PROPOSED RULE MAKING

CR-102 (June 2012)
(Implements RCW 34.05.320)
Do **NOT** use for expedited rule making

Agency: Health Care Authority, Public Employees Benefits Board (PEBB) – PEBB Admin # 2014-02

☒ **Preproposal Statement of Inquiry was filed as WSR** 14-12-067**; or**
☐ **Expedited Rule Making--Proposed notice was filed as WSR** _____**; or**
☐ **Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1).**

☒ **Original Notice**
☐ **Supplemental Notice to WSR** _____
☐ **Continuance of WSR** _____

Title of rule and other identifying information: PEBB rules related to enrollment in Chapter 182-08 WAC; eligibility in Chapter 182-12 WAC; and appeals in Chapter 182-16 WAC.

Hearing location(s):
Health Care Authority
Cherry Street Plaza Building; Sue Crystal Conf Rm 106A
626 - 8th Avenue, Olympia WA 98504

Metered public parking is available street side around building. A map is available at:
http://maa.dshs.wa.gov/pdf/CherryStreetDirectionsNMap.pdf
or directions can be obtained by calling: 360-725-1000

Date: **September 9, 2014** Time: **10:00 a.m.**

Submit written comments to:
Name: HCA Rules Coordinator
Address: PO Box 45504, Olympia WA, 98504-5504
Delivery: 626 – 8th Avenue, Olympia WA 98504
e-mail arc@hca.wa.gov
fax (360)586-9727

by **5:00 p.m. on September 9, 2014**

Date of intended adoption: Not sooner than September 10, 2014 (Note: This is **NOT** the **effective** date)

Assistance for persons with disabilities: Contact Kelly Richters by September 2, 2014

TTY (800) 848-5429 or (360) 725-1307 or e-mail: kelly.richters@hca.wa.gov

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

See attachment

Reasons supporting proposal: Compliance with federal regulation, state law.

Statutory authority for adoption: RCW 41.05.160

Statute being implemented: 3ESSB 5034

Is rule necessary because of a:

Federal Law?	☐ Yes	☒ No
Federal Court Decision?	☐ Yes	☒ No
State Court Decision?	☐ Yes	☒ No

If yes, CITATION:

DATE
July 31, 2014

NAME (type or print)
Kevin M. Sullivan

SIGNATURE
Kevin M. Sullivan

TITLE
HCA Rules Coordinator

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: July 31, 2014
TIME: 2:18 PM

WSR 14-16-073

(COMPLETE REVERSE SIDE)

Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters: None

Name of proponent: Health Care Authority

☐ Private
☐ Public
☒ Governmental

Name of agency personnel responsible for:

	Name	Office Location	Phone
Drafting.....	Rob Parkman	Cherry Street Plaza, 626 8th Avenue SE, Olympia, Washington	(360) 725-0883
Implementation....	Barbara Scott	Cherry Street Plaza, 626 8th Avenue SE, Olympia, Washington	(360) 725-0830
Enforcement.....	Mary Fliss	Cherry Street Plaza, 626 8th Avenue SE, Olympia, Washington	(360) 725-0822

Has a small business economic impact statement been prepared under chapter 19.85 RCW or has a school district fiscal impact statement been prepared under section 1, chapter 210, Laws of 2012?

☐ Yes. Attach copy of small business economic impact statement or school district fiscal impact statement.

A copy of the statement may be obtained by contacting:
Name:
Address:

phone ( ) _____
fax ( ) _____
e-mail _____

☒ No. Explain why no statement was prepared.

The Joint Administrative Rules Review Committee has not requested the filing of a small business economic impact statement, and there will be no costs to small businesses.

Is a cost-benefit analysis required under RCW 34.05.328?

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

phone ( ) _____
fax ( ) _____
e-mail _____

☒ No: Please explain:

RCW 34.05.328 does not apply to Health Care Authority rules unless requested by the Joint Administrative Rules Committee or applied voluntarily.

Attachment to CR-102

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

Amends existing rules, repeals one rule, and adds twenty-two new rules in Title 182 WAC specific to the PEBB Program with the following effect:

1. Implement PEB Board policy resolution to amend the error correction process to address retroactive enrollment.

2. Makes technical amendments to:

   - Clarify requirements for submitting a medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP) enrollment form.
   - Clarify which employing agency is responsible for payment of the employer contribution when an employee transfers between agencies.
   - Clarify which individuals are not eligible as employees for participation in Public Employees Benefits Board (PEBB) benefits.
   - Add an exception in the rule that prohibits dual enrollment in a PEBB health plan to address instances where a dependent is dual eligible for a partial month.
   - Replace the phrase “comprehensive group medical coverage” with “employer-based group health insurance” throughout.
   - Clarify that the employer contribution toward PEBB benefits ends on the last day of the month when an individual ceases to be eligible.
   - The retiree dental rule to allow early termination of dental if the retiree becomes eligible for employer dental.
   - The retiree deferral rules to provide clarity regarding the effective date of a deferral.
   - Clarify that a retiree’s dependent may not enroll in dental coverage only.
   - The rule that authorizes employees to enroll in PEBB retiree insurance in the case of a retroactive disability retirement awarded by DRS or a higher education authority so it is clear that the retirement must be due to disability.
   - Clarify that references to “registered domestic partner” includes both a state registered domestic partner and 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.
   - Clarify the notice required when a dependent is no longer eligible for PEBB benefits.
   - The special open enrollment rules to account for dependents that move from the U.S. to outside the U.S.

- Clarify when coverage begins for a child enrolled in coverage based on a National Medical Support Notice or court order.
- The surcharge rules to account for issues identified during the implementation phase.
- The wellness rules to account for issues identified during the implementation phase.
- Provide additional definitions of terms used in the rules.
- The appeal rules to address appeals regarding a denial of FSA or DCAP enrollment.
- Clarify all affected rules to appropriately include “charter schools” with school districts and educational service districts by adding a definition of school districts which includes charter schools.
- Add general hearing rules and procedures that apply to an administrative hearing of a PEBB appeal committee decision.
- To require that forms and paperwork must be received within the stated timelines instead of submitted or sent within the timeline.

3. In addition to these specific changes, HCA conducted a full review of these chapters and made some changes for readability.

AMENDATORY SECTION (Amending WSR 14-08-040, filed 3/26/14, effective 4/26/14)

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 a medical plan, or employees may enroll in or change their election under the DCAP, the medical 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).

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

((~~"Comprehensive employer-sponsored medical" includes insurance coverage continued by the employee or his or her dependent under COBRA. It does not include an employer's retiree coverage, with the exception of a federal retiree plan.~~)) "Calendar days" or "days" means all days including Saturdays, Sundays, and all legal holidays as set forth in RCW 1.16.050.

"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 ((~~medical insurance~~)) 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 files, or other printed or written items.

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

"Employer group" means those employee organizations representing state civil service employees, counties, municipalities, political subdivisions, the Washington health benefit exchange, tribal governments, school districts, charter schools, and educational service districts participating in PEBB insurance coverage under contractual agreement 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.

"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 plan" means the Federal Employees' Health Benefits Program (FEHB) and Tricare.

"Health plan" ((~~or "plan"~~)) means a plan offering medical ((~~coverage~~)) or dental ((~~coverage~~)), 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.

"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.

"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.

"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 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 program" means the program within the HCA which administers insurance and other benefits for eligible employees (as defined in WAC 182-12-114), eligible retired and disabled employees (as defined in WAC 182-12-171), eligible dependents (as defined 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 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.

((~~"Premium surcharge implementation period" means the period from April 1 through May 15, 2014, when subscribers may change their health plan enrollment and premium payment plan election to be effective July 1, 2014. Subscribers may change health plans and enroll or remove dependents from coverage. Additionally, employees may enroll in or waive enrollment in a medical plan and enroll in or change their premium payment plan election.~~))

"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 a medical plan, 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 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.

"Termination of the employment relationship" means that an employee resigns or an employee is terminated and the employing agency has no anticipation that the employee will be rehired.

"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, chewing tobacco, snuff, and other tobacco products. It does not include 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 ((~~comprehensive group medical coverage as required~~)) employer-based group medical insurance as allowed under WAC 182-12-128, or is on approved educational leave and obtains ((~~comprehensive group health plan coverage~~)) other employer-based group health insurance as allowed under WAC 182-12-136.

