge, or enrollment decisions based only on circumstances that arose due to delays caused by the employing state agency or error(s) made by the employing state agency.

(2) Any employee or employee's dependent who disagrees with the employing state agency's decision in response to a request for review, as described in subsection (1) of this section, may appeal that decision by submitting a notice of appeal to the PEBB appeals committee. The PEBB appeals manager must receive the notice of appeal no later than thirty days after the date of the employing state agency's written decision on the request for review.

The contents of the notice of appeal are to be provided ((~~in accordance with~~)) as described in WAC 182-16-040.

(a) The PEBB appeals manager shall notify the appellant in writing when the notice of appeal has been received.

(b) The PEBB appeals committee shall render a written decision to the appellant within thirty days of receiving the notice of appeal. The committee may extend the thirty-day time requirement for rendering a decision upon issuing a written finding of a good reason explaining the cause for the delay.

(c) Any appellant who disagrees with the decision of the PEBB appeals committee may request an administrative hearing, as described in WAC 182-16-050.

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

WAC 182-16-038 How can an entity or organization appeal a decision of the health care authority to deny an employer group application? An entity or organization whose employer group application is denied by the authority may appeal the decision to the public employees benefits board (PEBB) appeals committee. For rules regarding eligible entities, see WAC 182-12-111. The PEBB appeals manager must receive the notice of appeal no later than thirty days after the date of the denial notice. The contents of the notice of appeal are to be provided ((~~in accordance with~~)) as described in WAC 182-16-040.

(1) The PEBB appeals manager shall notify the ((~~appealing party~~)) appellant in writing when the notice of appeal has been received.

(2) The PEBB appeals committee shall render a written decision to the appellant on the notice of appeal within thirty days of receiving the notice of appeal. The committee may extend the thirty-day time requirement for rendering a decision upon issuing a written finding of a good reason explaining the cause for the delay.

(3) Any ((~~appealing party~~)) appellant aggrieved with the decision of the PEBB appeals committee may request an administrative hearing, as described in WAC 182-16-050.

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

WAC 182-16-040 What should the request for review or notice of appeal contain? A request for review or notice of appeal should contain all of the following:

(1) The name and mailing address of the ((~~appealing~~)) party submitting the request for review or notice of appeal;

(2) The name and mailing address of the appealing party's representative, if any;

(3) Documentation, or reference to documentation, of decisions previously rendered through the appeal process, if any;

(4) A statement identifying the specific portion of the decision being appealed and clarifying what is believed to be unlawful or in error;

(5) A statement of facts in support of the appealing party's position;

(6) Any information or documentation that the appealing party would like considered and substantiates why the decision should be reversed. Information or documentation submitted at a later date, unless specifically requested by the PEBB appeals manager, may not be considered in the appeal decision;

(7) The type of relief sought;

(8) A statement that the appealing party has read the notice of appeal and believes the contents to be true and correct; and

(9) The signature of the appealing party or the appealing party's representative.

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

WAC 182-16-050 How can an ((~~enrollee or entity request an administrative hearing if~~)) appellant aggrieved by a written decision made by the public employees benefits board (PEBB) appeals committee request an administrative hearing? (1) Any ((~~party~~)) appellant aggrieved by a written decision of the public employees benefits board (PEBB) appeals committee, may request an administrative hearing.

(2) The request must be made in writing to the PEBB appeals manager. The PEBB appeals manager must receive the written request for an administrative hearing no later than thirty calendar days ((~~of~~)) after the date ((~~after~~)) of the written decision ((~~by~~)) letter from the PEBB appeals committee.

(3) The director, or his or her designee, shall preside at all hearings resulting from the filings of appeals under this section.

(4) All hearings must be conducted in compliance with WAC 182-16-050 through 182-16-110, chapter 34.05 RCW, and chapter 10-08 WAC, as described in WAC 182-16-010(2).

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

WAC 182-16-052 Requirements to appear and represent a party in the administrative hearing process. (1) All parties must provide the presiding officer and all other parties with their name, address, and telephone number.

(2) The appellant may act as his or her own representative or have anyone represent him or her, except employees of the health care authority (HCA) or HCA's authorized agents.

(3) If the ((~~party who requested a hearing~~)) appellant is represented by a ((~~party~~)) 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 hearing representative with a signed, written consent permitting release to the nonattorney representative of personal health information protected by state or federal law.