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

WAC 182-08-180 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 must be paid, and are due from the employing agency, subscriber or beneficiary to the health care authority (HCA). If a subscriber's account is past due and it is determined by the authority that full payment of the unpaid balance in a lump sum ((~~is~~)) would be considered a hardship, the ((~~HCA~~)) authority may develop a reasonable repayment plan with the subscriber or beneficiary upon request.

(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 em-

ploying agency any excess premium paid during the three month adjustment period, except as indicated in WAC 182-12-148(4).

(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 director 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 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 14-08-040, filed 3/26/14, effective 4/26/14)

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

(a) A subscriber must attest to whether any enrollee on his or her public employees benefits board (PEBB) medical plan engages in tobacco use. The subscriber must attest during the following times:

(i) ((~~During the premium surcharge implementation period from April 1 through May 15, 2014;~~

~~(ii) No later than thirty-one days after an employee is~~)) When an employee who is newly eligible or regains eligibility for the employer contribution toward PEBB benefits submits an enrollment form to add PEBB medical as described in WAC 182-08-197 (1) or (3). If the attestation results in a surcharge it will take effect the same time PEBB medical begins;

((~~(iii)~~)) (ii) When there is a change in the tobacco use status of any enrollee on the subscriber's PEBB medical plan((~~; and~~

~~(iv) Whenever a dependent is enrolled in PEBB medical coverage on the subscriber's account~~)). If the change in status results in a surcharge being added or removed, the change to the surcharge will take effect 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) When a subscriber submits an enrollment form to add a dependent to his or her PEBB medical as described in WAC 182-12-262. If enrolling the dependent results in a surcharge being added, it will take effect the same time PEBB medical begins;

(iv) When an enrollee elects to continue health plan coverage as described in WAC 182-12-146. If the attestation results in a surcharge it will take effect the same time PEBB medical begins. This action is required only if the enrollee has not previously attested as described in (a) of this subsection;

(v) When an employee or retiree submits an enrollment form to enroll in PEBB medical as described in WAC 182-12-171 (1)(a), 182-12-200 (2)(a) and (b), or 182-12-205 (4)(a), (b), and (d). If the attestation results in a surcharge it will take effect the same time PEBB medical begins. This action is required only if the retiree has not previously attested as described in (a) of this subsection; and

(vi) When a survivor spouse, registered domestic partner, or dependent child submits an enrollment form to enroll in PEBB medical as described in WAC 182-12-250(5) or 182-12-265. If the attestation results in a surcharge it will take effect the same time PEBB medical begins. This action is required only if the survivor has not previously attested as described in (a) of this subsection.

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 medical enrollment 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 until the employee enrolls in a PEBB medical plan.

(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.

((~~Note: A subscriber, who failed to submit or submitted an inaccurate attestation, may submit an attestation by August 29, 2014, to seek reimbursement for tobacco use premium surcharges imposed in July and August of 2014.~~))

(c) The PEBB program will provide a reasonable alternative for enrollees who use tobacco products so a subscriber can avoid the tobacco use premium surcharge:

(i) All enrollees have access to a free tobacco cessation program through their medical plan. A subscriber can avoid the surcharge if enrollees who use tobacco products ((~~enroll~~)) are enrolled in their plan's tobacco cessation program.

(ii) ((~~The PEBB program will work with a subscriber to accommodate a physician's recommendation that addresses an enrollee's use of tobacco products.~~

~~(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's account will incur a premium surcharge if an enrolled spouse or registered domestic partner chose not to enroll in employer-based group medical insurance that has premiums less than ninety-five percent of the 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 enrolls~~)) with a spouse or registered domestic partner enrolled under his or her PEBB medical must attest during the following times:

(i) ((~~During the premium surcharge implementation period from April 1 through May 15, 2014;~~

~~(ii) No later than thirty-one days after the employee is newly eligible or regains eligibility for the employer contribution towards PEBB benefits as described in WAC 182-08-197;~~

~~(iii) Whenever a spouse or domestic partner is enrolled in medical coverage on the subscriber's account;~~

~~(iv)~~)) When an employee who is newly eligible or regains eligibility for the employer contribution toward PEBB benefits submits an enrollment form to add PEBB medical as described in WAC 182-08-197 (1) or (3). If the attestation results in a surcharge it will take effect the same time PEBB medical begins;

(ii) When a subscriber submits an enrollment form to add a spouse or registered domestic partner to his or her PEBB medical as described in WAC 182-12-262. If enrolling the spouse or registered domestic partner results in a surcharge being added, the surcharge will take effect 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) During the annual open enrollment((~~; or~~ ~~(v)~~)). If attesting results in a surcharge being added or removed, the change to the surcharge begins January 1st of the following year; and

(iv) When there is a change in the spouse's or registered domestic partner's employer-based group medical insurance. If attesting results in a surcharge being added or removed, the change to the surcharge will take effect 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.

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 medical enrollment 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 until the employee enrolls in a PEBB medical plan.
(3) An employee who covers his or her spouse or registered domestic partner who has waived his or her own PEBB medical must attest, but a premium surcharge will not be applied.

(b) A premium surcharge will be applied to the account of subscribers who do not attest as described in (a) of this subsection.

((Note: ~~A subscriber, who failed to submit or submitted an inaccurate attestation, may submit an attestation by August 29, 2014, to seek reimbursement for the WAC 182-08-185(2) premium surcharges imposed in July and August of 2014.~~))

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

WAC 182-08-187 How do employing agencies correct enrollment errors and is there a limit on retroactive enrollment? If an employing agency fails to notify an employee of his or her eligibility for public employees benefits board (PEBB) benefits and the employer contribution as required in WAC 182-12-113 or the employer group contract, or fails to accurately enroll insurance coverage, the agency is authorized and required to correct the error as described in this section.

The employing agency or PEBB designee must enroll the employee in PEBB benefits as described in subsection (1) of this section, reconcile premium payments 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), ((~~it~~)) 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 enrollment forms default to enrollment according to WAC 182-08-197 (1)(b).

(1) **Enrollment.**

(a) Medical and dental enrollment is ((~~limited to three months prior to the date enrollment is processed~~)) effective the first day of the month following the date the enrollment error is identified, unless the authority determines additional recourse is warranted, as de-

scribed 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 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 insurance coverage 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 account (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 FSA or DCAP as elected, the employee may adjust his or her election. The employee may either participate at the amount originally elected with a corresponding increase in contributions for the balance of the plan year, or participate at a reduced amount for the plan year by maintaining the per-pay period contribution in effect.

(2) **Premium payments.**

(a) The employing agency must remit to the authority the employer contribution and the employee contribution for health plan premiums, 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 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 ((~~coverage~~)) 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) 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. 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 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 13-22-019, filed 10/28/13, effective 1/1/14)

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 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 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 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 medical is waived.

(4) Employees of employer groups 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 medical is waived.

(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 ((~~benefits~~)) medical insurance 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 defined in WAC 182-12-114 or 182-12-131.

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

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

WAC 182-08-197 When must a newly eligible employee((s)), or an employee((s)) who regains eligibility for the employer contribution, select public employees benefits board (PEBB) benefits and complete enrollment forms? An employee((s)) who ((are)) 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) ((The)) An employee must complete the required forms indicating enrollment elections and return the forms to his or her employing agency. Forms must be received by the 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) ((The)) An employee may enroll in optional life and optional long-term disability (LTD) insurance up to the guaranteed issue without evidence of insurability if enrollment forms are returned to the employee's employing agency as required. An employee may apply for enrollment in optional life and LTD insurance coverage over the guaranteed issue at any time during the calendar year by submitting the evidence of insurability form to the vendor for approval.

((Note: An employee may apply for optional life and optional long-term disability insurance after the period of time described in this subsection by providing evidence of insurability and receiving approval from the contracted vendor.))

(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 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 ((becoming)) 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 enrollment form to his or her state agency or PEBB designee. The form must be received by the state agency or PEBB designee no later than thirty-one days after ((becoming)) the employee becomes eligible for PEBB benefits.

(b) If a newly eligible ((employee does not return enrollment forms to his or her)) employee's employing agency does not receive the employee's forms indicating medical, dental, and LTD choice within thirty-one days and life insurance choice within sixty days of the employee becoming eligible, his or her coverage will be enrolled as follows:

(i) Medical enrollment will be Uniform Medical Plan Classic;

(ii) Dental enrollment will be Uniform Dental Plan;

(iii) Basic life insurance;

(iv) Basic long-term disability insurance; and

(v) Dependents will not be enrolled.

(2) The employer contribution toward 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 insurance coverage following a period of leave described in WAC 182-12-133(1) and 182-12-142 (1) and (2):

(a) The employee must complete and return the required forms indicating enrollment elections to his or her employing agency except as described in (d) of this subsection. Forms must be received no later than thirty-one days after ((~~regaining~~)) 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;

(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 when he or she regains eligibility for the employer contribution.

(b) An employee in any of the following circumstances does not have to return an optional LTD insurance election form. His or her optional LTD insurance will be automatically reinstated:

(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.

Exception: An employee's 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 employees between any entities described in WAC 182-12-111 and participating in PEBB benefits. Insurance coverage elections also remain the same when employees have a break in employment that does not interrupt his or her employer contribution toward PEBB insurance coverage.

(c) If an ((~~employee does not return the required forms to his or her~~)) employee's employing agency does not receive the forms within thirty-one days of the employee regaining eligibility, medical, dental, life, and LTD 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 enrollment form to his or her state agency or PEBB designee. The form must be received by the employee's state agency or PEBB designee no later than thirty-one days after ((~~becoming~~)) 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.

AMENDATORY SECTION (Amending WSR 14-08-040, filed 3/26/14, effective 4/26/14)

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. Employees submit the enrollment forms to their employing agency. All other subscribers submit the enrollment forms to the PEBB program. The required enrollment forms must be received no later than the ((~~end~~)) 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 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. Employees submit the enrollment forms to their employing agency. All other subscribers submit the enrollment forms to the ((~~public employees benefits board (~~))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 employer contribution toward employer-based group health ((~~coverage~~)) insurance;

(d) 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 sub-

scriber 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) 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 registered domestic partner is not an eligible dependent);

(f) 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) 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) 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 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) 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) 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.

((~~(3)~~ **During the premium surcharge implementation period:** ~~Subscribers may change health plans during the premium surcharge implementation period from April 1 through May 15, 2014. The subscriber must submit the required enrollment forms to change his or her health plan no later than May 15, 2014. Enrollment in the new health plan will begin July 1, 2014.~~))

AMENDATORY SECTION (Amending WSR 14-08-040, filed 3/26/14, effective 4/26/14)

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 enrollment form must be submitted to his or her employing agency. To enroll or reenroll in medical FSA or DCAP the employee must submit((~~, in paper or online,~~)) the required enrollment form ((~~to enroll or reenroll~~)) to his or her employing agency or public employees benefits board (PEBB) 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 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 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 enrollment forms as instructed on the forms. The required enrollment 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 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 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 ((~~public employees benefits board (~~))PEBB((~~)~~)) eligibility criteria because:

• Employee has a change in marital status;

• Employee's domestic partnership with a 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 employer contribution toward employer-based group health ((~~coverage~~)) insurance;

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

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

(vii) 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) 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 registered domestic partner is not an eligible dependent);

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

(x) 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) 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 cancels enrollment in a medicare Part D plan;

(xii) 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) ((~~Employee has a change in the cost of insurance coverage because of a premium surcharge;~~

~~(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 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.

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) **Flexible spending account (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 ((~~approval by the FSA administrator~~)) the later of the event date or the date the 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 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 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 ((~~approval by the DCAP administrator~~)) the later of the event date or the date the 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 ((~~employer~~)) 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 relative as defined in Section 152 (d)(1) through (5), incorporating the rules of Section 152 (b)(1) through (3) of the IRC.

((~~(4) **During the premium surcharge implementation period:** An eligible employee may enroll in or change his or her election under the state's premium payment plan from April 1 through May 15, 2014. The employee must submit, in paper or online, the required enrollment form to enroll or change his or her election no later than May 15, 2014. The enrollment or change in election will begin July 1, 2014.~~))

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

WAC 182-08-235 Employer group application process. This section applies to employer groups as defined in WAC 182-08-015. An employer group may apply to obtain insurance coverage through a contract with the health care authority (HCA). With the exception of ((~~K-12~~)) school districts and educational service districts, the authority will approve or deny ((~~the~~)) applications through the evaluation criteria described in WAC 182-08-240. To apply, ((~~the~~)) employer groups must submit the documents and information described in this rule to the public employees benefits board (PEBB) program at least sixty days before the requested coverage effective date. ((~~K-12~~)) School districts and educational service districts are only required to provide the documents described in subsections (1), (2), and (3) of this section. If ((~~a K-12~~)) school ((~~district is~~)) districts or educational service districts are required by the superintendent of public instruction to purchase insurance coverage provided by the authority, ((~~the school district is~~)) they are required to submit documents and information described in subsections (1)(c), (2), and (3) of this section.

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

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

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

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

(d) A statement of whether the employer group is requesting only medical or medical, dental, life and LTD insurance. ((~~K-12~~)) School districts and educational service districts must purchase medical, dental, life, and LTD insurance.

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

(3) 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) 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 demographic data, by member, with each member classified as employee, spouse or ((~~state~~)) registered domestic partner, or child:

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

(b) Age;

(c) Gender;

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

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

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

(5) 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 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) Employer groups with greater than two thousand five hundred eligible employees must submit to an actuarial evaluation of the group. The employer group must pay for the cost of the evaluation. This cost is nonrefundable. An employer 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.

AMENDATORY SECTION (Amending WSR 14-08-040, filed 3/26/14, effective 4/26/14)

WAC 182-08-245 Employer group participation requirements. This section applies to an employer group as defined in WAC 182-08-015 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 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 insurance coverage in accordance with the criteria outlined in the employer group'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 that only 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 may be considered eligible by the employer group; and

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

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

(a) The premium rate structure for ((~~K-12~~)) school districts and educational service districts 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 choice and family enrollment. School districts and educational service districts must collect an amount equal to the premium surcharge(s) 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 described in (a) of this subsection will be a tiered rate based on health plan choice and family enrollment. Employer groups must collect an amount equal to the premium surcharge(s) 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) If an employer group wants to make subsequent changes to the contract, the changes must be submitted to the authority for approval.

(4) The employer group must maintain participation in PEBB insurance coverage for at least one full year. An employer group 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 must provide written notice to the PEBB program at least sixty days before the requested termination date.

(5) Upon approval to purchase insurance through a contract with the authority, the employer group must provide a list of employees and dependents that are enrolled in COBRA benefits and the remaining number of months available to them based on their qualifying event. These employees and dependents may enroll in PEBB medical and dental as CO-

BRA enrollees for the remainder of the months available to them based on their qualifying event.

(6) 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 14-08-040, filed 3/26/14, effective 4/26/14)

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 a medical plan, or employees may enroll in or change their election under the DCAP, the medical 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).

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

((~~"Comprehensive employer-sponsored medical" includes insurance coverage continued by the employee or his or her dependent under COBRA. It does not include an employer's retiree coverage, with the exception of a federal retiree plan.~~)) "Calendar days" or "days" means all days including Saturdays, Sundays, and all legal holidays as set forth in RCW 1.16.050.

"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 ((~~medical insurance~~)) 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 files, or other printed or written items.

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

"Employer group" means those employee organizations representing state civil service employees, counties, municipalities, political subdivisions, the Washington health benefit exchange, tribal governments, school districts, charter schools, and educational service districts participating in PEBB insurance coverage under contractual agreement 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.

"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 Plan" means the Federal Employees Health Benefits program (FEHB) and Tricare.

"Health plan" ((~~or "plan"~~)) means a plan offering medical ((~~coverage~~)) or dental ((~~coverage~~)), 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.

"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 program" means the program within the HCA which administers insurance and other benefits for eligible employees (as defined in WAC 182-12-114), eligible retired and disabled employees (as defined in WAC 182-12-171), eligible dependents (as defined 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 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.