((~~(3)~~)) (4) An attorney admitted to practice law in Washington state, who wishes to represent the ((~~party who requested a hearing~~)) 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. The attorney must file a written notice of withdrawal of representation with the presiding officer's office and serve all parties with the notice.

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

WAC 182-16-055 Mailing address changes. (1) The ((~~party who requested the hearing must tell~~)) appellant must notify the hearing representative and the presiding officer as soon as possible, when the ((~~party's~~)) appellant's mailing address changes.

(2) If ((~~that party~~)) the appellant does not notify the hearing representative and the presiding officer of a change in the ((~~party's~~)) appellant's mailing address and the presiding officer and hearing representative continue to ((~~mail~~)) serve notices and other important documents to the last known mailing address, the documents will be deemed ((~~received by the party~~)) served on the appellant.

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

WAC 182-16-061 Presiding officers—Assignment, motions of prejudice, and disqualification. (1) **Assignment:** A presiding officer will be assigned at least five business days before a hearing. A party may ask which presiding officer is assigned to a hearing by contacting the presiding officer's office listed on the notice of hearing. If requested by a party, the presiding officer's office must send the name of the assigned presiding officer to all parties, by ((~~e-mail~~)) electronic mail or in writing, at least five business days before the scheduled hearing date.

(2) **Motion of prejudice:** Any party requesting a different presiding officer may file a written motion of prejudice against the presiding officer assigned to the matter before the presiding officer rules on a discretionary issue in the case, admits evidence, or takes testimony.

(a) A motion of prejudice must include a declaration stating that a party does not believe the presiding officer can hear the case fairly. Service of copies of the motion must also be ((~~mailed~~)) made to all parties listed on the notice of hearing.

(b) Any party's first motion of prejudice will be automatically granted. Any subsequent motion of prejudice made by a party may be granted or denied at the discretion of the presiding officer no later than seven days after receiving the motion.

(c) A party may make an oral motion of prejudice at the beginning of a hearing before the presiding officer rules on a discretionary issue in the matter, admits evidence, or takes testimony if:

(i) The presiding officer was not assigned at least five business days before the date of the hearing; or

(ii) The presiding officer was changed within five business days of the date of the hearing.

(3) **Disqualification:** A presiding officer may be disqualified from presiding over a hearing for bias, prejudice, conflict of interest, or ex parte contact with a party to the hearing.

(a) Any party may file a petition to disqualify a presiding officer ((~~pursuant to~~)) as described in RCW 34.05.425. A petition to disqualify must be in writing and service promptly ((~~mailed~~)) made to all

parties and the presiding officer upon discovering facts of possible grounds for disqualification.

(b) The presiding officer whose disqualification is requested will determine whether to grant or deny the petition in a written order, stating facts and reasons for the determination. The presiding officer must ((~~mail~~)) serve the order no later than seven days after receiving the petition for disqualification.

NEW SECTION

WAC 182-16-067 Service of documents on another party. (1) When the rules in this chapter or in other PEBB program rules or statutes require a party to serve copies of documents on other parties, a party must send copies of the documents to all other parties or their representatives in accordance with this section.

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

(a) Personal service (hand delivery);

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

(c) Fax;

(d) Commercial delivery service; or

(e) Legal messenger service.

(3) A party must serve all other parties or their representatives whenever the party files a motion, pleading, brief, or other document with the presiding officer's office, or when required by law.

(4) Service is complete when:

(a) Personal service is made;

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

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

(d) Fax produces proof of transmission;

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

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

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

(a) A signed affidavit or certificate of mailing;

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

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

(d) Proof of fax transmission.

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

(7) If the document is a subpoena, follow the compliance procedure as described in WAC 182-16-085.

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

WAC 182-16-070 Calculating when a hearing deadline ends. (1) When counting days to calculate when a hearing deadline ends ((~~under~~)) as described in WAC 182-16-050 through 182-16-110:

(a) Do not include the day of the action, notice, or order. For example, if service of a hearing decision is ((~~mailed~~)) made on Tuesday and the party has twenty-one calendar days to request a review, start counting the days with Wednesday.

(b) If the last day of the period is a Saturday, Sunday, or legal holiday, the deadline is the next business day.

(2) The deadline is 5:00 p.m. on the last day.