((~~"Premium surcharge implementation period" means the period from April 1 through May 15, 2014, when subscribers may change their health plan enrollment and premium payment plan election to be effective July 1, 2014. Subscribers may change health plans and enroll or remove dependents from coverage. Additionally, employees may enroll in or waive enrollment in a medical plan and enroll in or change their premium payment plan election.~~))

"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 a medical plan, 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 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.

"Termination of the employment relationship" means that an employee resigns or an employee is terminated and the employing agency has no anticipation that the employee will be rehired.

"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, chewing tobacco, snuff, and other tobacco products. It does not include 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 ((~~comprehensive group medical coverage as required~~)) employer-based group medical insurance as allowed under WAC 182-12-128, or is on approved educational leave and obtains ((~~comprehensive group health plan coverage~~)) other employer-based group health insurance as allowed under WAC 182-12-136.

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

WAC 182-12-111 Eligible entities and individuals. 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 insurance coverage for groups of employees described in subsection (a) of this section at the option of each employer group:

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

• Bargaining units may elect to participate separately from the whole group;

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

• 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) The employer group must apply through the process described in WAC 182-08-235. ((~~K-12~~)) School district and educational service district applications ((~~are required to~~)) must provide the documents described in WAC 182-08-235 (1), (2), and (3). If a ((~~K-12~~)) 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 are subject to review and approval by the health care authority (HCA). With the exception of ((~~K-12~~)) a school district((~~s and~~)) or educational service district((~~s~~)), the authority will approve or deny an employer group's application based on the employer group ((~~eligibility~~)) evaluation criteria described in WAC 182-08-240.

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

(3) **School districts and educational service districts.** In addition to subsection (2) of this section, the following applies to school districts and educational service districts:

(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 as would be charged to state employees for each participating school district or educational service district.

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

(5) **Eligible nonemployees.**

(a) Blind vendors means a "licensee" as defined in RCW 74.18.200: Vendors actively operating a business enterprise program facility in the state of Washington and deemed eligible by the department of services for the blind may voluntarily participate in PEBB medical.

(i) Vendors that do not enroll when first eligible may enroll only during the annual open enrollment period offered by the HCA or the first day of the month following loss of other insurance coverage.

(ii) Department of services for the blind will notify eligible vendors of their eligibility in advance of the date that they are eligible to apply for enrollment in PEBB medical.

(iii) The eligibility requirements for dependents of blind vendors shall be the same as the requirements for dependents of the state employees in WAC 182-12-260.

(iv) An individual licensee or vendor who ceases to actively operate a facility becomes ineligible to participate in PEBB medical as described in (a) of this subsection. Individuals losing coverage may continue enrollment in PEBB medical on a self-pay basis under COBRA as described in WAC 182-12-146(5).

(v) An individual licensee or vendor is 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 insurance coverage as long as they remain eligible under that section.

(6) **Individuals and entities ((~~that are~~)) 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 employees under RCW 41.05.011.

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

WAC 182-12-123 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, individuals who have more than one source of eligibility for enrollment in PEBB health plan coverage (called "dual eligibility") are limited to one enrollment.

Exception: An enrolled dependent who becomes eligible for PEBB benefits as an employee as described in WAC 182-12-114 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.

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

(3) Children eligible for medical and dental under two subscribers may be enrolled as a dependent under the health plan of only one subscriber.

(4) An employee who is eligible for the employer contribution towards insurance coverage due to employment in more than one PEBB-participating employing agency must choose to enroll under only one employing agency.

Exception: Faculty who stack to establish or maintain eligibility under 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).

AMENDATORY SECTION (Amending WSR 14-08-040, filed 3/26/14, effective 4/26/14)

WAC 182-12-128 When may ((~~an~~)) employees waive or enroll in public employees benefits board (PEBB) medical ((~~plans~~))? Employees must enroll in dental, basic life, and basic long-term disability insurance (unless the employing agency does not participate in these public em-

ployees benefits board (PEBB) insurance coverages). However, employees may waive PEBB medical if they ((~~have~~)) are enrolled in other ((~~comprehensive~~)) employer-based group medical ((~~coverage~~)) insurance.

(1) Employees may waive enrollment in PEBB medical by submitting the required enrollment form to their employing agency during the following times:

(a) **When the employee becomes eligible:** Employees may waive medical when they become eligible for PEBB benefits. Employees must indicate they are waiving medical on the required enrollment form they submit to their employing agency. The enrollment form must be received no later than thirty-one days after the date they become eligible (see WAC 182-08-197). Medical will be waived as of the date the employee becomes eligible for PEBB benefits.

(b) **During the annual open enrollment:** Employees may waive medical during the annual open enrollment ((~~if they submit the required enrollment form to~~)) period. The required enrollment form must be received by their employing agency before the end of the annual open enrollment. Medical will be waived beginning January 1st of the following year.

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

((~~(d) **During the premium surcharge implementation period:** Employees may waive PEBB medical coverage during the premium surcharge implementation period from April 1 through May 15, 2014. The employee must submit the required enrollment form no later than May 15, 2014. Medical coverage will be waived beginning July 1, 2014.~~))

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

(3) Once medical is waived, enrollment is only allowed during the following times:

(a) During the annual open enrollment;

(b) During a special open enrollment created by an event that allows for enrollment outside of the annual open enrollment as described in subsection (4) of this section. In addition to the required forms, the PEBB program will require the employee to provide evidence of eligibility and evidence of the event that creates a special open enrollment((~~;~~

~~(c) During the premium surcharge implementation period from April 1 through May 15, 2014. The employee must submit the required enrollment forms no later than May 15, 2014. Enrollment in medical will begin July 1, 2014~~)).

(4) **Special open enrollment:** Employees may waive enrollment in medical or enroll in medical if a special open enrollment event occurs. The change in enrollment must be allowable under the Internal Revenue Code (IRC) and correspond to and be consistent with the event that creates the special open enrollment for the employee, the employee's dependent, or both. Employees must provide evidence of the event that created the special open enrollment. Any one of the following events may create a special open enrollment:

(a) Employee 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) 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 employer contribution toward employer-based group ((~~health coverage~~)) medical insurance;

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

(e) 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) 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 registered domestic partner is not an eligible dependent);

(g) 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) 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).

To waive or enroll during a special open enrollment, the employee must submit the required forms to his or her employing agency. The forms must be received by the employing agency no later than sixty days after the event that creates the special open enrollment.

Medical will be waived the end of the month following the later of the event date or the date the form is received. If the later day is the first of the month, 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, medical will be waived the first of the month in which the event occurs.

Enrollment in medical 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, 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, enrollment in medical will begin the first of the month in which the event occurs.

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

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

describes under what circumstances ((~~an~~)) employee<u>s</u> maintain((~~s~~)) eligibility for the employer contribution toward insurance coverage.

(1) **Maintaining the employer contribution.** Except as described in subsections (2), (3), and (4) of this section, ((~~an~~)) employee<u>s</u> who ((~~has~~)) <u>have</u> established eligibility for benefits under WAC 182-12-114 ((~~is~~)) <u>are</u> eligible for the employer contribution each month in which ((~~he or she is~~)) <u>they are</u> in pay status eight or more hours per month.

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

(a) ((~~A~~)) <u>B</u>enefits-eligible seasonal employee<u>s</u> (eligible under WAC 182-12-114(2)) who work((~~s~~)) a season of less than nine months ((~~is~~)) <u>are</u> eligible for the employer contribution in any month of ((~~his or her~~)) <u>the</u> season in which ((~~he or she is~~)) <u>they are</u> in pay status eight or more hours during that month. The employer contribution toward 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) ((~~A~~)) <u>B</u>enefits-eligible seasonal employee<u>s</u> (eligible under WAC 182-12-114(2)) who work((~~s~~)) a season of nine months or more ((~~is~~)) <u>are</u> eligible for the employer contribution:

(i) In any month of ((~~his or her~~)) <u>the</u> season in which ((~~he or she is~~)) <u>they are</u> in pay status eight or more hours during that month; and

(ii) Through the off season following each season worked.

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

(a) Benefits-eligible faculty anticipated to work the entire instructional year or equivalent nine-month period (eligible under 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 WAC 182-12-114 (3)(a)(ii)) are eligible for the employer contribution each quarter or semester in which ((~~the~~)) employee<u>s</u> work((~~s~~)) half-time or more.