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

WAC 182-16-071 Time requirements for service of notices ((~~mailed~~)) made by the presiding officer. (1) The presiding ((~~officer must mail~~)) officer's office must serve a notice of a hearing to all parties and their representatives at least ((~~fourteen~~)) twenty-one calendar days before the hearing date. The parties may agree to, but the presiding officer cannot impose, a shorter notice period.

(2) If a prehearing conference or dispositive motion hearing is scheduled, the presiding officer must ((~~mail~~)) 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 presiding officer may change any scheduled 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 presiding 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 presiding officer must reschedule a hearing if necessary to comply with the notice requirements in this section.

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

WAC 182-16-072 Hearing location. (1) A presiding officer must be present at all hearings. Hearings may be held either in person or telephonically.

(a) A telephonic hearing is where all parties and the presiding officer are present by telephone.

(b) An in-person hearing is where the ((~~party that requested the hearing~~)) appellant appears face-to-face with the presiding officer. The other parties can choose to appear either in person or by telephone, but cannot be ordered to appear in person.

(2) Whether a hearing is held in person or telephonically, the parties have the right to see all documents, hear all testimony, and question all witnesses.

(3) If a hearing is originally scheduled to be held in-person, the ((~~party that requested the hearing~~)) appellant may ask the presiding officer to change the in-person hearing to a telephonic hearing. Once a telephonic hearing begins, the presiding officer may stop, reschedule, and change the telephonic hearing to an in-person hearing if any party makes such a request.

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

WAC 182-16-073 Rescheduling and continuances. (1) Any party may request the presiding officer to reschedule a hearing if a rule requires notice of a hearing and the amount of notice required was not provided.

(a) The presiding officer must reschedule the hearing under circumstances identified in this subsection (1) 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 hearing either orally or in writing.

(a) In each administrative hearing, the presiding officer must grant each party's first request for a continuance. The continuance may be up to thirty calendar days.

(b) The presiding 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 presiding officer's office 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 hearing date. All orders of continuance must provide a new deadline ((~~for mailing documents to~~)) for filing documents with the presiding officer. The new ((~~mailing~~)) filing deadline can be no less than ten calendar days prior to the new 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 presiding officer granted the continuance.

(3) Regardless of whether a party has been granted a continuance as described in subsection (1) of this section, the presiding officer must grant a continuance if a new issue is raised during the hearing and a party requests a continuance.

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

WAC 182-16-080 Determining if an administrative hearing right exists. (1) ((~~A party~~)) An appellant has a right to a hearing only if a law or program rule gives that right. If the ((~~party~~)) appellant is not sure whether a hearing right exists, they may request a hearing to protect their rights.

(2) The right to a hearing does not exist unless:

(a) The public employees benefits board (PEBB) appeals committee has issued a written decision ((~~under~~)) as described in WAC 182-16-030 (2)(b), 182-16-032(7), 182-16-035(4), 182-16-036 (1)(f), (2)(b), (3)(b), or 182-16-038(2); and

(b) A hearing of the PEBB appeals committee's written decision has been ((~~timely~~)) requested ((~~pursuant to~~)) timely as described in WAC 182-16-050.

(3) If the hearing representative or the presiding officer questions the right to a hearing, the presiding officer must decide whether a hearing right exists, in a written ruling, prior to reviewing and ruling on any other issues.

(4) If the presiding officer decides a person or entity does not have a right to a hearing, the matter must be dismissed.

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

WAC 182-16-081 Prehearing conferences. (1) A prehearing conference is a formal proceeding conducted on the record by a presiding officer to prepare for a hearing.

(a) The presiding officer must record a prehearing conference using audio recording equipment.

(b) The presiding officer may conduct a prehearing conference in person, by telephone conference call, or in any other manner acceptable to the parties.

(2) Any party can request a prehearing conference. The presiding officer must grant each party's first request for a prehearing conference if it is filed with the presiding officer at least seven business days before the next scheduled hearing date. The presiding officer may grant requests for additional prehearing conferences.

(3) The ((~~party requesting the hearing~~)) appellant must attend or participate in any scheduled prehearing conference. If the ((~~party requesting the hearing~~)) appellant does not attend or participate in a scheduled prehearing conference, the presiding officer will enter an order of default dismissing the matter.