(c) Summer or off-quarter/semester coverage: All benefits-eligible faculty (eligible under WAC 182-12-114(3)) 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 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 WAC 182-12-114(3)) 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 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 agen-

cy 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 WAC 182-12-114(3)) 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 insurance coverage under the criteria 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 ((~~an employee is~~)) employees are not in pay status for at least eight hours, ((~~the~~)) employees:

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

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

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

(a) When ((~~the~~)) employees fail((~~s~~)) 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 ((~~the~~)) employee~~s~~ move((~~s~~)) to a position that is not anticipated to be eligible for benefits under WAC 182-12-114, not including changes in position due to a layoff.

The employer contribution toward PEBB ((~~medical, dental and life insurance for an employee, spouse, state registered domestic partner, or child ceases at 12:00 midnight,~~)) benefits cease for employees and their enrolled dependents the last day of the month in which ((~~the employee is~~)) employees are eligible for the employer contribution under this section.

Exception: 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.

(8) **Options for continuation coverage by self-paying.** During temporary or permanent loss of the employer contribution toward 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 WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, and 182-12-270.

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

WAC 182-12-136 May ((~~an~~)) employee~~s~~ 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 ((~~comprehensive health plan coverage under another group plan~~)) other employer-based group medical or dental insurance, or both, may waive ((~~continuance~~)) continuation of such coverage for each full calendar month in which they maintain coverage under the other ((~~comprehensive group health plan~~)) insurance. 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 ((~~comprehensive group health plan coverage~~)) employer-based group medical or dental insurance ends, provided evidence of such other ((~~comprehensive group health plan~~)) coverage is provided to the PEBB program upon application for reenrollment.

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

WAC 182-12-171 When are retiring employees eligible to enroll in public employees benefits board (PEBB) retiree insurance coverage? (1) **Procedural requirements.** Retiring employees must meet these procedural requirements to enroll or defer enrollment in public employees

benefits board (PEBB) retiree insurance coverage, as well as have substantive eligibility under subsection (2) or (3) of this section((~~.~~)):

(a) The ((~~employee must submit the appropriate forms~~)) employee's form to enroll or defer enrollment in retiree insurance coverage ((~~within~~)) must be received by the PEBB program no later than sixty days after the employee's employer paid or COBRA coverage ends. The effective date of health plan enrollment will be the first day of the month following the loss of ((~~other~~)) employer paid or COBRA coverage.

Exception: The effective dates of health plan enrollment for retirees who defer enrollment in a PEBB health plan at or after retirement are identified in WAC 182-12-200 and 182-12-205.

Employees who do not enroll in a ((~~public employees benefits board (~~))PEBB((~~)~~)) health plan at retirement are only eligible to enroll at a later date if they have deferred enrollment ((~~as identified~~)) and maintained continuous enrollment in other coverage as described in WAC 182-12-200 or 182-12-205 ((~~and maintained comprehensive employer-sponsored medical as defined in WAC 182-12-109~~)).

(b) ((~~The~~)) Employees and 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 the employee 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.

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 under COBRA (see WAC 182-12-146).

(2) **Substantive eligibility requirements.** Eligible employees (as described in WAC 182-12-114 and 182-12-131) who end public employment after becoming vested in a Washington state-sponsored retirement plan (as ((~~defined~~)) described in subsection (4) of this section) are eligible to continue insurance coverage as a retiree if they meet procedural and substantive eligibility requirements. To be eligible to continue 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 or COBRA coverage ends.

Employees who do not meet their Washington state-sponsored retirement plan's age requirement when their employer paid or COBRA coverage ends, but who meet the age requirement within sixty days of coverage ending, may request that their eligibility be reviewed by the PEBB appeals committee to determine eligibility (see WAC 182-16-032). Employees must meet PEBB retiree insurance coverage election procedural requirements as described in subsection (1) of this section.

Employees must immediately begin to receive a monthly retirement plan payment, with exceptions described below:

• Employees who receive a lump-sum payment instead of a monthly retirement plan payment are 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;

• Employees who are members of a Plan 3 retirement, also called separated employees (defined in RCW 41.05.011(20)), are eligible if they meet their Plan 3 retirement plan's eligibility criteria ((~~when PEBB employee insurance or COBRA coverage ends~~)). They do not have to receive a retirement plan payment to enroll in retiree insurance coverage;

• Employees who are members of a Washington higher education retirement plan are eligible if they immediately begin to receive a

monthly retirement plan payment, or meet their plan's retirement eligibility criteria, or are at least age fifty-five with ten years of state service;

• Employees not retiring under a Washington state-sponsored retirement plan must meet the same age and years of service as if the person had been employed as a member of either public employees retirement system Plan 1 or Plan 2 for the same period of employment; or

• Employees who retire from a local government or tribal government that participates in PEBB insurance coverage for their employees are eligible to continue PEBB insurance coverage as retirees if the employees meet the procedural and eligibility requirements under this section.

(a) **Local government employees.** If the local government ends participation in PEBB insurance coverage, employees who enrolled after September 15, 1991, are no longer eligible for PEBB retiree insurance coverage. These employees may continue ((~~PEBB~~)) health plan ((~~enrollment~~)) coverage under COBRA (see WAC 182-12-146).

(b) **Tribal government employees.** If a tribal government ends participation in PEBB insurance coverage, its employees are no longer eligible for PEBB retiree insurance coverage. These employees may continue ((~~PEBB~~)) health plan ((~~enrollment~~)) coverage under COBRA (see WAC 182-12-146).

(c) **Washington state ((~~K-12~~)) school district and educational service district employees for districts that do not participate in PEBB insurance coverage.** Employees of Washington state ((~~K-12~~)) school districts and educational service districts who separate from employment after becoming vested in a Washington state-sponsored retirement system are eligible to enroll in PEBB health plans as a retiree when retired or permanently and totally disabled.

Except for employees who are members of a retirement Plan 3, employees who separate on or after October 1, 1993, must immediately begin to receive a monthly retirement plan payment from a Washington state-sponsored retirement system. Employees who receive a lump-sum payment instead of a monthly retirement plan payment are 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.

Employees who are members of a Plan 3 retirement, also called separated employees (defined in RCW 41.05.011(20)), are eligible if they meet their Plan 3 retirement plan's eligibility criteria ((~~when employer paid or COBRA coverage ends~~)). They do not have to receive a retirement plan payment to enroll in PEBB retiree insurance coverage.

Employees who retired as of September 30, 1993, and began receiving a retirement allowance from a state-sponsored retirement system (as defined in chapters 41.32, 41.35 or 41.40 RCW) are eligible if they enrolled in a PEBB health plan not later than the HCA's annual open enrollment period for the year beginning January 1, 1995.

(3) **Substantive eligibility for elected and full-time appointed officials of the legislative and executive branches.** Employees who are elected and full-time appointed state officials (as defined under WAC 182-12-114(4)) who voluntarily or involuntarily leave public office are eligible to continue ((~~PEBB~~)) insurance coverage as a retiree if they meet procedural requirements of subsection (1) of this section.

(4) **Washington state-sponsored retirement systems include:**

• Higher education retirement plans;

• Law enforcement officers' and firefighters' retirement system;

- Public employees' retirement system;
- Public safety employees' retirement system;
- School employees' retirement system;
- State judges/judicial retirement system;
- Teachers' retirement system; and
- State patrol retirement system.

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

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

WAC 182-12-200 May ((a)) retiree<u>s</u> who ((~~is~~)) <u>are</u> enrolled as a dependent in a ((~~PEBB health plan or~~)) <u>public employees benefits board (PEBB), a Washington state ((~~K-12~~)) school district, or Washington state educational service district</u> sponsored health plan defer enrollment ((~~in a PEBB retiree health plan~~)) <u>under PEBB retiree insurance coverage</u>? <u>The following provisions apply when retirees defer enrollment under public employees benefits board (PEBB) retiree insurance coverage when enrolled as a dependent in a PEBB, Washington state school district, or Washington state education service district sponsored health plan:</u>

<u>(1)</u> Retirees who are enrolled in a PEBB ((~~or~~))<u>,</u> Washington state ((~~K-12~~)) school <u>district, or Washington state educational service</u> district sponsored medical plan as a dependent may defer enrollment in a PEBB ((~~retiree~~)) health plan. Retirees who defer enrollment in medical cannot remain enrolled in dental.