(4) During a prehearing conference the parties and the presiding officer may:

(a) Identify the issue(s) to be decided;

(b) Agree to the date, time, and place of any requested or necessary hearing(s);

(c) Identify accommodation and safety issues; or

(d) ((~~Set a deadline to exchange a proposed witness list and~~)) Establish a schedule for:

(i) The exchange and filing of briefs;

(ii) Provide a list of proposed witnesses;
(iii) Providing exhibit lists; and
(iv) Providing proposed exhibits before the hearing.

(5) After the prehearing conference ends, the presiding officer must enter a written order that recites the action taken at the prehearing conference, a case schedule outlining hearing dates and deadlines for exchanging witness lists and exhibits, and any other agreements reached by the parties.

(6) The presiding officer must ((~~mail~~)) serve the prehearing order to the parties at least fourteen calendar days before the next scheduled hearing.

(7) A party may object to the prehearing order by notifying the presiding officer in writing no later than ten days after the ((~~mailing~~)) service date of the order. The presiding officer must ((~~mail~~)) serve a written ruling on the objection.

(8) If no objection is made to the prehearing order, the order determines how the case will be conducted by the presiding officer, including whether a hearing will be in person or held by telephone conference, unless the presiding officer enters an amended prehearing conference order.

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

WAC 182-16-082 Dispositive motions. (1) A dispositive motion is a written motion that could dispose of one or all the issues in an administrative hearing request, such as a motion to dismiss or motion for summary judgment. The presiding officer may only consider written dispositive motions filed with the presiding officer.

(2) ((~~Any party may~~)) To request a dispositive motion hearing ((~~by filing~~)) a party must file a written dispositive motion with the presiding officer and ((~~mailing~~)) serves a copy of the motion to all other parties. The presiding officer may also set a dispositive motion hearing, and request briefing from the parties, to address any possible dispositive issues the presiding officer believes must be addressed before the hearing.

(3) The deadline to ((~~mail~~)) file a timely dispositive motion shall be ten calendar days before the scheduled hearing.

(4) Upon receiving a dispositive motion, a presiding officer:

(a) Must convert the scheduled hearing to a dispositive motion hearing when:

(i) The dispositive motion is timely filed with the presiding 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 presiding officer may conduct the dispositive motion hearing in person or by telephone conference. For dispositive motion hearings scheduled to be held in person, the 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. If the party

requesting the hearing does not attend and participate in the dispositive motion hearing, the presiding officer will enter an order of default.

(7) During a dispositive motion hearing, the presiding officer can only consider the filed dispositive ((~~motion(s)~~)) motions, any response to ((~~that motion(s)~~)) the motions, and argument on the ((~~motion(s)~~)) motions. Prior to rescheduling any necessary hearings, the presiding officer must ((~~mail~~)) serve a written order on the dispositive ((~~motion(s)~~)) motions.

(8) The presiding officer must ((~~mail~~)) serve the written order on the dispositive ((~~motion(s)~~)) 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 ((~~pursuant to~~)) as described in WAC 182-16-105 and 182-16-110.

NEW SECTION

WAC 182-16-085 Subpoenas. (1) Presiding officers, the hearing representative, and attorneys for the parties may prepare subpoenas in accordance with Civil Rule 45, unless otherwise stated. Any party may request the presiding officer to prepare a subpoena on his or her behalf.

(2) The presiding officer may schedule a prehearing conference to decide whether to issue a subpoena.

(3) If a party requests the presiding 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 presiding 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 of 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 may request the presiding officer quash (set aside) or change a subpoena request at any time before the deadline given in the subpoena.

(7) A presiding officer may quash (set aside) or change a subpoena if it is unreasonable.

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

WAC 182-16-090 Orders of dismissal—Reinstating a hearing after an order of dismissal. (1) An order of dismissal is an order from the presiding officer ending the matter. The order is entered because the party who requested the hearing withdrew the administrative hearing request, the appellant is no longer aggrieved, the presiding officer granted a dispositive motion dismissing the matter, or the presiding officer entered an order of default because the party who requested a hearing failed to attend or refused to participate in the hearing.

(2) The order of dismissal becomes a final order if no party files a request to vacate the order ((~~pursuant to~~)) as described in subsections (3) through (7) of this section.

(3) If the presiding officer enters and ((~~mails~~)) serves an order dismissing the hearing, the ((~~party that originally requested the hearing~~)) 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 presiding officer must schedule and ((~~mail~~)) serve notice of a prehearing conference as described in ((~~accordance with~~)) WAC 182-16-071. 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 presiding 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 presiding 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 public employees benefits board (PEBB) appeals committee decision will stand.

(6) If the presiding officer finds good cause, as described in subsection (8) of this section, for the order of dismissal to be vacated, the presiding officer must enter and ((~~mail~~)) 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 presiding officer will conduct a hearing at which the parties may present argument and evidence about issues raised in the original request for hearing. The hearing may occur immediately following the prehearing conference on the request to vacate only if agreed to by the parties and the presiding officer, otherwise a hearing date must be scheduled by the presiding 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 section. This good cause exception does not apply to any other chapter(s) or section(s) in Title 182 WAC.

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

WAC 182-16-091 Settlement agreements. (1) If the parties reach a mutually agreeable solution the agreement must be in writing.

(2) Any written agreements will be entered into the record by either party for consideration by the presiding officer.

(3) If all of the issues are resolved by the written agreement, the presiding officer will enter and ((~~mail~~)) serve an order of dismissal.

(4) If all of the issues are not resolved by a written agreement, either party, or the presiding officer, may request a prehearing conference before a hearing on any remaining issues can occur.

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

WAC 182-16-092 Withdrawing the request for an administrative hearing. (1) The ((~~party who requested an administrative hearing of a public employees benefits board (PEBB) appeals committee decision~~)) appellant may withdraw the administrative hearing request for any reason, and at any time, by contacting the hearing representative who will coordinate the withdrawal with the presiding officer.

(2) The request for withdrawal must generally be made in writing. An oral withdrawal by the appellant is permitted during a hearing when both the presiding officer and hearing representative are present.

(3) After a withdrawal request is received, the presiding officer must cancel any scheduled hearings and enter and ((~~mail~~)) serve a written order dismissing the case. If a hearing request is withdrawn, the ((~~party~~)) appellant will not be able to request another administrative hearing on the same PEBB appeals committee decision.

(4) If ((~~a party~~)) an appellant withdraws an administrative hearing request, the order of dismissal may only be vacated (set aside) ((~~according to~~)) as described in WAC 182-16-090.

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

WAC 182-16-100 Final order deadline—Required information. (1) Within ninety days after the hearing record is closed, the presiding officer shall ((~~mail~~)) serve a final order that shall be the final decision of the authority. The presiding officer shall ((~~mail~~)) serve a copy of the final order to all parties.

(2) The presiding 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 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-16-105 Motion for reconsideration and response—Process. (1) Reconsideration means asking the presiding officer to reconsider his or her final order because the party believes the presiding officer made a mistake of law, mistake of fact, or clerical error. Within ten business days after the date the presiding officer's service date of the final order, a party may file a motion for reconsideration, stating the specific grounds upon which the relief is requested.

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

(3) The other parties may respond to the motion 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.

(4) Motions for reconsideration must be filed with the presiding officer who entered the final order.

(5) If a party files a motion for reconsideration:

(a) The presiding officer must receive the motion for reconsideration on or before the tenth business day after the service date of the final order ((~~was mailed~~)).

(b) The party filing the motion must send copies of the motion to all other parties.

(c) Within five business days of receiving a motion for reconsideration, the presiding officer must ((~~mail~~)) serve to all parties a notice that provides the date the motion for reconsideration was received.

(d) Responses to a motion for reconsideration must be received by the presiding officer no later than seven business days after the service date of the presiding officer's notice as described in (c) of this subsection ((~~was mailed~~)), or the response will not be considered.

(e) Service of responses to a motion for reconsideration must be ((~~mailed~~)) made to all parties.

(6) If a party needs more time to file a motion for reconsideration or respond to a motion for reconsideration, the presiding officer may extend the deadline if the party makes a written request by the deadline.

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

WAC 182-16-110 Judicial review of final order. (1) Judicial review is the process of appealing a final order to a court.

(2) The ((~~party that requested the administrative hearing~~)) appellant may appeal a final order by filing a written petition for judicial review that meets the requirements of RCW 34.05.546. The public employees benefits board (PEBB) program may not request judicial review.

(3) The ((~~party~~)) appellant should consult RCW 34.05.510 through 34.05.598 for further details and requirements of the judicial review process.