<u>(2)</u> Retirees who defer may later enroll themselves and their dependents in ((~~PEBB retiree~~)) medical, or medical and dental, if they provide evidence of continuous enrollment in a PEBB ((~~or K-12~~))<u>, Washington state</u> school <u>district, or Washington state educational service</u> district sponsored medical plan. Continuous enrollment must be from the date the retiree deferred enrollment in <u>PEBB</u> retiree insurance <u>coverage</u>. Retirees may enroll:

((~~(1)~~)) <u>(a)</u> During ((~~any~~)) <u>the</u> PEBB annual open enrollment period. ((~~(Enrollment in~~)) <u>The required enrollment form must be received by the PEBB program no later than the last day of the open enrollment period.</u> PEBB health plan ((~~will~~)) <u>coverage</u> begin<u>s</u> January 1st ((~~after the annual open enrollment period.)~~)) <u>of the following year</u>; or

((~~(2) No later than sixty days after~~)) <u>(b) When</u> enrollment in the PEBB ((~~or K-12~~))<u>, Washington state</u> school district<u>, or Washington state educational service district</u> sponsored medical plan ends((~~. (Enrollment in the~~)) <u>or such coverage under COBRA ends. The required enrollment form and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after such coverage ends.</u> PEBB health plan ((~~will~~)) <u>coverage</u> begin<u>s</u> the first day of the month after the PEBB ((~~or K-12~~))<u>, Washington state</u> school <u>district, or Washington state educational service</u> district ((~~health~~)) <u>sponsored medical</u> plan ends.((~~)~~))

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

WAC 182-12-205 May ((a)) retirees defer enrollment ((~~in a~~)) under public employees benefits board (PEBB) ((~~health plan~~)) retiree insurance coverage at or after retirement? ((~~Except as stated in subsection (1)(c) of this section, if a~~)) The following provisions apply when retirees defer enrollment under public employees benefits board (PEBB) retiree insurance coverage when enrolled in other coverage:

(1) Retirees who defer((~~s~~)) enrollment in a ((~~public employees benefits board (~~))PEBB((~~)~~)) health plan((~~, they~~)) also defer enrollment for all eligible dependents, except as stated in subsection (2)(c) of this section.

((~~(1)~~)) (2) Retirees may defer enrollment in a PEBB health plan at or after retirement if continuously enrolled in other ((~~coverage~~)) medical as described in this subsection((~~:~~)). Retirees who defer enrollment in medical automatically defer enrollment in dental. Retirees must enroll 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 ((~~comprehensive employer-sponsored medical~~)) employer-based group medical insurance as an employee or the dependent of an employee, or such medical insurance continued under COBRA.

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

((~~(2)~~)) (3) To defer PEBB health plan enrollment, ((~~the retiree~~)) retiring employees or enrolled subscribers must submit the required forms to the PEBB program requesting to defer. ((~~The PEBB program must receive the form before health plan enrollment is deferred or no later than sixty days after the date the retiree becomes eligible to apply for PEBB retiree insurance coverage.~~

~~(3)~~)) (a) If retiring employees submit the required forms to defer enrollment in a PEBB health plan after their employer paid or COBRA coverage ends as described in WAC 182-12-171 (1)(a), enrollment will be deferred the first of the month following the date their employer paid or COBRA coverage ends. The forms must be received by the PEBB program no later than sixty days after the employer paid or COBRA 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 their deferral form is received by the PEBB program.

(4) Retirees who defer may later enroll themselves and their dependents in a PEBB ((~~retiree medical, or medical and dental,~~)) health plan as follows:

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

(i) During the PEBB annual open enrollment period. The required enrollment 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) ((~~No later than sixty days after~~)) When their ((~~comprehensive employer-sponsored~~)) employer-based group medical insurance or such coverage under COBRA ends. The required enrollment 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 ((~~comprehensive employer-sponsored~~)) employer-based group medical insurance or COBRA 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 ((~~a federal retiree medical plan~~)) such coverage to the PEBB program:

(i) During the PEBB annual open enrollment period. The required enrollment 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) ((~~No later than sixty days after~~)) When the federal retiree medical coverage ends. The required enrollment 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 creditable coverage to the PEBB program:

(i) During the PEBB annual open enrollment period. The required enrollment 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) ((~~No later than sixty days after~~)) When their medicaid coverage ends. The required enrollment 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 enrollment form must be received by the PEBB program no later than the last day of the calendar year when 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 ((~~exchange~~)) such coverage to the PEBB program:

(i) During the PEBB annual open enrollment period. The required enrollment 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) ((~~No later than sixty days after~~)) When exchange coverage ends. The required enrollment 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 dependent(s) in PEBB medical than a medical assistance program.

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

WAC 182-12-208 What are the requirements regarding enrollment in ((~~retiree~~)) dental under public employees benefits board (PEBB) retiree insurance coverage? ((~~(1)~~)) 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 ((~~or dependent enrolled in retiree insurance coverage, may not~~)) and his or her dependents must be enrolled in medical to enroll in dental ((~~unless he or she is also enrolled in medical~~)).

((~~(2)~~)) (3) A subscriber enrolling in dental must stay enrolled ((~~in dental~~)) for at least two years before dental can be dropped unless he or she defers 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 continued under COBRA, may drop PEBB dental before completing the two-year enrollment requirement. The subscriber and enrolled dependents will be removed from PEBB dental the last day of the month following the date the required enrollment 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 enrollment 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 ends. The required enrollment 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 13-22-019, filed 10/28/13, effective 1/1/14)

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

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

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

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

(a) To continue to self-pay premiums and keep retiree life insurance in place during the period he or she is eligible for employee life insurance; or

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

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

WAC 182-12-211 ((~~If department of retirement systems or the appropriate higher education authority makes a formal determination of retroactive eligibility, may the retiree~~)) May an employee who is determined to be retroactively eligible for disability retirement enroll in public employees benefits board (PEBB) retiree insurance coverage?

(1) ((~~When the Washington state department of retirement systems (DRS), or the appropriate higher education authority, makes a formal determination that a person is retroactively eligible for a pension benefit or a supplemental retirement plan benefit under the higher education HERP plan, that person may apply for enrollment in a public employees benefits board (PEBB) health plan only if the application is made within sixty days after the date of written notice from DRS or from the appropriate higher education authority. Employees must~~)) An employee who is determined to be retroactively eligible for a disability retirement is eligible to enroll in public employees benefits board (PEBB) retiree insurance coverage if:

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

(b) The employee's enrollment form and a copy of his or her formal determination letter are received by the PEBB program no later than sixty days after the date on the determination letter; and

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

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

(a) The employee's retirement ((~~eligibility~~)) date as stated in the ((~~written notice~~)) formal determination letter; or ((~~the date of the written notice described in subsection (1) of this section, at the option of the retiree, must be sent with the application to the PEBB program~~))

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

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

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

WAC 182-12-250 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 ((~~health plans administered by the~~)) public employees benefits board (PEBB) ((~~program within health care authority (HCA)~~)) 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 ((~~a PEBB health plan~~)) 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 ((~~a PEBB health plan~~)) 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 1); 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 must be paid by the survivor except as provided in RCW 41.26.510(5) and 43.43.285 (2)(b).

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

(a) Enroll in a PEBB health plan:

(i) Enroll in medical; or

(ii) Enroll in medical and dental.

(iii) Survivors enrolling in dental must stay enrolled ((~~in dental~~)) for at least two years before dental can be dropped, unless they

defer 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((~~(1)~~)) (2).

(ii) Survivors may enroll in a PEBB health plan as described in WAC 182-12-205(4) when they lose ((~~comprehensive employer-sponsored medical~~)) other coverage. Survivors ((~~will need to~~)) must provide evidence that they were continuously enrolled in ((~~comprehensive employer-sponsored medical when applying for a PEBB health plan, and apply within sixty days after the date their other coverage ended~~)) other such coverage when enrolling in a PEBB health plan. The required enrollment 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 ((~~a PEBB health plan~~)) retiree insurance coverage if they:

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

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

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

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 reserves the right to 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 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 re-

quires the subscriber to provide health insurance for the former spouse.

(2) 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) 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 age twenty-six except as described in (i) of this subsection. Children are defined as the subscriber's:

(a) Children as defined 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 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 ((~~employee~~)) 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 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 insurance coverage.

AMENDATORY SECTION (Amending WSR 14-08-040, filed 3/26/14, effective 4/26/14)

WAC 182-12-262 When may subscribers enroll or remove eligible dependents? (1) **Enrolling dependents in ((~~health plan coverage~~)) 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 ((~~(1)~~)) (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) ((~~insurance coverage~~)) 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.

((~~(d) **During the premium surcharge implementation period.** Subscribers may enroll dependents during the premium surcharge implementation period from April 1 through May 15, 2014. Employees must submit the required enrollment forms to their employing agency and all other subscribers submit the required forms to the PEBB program no later than May 15, 2014. PEBB health plan coverage will begin July 1, 2014.~~))

(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 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 ((~~any~~)) the last day of the month the dependent ((~~ceasing to be eligible~~)) 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((~~; or~~

~~(iii) During the premium surcharge implementation period. Subscribers may remove dependents during the premium surcharge implementation period from April 1 through May 15, 2014. To remove a dependent the employee must submit the required form no later than May 15, 2014. The dependent will be removed June 30, 2014~~)).

(c) **Retirees, survivors, and enrollees with PEBB continuation coverage under WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, or 182-12-148 may remove dependents** from their 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 coverage prospectively.

(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 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 form is received. If that day is the first of the month, the change in enrollment begins on that day.

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

• Dependents 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 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 a 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 employer contribution toward employer-based group health ((~~coverage~~)) insurance;

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

(e) 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) 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 registered domestic partner is not an eligible dependent);

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

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

(4) **Enrollment requirements. Subscribers must submit the required enrollment 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 dependent(s) 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 ((~~subscriber must submit 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 ((~~subscriber must submit the~~)) required enrollment 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 an enrollment form as soon as possible to ensure timely payment of claims. If adding the child increases the premium, ((~~the subscriber must submit~~)) the required enrollment 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 ((~~subscriber must submit the~~)) required form(s) 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, ((~~the subscriber must submit the~~)) required forms must be received no later than sixty days after the event that creates the special open enrollment.

((~~(g) If a subscriber wants to enroll eligible dependents during the premium surcharge implementation period from April 1 through May 15, 2014, the subscriber must submit required forms no later than May 15, 2014.~~))

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

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

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

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

(a) The child's other parent; or

(b) Child support enforcement program.

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

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

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

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

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

(4) ((~~Health plan enrollment~~)) Changes to health plan coverage or enrollment described in subsection (3)(a) through (c) of this section

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

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

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 forms to enroll or defer enrollment in ((~~a PEBB medical plan~~)) 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 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 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 ((~~in a PEBB health plan~~)) as a survivor under retiree insurance coverage. The dependent must submit the appropriate 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 pro-

vide 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 is eligible to enroll or defer enrollment ((~~in a health plan~~)) 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 form to enroll or defer enrollment in ((~~a PEBB medical plan~~)) 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 WAC 182-12-260.

(4) If a premium payment received by the authority is sufficient 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 WAC 182-12-200 and 182-12-205.

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

WAC 182-12-270 What options for continuation coverage are available to dependents who cease to meet the eligibility criteria 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 public employees benefits board (PEBB) program must receive the appropriate 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 WAC 182-12-250 or 182-12-265; or

(2) Dependents who lose eligibility because they no longer meet the eligibility criteria 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 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 12-20-022, filed 9/25/12, effective 11/1/12)

WAC 182-16-010 ((~~Adoption of model rules of procedure.~~)) 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. ((~~Those~~)) The model rules of procedure may be found in chapter 10-08 WAC. Other procedural rules adopted in ((~~this title~~)) 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 ((~~this title~~)) WAC 182-16-025 through 182-16-040, the procedural rules adopted ((~~in this title~~)) 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 appeal 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.

AMENDATORY SECTION (Amending WSR 14-08-040, filed 3/26/14, effective 4/26/14)

WAC 182-16-020 Definitions. As used in this chapter the term:

"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, with regard to PEBB benefits in-

cluding, but not limited to, actions or communications expressly designated as a "denial," "denial notice," or "cancellation notice."

"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 files, or other printed or written items.

"Employer group" means those employee organizations representing state civil service employees, counties, municipalities, political subdivisions, the Washington health benefit exchange, tribal governments, school districts, charter schools, and educational service districts participating in PEBB insurance coverage under contractual agreement 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.

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

"Health plan" ((~~or "plan"~~)) means a plan offering medical ((~~coverage~~)) or dental ((~~coverage~~)), 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 opportunity to be heard in a dispute about a decision made by the PEBB appeals committee, including prehearing conferences, dispositive motion hearings, 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 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 program" means the program within the HCA which administers insurance and other benefits for eligible employees (as defined in WAC 182-12-114), eligible retired and disabled employees (as defined in WAC 182-12-171), eligible dependents (as defined 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 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.

"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, chewing tobacco, snuff, and other tobacco products. It does not include 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 14-08-040, filed 3/26/14, effective 4/26/14)

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((~~, or a PEBB wellness incentive,~~)) may appeal that decision to the employer group through the process established by the employer group.

Exception: ((~~Appeals by an~~)) Any employee of an employer group ((~~or his or her dependent based on eligibility or enrollment~~)) aggrieved by a decision((~~s~~)) regarding life insurance ((~~or~~)), LTD insurance ((~~must be made~~)), 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 ((~~public employee benefits~~)) PEBB eligibility, enrollment, premium payments, premium surcharge, ((~~or~~)) 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 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 ((~~enrollee~~)) employee aggrieved by a decision regarding the ((~~medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP) offered~~)) 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 14-08-040, filed 3/26/14, effective 4/26/14)

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 ((~~within~~)) no later than thirty days ((~~of~~)) after the date of the initial denial notice. The contents of the request for review are to be provided in accordance with 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.

(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 ((~~within~~)) no later than thirty days ((~~of~~)) 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 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 ((~~cause~~)) 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 14-08-040, filed 3/26/14, effective 4/26/14)

WAC 182-16-032 How can a decision made by the public employees benefits board (PEBB) program regarding eligibility, enrollment, premium payments, premium surcharge, ((~~or~~)) eligibility to participate in the PEBB wellness incentive program or receive a PEBB wellness incentive; or a decision made by an employer group regarding life insurance or LTD insurance be appealed? (1) ((~~An~~)) A decision made by the public employees benefits board (PEBB) program regarding eligibility, enrollment, premium payment, premium surcharge, or eligibility to participate in the PEBB wellness incentive program, or eligibility to receive a PEBB wellness incentive ((~~decision made by the public employees benefits board (PEBB) program~~)), may be appealed by submitting a notice of appeal to the PEBB appeals committee.

(2) ((~~An eligibility or enrollment~~)) A decision made by an employer group regarding life insurance ((~~or~~)), LTD insurance, eligibility to participate in the PEBB wellness incentive program, or eligibility to receive a PEBB wellness incentive may be appealed by submitting a notice of appeal to the PEBB appeals committee.

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

(4) The notice of appeal from an employee or employee's dependent must be received by the PEBB appeals manager ((~~within~~)) no later than thirty days ((~~of~~)) after the date of the denial notice.

(5) The notice of appeal from a retiree, self-pay enrollee, or dependent of a retiree or self-pay enrollee must be received by the PEBB appeals manager ((~~within~~)) no later than sixty days ((~~of~~)) after the date of the denial notice.

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

(7) 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 ((~~cause~~)) reason explaining the cause for the delay.

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

NEW SECTION

WAC 182-16-035 How can a subscriber appeal a decision regarding the administration of wellness incentive program requirements? (1) Any subscriber aggrieved by a decision regarding the completion of the

wellness incentive program requirements or request for a reasonable alternative to a wellness incentive program requirement may appeal that decision to the third-party administrator contracted to administer the PEBB wellness incentive program.

(2) Any subscriber who disagrees with a decision in response to an appeal filed with the third-party administrator that administers the wellness incentive program may appeal to the public employees benefits board (PEBB) appeals committee.

(a) The notice of appeal from an employee must be received by the PEBB appeals manager 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 WAC 182-16-040.

(b) The notice of appeal from a retiree or self-pay enrollee must be received by the PEBB appeals manager no later than sixty days after the date of the denial notice. The contents of the notice of appeal are to be provided in accordance with WAC 182-16-040.

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

(4) 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.

(5) 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 12-20-022, filed 9/25/12, effective 11/1/12)

WAC 182-16-036 How can an ((~~enrollee~~)) employee appeal a decision regarding the administration of benefits offered under the state's salary reduction plan? (1) Any ((~~enrollee~~)) employee who disagrees with a decision that denies enrollment in a benefit offered under the state's salary reduction plan may appeal that decision to the public employees benefits board (PEBB) appeals committee. The PEBB appeals manager must receive the notice of appeal no later than thirty days after the date of the denial notice by the PEBB program. The contents of the notice of appeal are to be provided in accordance with 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.

(2) Any employee aggrieved by a decision regarding a claim for benefits under the medical flexible spending arrangement (FSA) and dependent care assistance program (DCAP) offered under the state's salary reduction plan may appeal that decision to the third-party admin-

istrator contracted to administer the plan by following the appeal process of the third-party administrator.

((~~(2)~~)) Any ((~~enrollee~~)) employee who disagrees with a decision in response to an appeal filed with the third-party administrator that administers the medical FSA and DCAP under the state's salary reduction plan may appeal to the ((~~public employees benefits board (~~))PEBB((~~)~~)) appeals committee. The PEBB appeals manager must receive the notice of appeal ((~~within~~)) no later than thirty days ((~~of~~)) after the date of the appeal decision by the third-party administrator that administers the medical FSA and DCAP ((~~offered under the state's salary reduction plan~~)). The contents of the notice of appeal are to be provided in accordance with 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 ((~~cause~~)) 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.

(3) Any ((~~enrollee~~)) employee aggrieved by a decision regarding the administration of the premium payment plan offered under the state's salary reduction plan may appeal that decision to the PEBB appeals committee. The PEBB appeals manager must receive the notice of appeal ((~~within~~)) no later than thirty days ((~~of~~)) after the date of the denial notice by the PEBB program. The contents of the notice of appeal are to be provided in accordance with 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 ((~~cause~~)) 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 12-20-022, filed 9/25/12, effective 11/1/12)

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 ((~~within~~)) no later than thirty days ((~~of~~)) after the date of the denial notice. The contents of the notice of appeal are to be provided in accordance with WAC 182-16-040.

(1) The PEBB appeals manager shall notify the appealing party 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 ((~~cause~~)) reason explaining the cause for the delay.

(3) Any appealing party 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 12-20-022, filed 9/25/12, effective 11/1/12)

WAC 182-16-050 How can an enrollee or entity request ((a)) an administrative hearing if aggrieved by a decision made by the public employees benefits board (PEBB) appeals committee? (1) Any party aggrieved by a 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 request for an administrative hearing ((~~within~~)) no later than thirty days of the date ((~~of~~)) after the written decision by the PEBB appeals committee.

(3) ((~~The authority shall set the time and place of the hearing and give not less than twenty days notice to all parties.~~

~~(4)~~)) The director, or his or her designee, shall preside at all hearings resulting from the filings of appeals under this ((~~chapter~~)) section.

((~~(5)~~)) (4) All hearings must be conducted in compliance with ((~~these rules~~)) WAC 182-16-050 through 182-16-110, chapter 34.05 RCW, and chapter 10-08 WAC ((~~as applicable.~~

~~(6) Within ninety days after the hearing record is closed, the director or his or her designee shall render a decision which shall be the final decision of the authority. A copy of that decision shall be mailed to all parties~~)), as described in WAC 182-16-010(2).

NEW SECTION

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) If the party who requested a hearing is represented by a party 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) An attorney admitted to practice law in Washington state, who wishes to represent the party who requested a hearing, must file a written notice of appearance containing the attorney's name, address,

and telephone number. The attorney must file a written notice of withdrawal of representation.

NEW SECTION

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

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

NEW SECTION

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 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. Copies of the motion must also be mailed 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 RCW 34.05.425. A petition to disqualify must be in

writing and promptly mailed 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 the petition in a written order, stating facts and reasons for the determination. The presiding officer must mail the order no later than seven days after receiving the petition for disqualification.

NEW SECTION

WAC 182-16-062 Authority of the presiding officer. (1) A presiding officer must hear and decide the issues de novo (anew) based on what is presented during a hearing and admitted into the record.

(2) A presiding officer has no inherent or common law powers, and is limited to those powers granted by the state constitution, statutes, or rules.

(3) A presiding officer may not decide that a rule is invalid or unenforceable. If the validity of a rule is raised during a hearing, the presiding officer may allow only argument to preserve the record for judicial review.

NEW SECTION

WAC 182-16-064 Applicable rules and laws. During a hearing, a presiding officer must first apply the applicable public employees benefits board (PEBB) program rules adopted in the Washington Administrative Code (WAC). If no PEBB program rule applies, the presiding officer must decide the issue according to the best legal authority and reasoning available, including federal and Washington state constitutions, statutes, regulations, significant decisions indexed as described in WAC 182-16-130, and court decisions.

NEW SECTION

WAC 182-16-066 Burden of proof and presumptions. (1) The burden of proof is a party's responsibility to provide evidence regarding disputed facts and persuade the presiding officer that a position is correct based on the standard of proof.

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

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

NEW SECTION

WAC 182-16-070 Calculating when a hearing deadline ends. (1) When counting days to calculate when a hearing deadline ends under WAC 182-16-050 through 182-16-110:

(a) Do not include the day of the action, notice, or order. For example, if a hearing decision is mailed 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.

NEW SECTION

WAC 182-16-071 Time requirements for notices mailed by the presiding officer. (1) The presiding officer must mail a notice of a hearing to all parties and their representatives at least fourteen 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 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.

NEW SECTION

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 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 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.

NEW SECTION

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) Before contacting the presiding officer to request a continuance, the party seeking a continuance must contact the other parties, if possible, to find out if they will agree to a continuance.

(b) The party making the request for a continuance must let the presiding officer know whether the other parties agreed to the continuance. If the parties agree to a continuance, the presiding officer must grant the continuance. If the parties do not agree to a continuance, the presiding officer must schedule a prehearing conference in accordance with the requirements of WAC 182-16-071 to decide whether to grant the continuance.

(c) After granting a continuance, the presiding officer must mail a new hearing notice at least fourteen calendar days before the new hearing date unless the parties agree to a shorter time period.

(d) If the presiding officer denies the continuance request after a prehearing conference is held pursuant to (b) of this subsection, the presiding officer must mail a written order setting forth the basis for denying the continuance request and may proceed with the hearing on the originally scheduled hearing date.

NEW SECTION

WAC 182-16-080 Determining if an administrative hearing right exists. (1) A party has a right to a hearing only if a law or program rule gives that right. If the party 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 WAC 182-16-030 (2)(b), 182-16-032(7), 182-16-035(4), 182-16-036 (1)(b), (3)(b), (4)(b), or 182-16-038(2); and

(b) A hearing of the PEBB appeals committee's written decision has been timely requested pursuant to 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.

NEW SECTION

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 must attend or participate in any scheduled prehearing conference. If the party requesting the hearing 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 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 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 date of the order. The presiding officer must mail 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.

NEW SECTION

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 request a dispositive motion hearing by filing a written dispositive motion with the presiding officer and mailing 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 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), any response to that motion(s), and argument on the motion(s). Prior to rescheduling any necessary hearings, the presiding officer must mail a written order on the dispositive motion(s).

(8) The presiding officer must mail the written order on the dispositive motion(s) 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 WAC 182-16-105 and 182-16-110.

NEW SECTION

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 subsections (3) through (7) of this section.

(3) If the presiding officer enters and mails an order dismissing the hearing, the party that originally requested the hearing 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 notice of a prehearing conference 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 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.

NEW SECTION

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 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.

NEW SECTION

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 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 a written order dismissing the case. If a hearing request is withdrawn, the party will not be able to request another administrative hearing on the same PEBB appeals committee decision.

(4) If a party withdraws an administrative hearing request, the order of dismissal may only be vacated (set aside) according to WAC 182-16-090.

NEW SECTION

WAC 182-16-100 Final order deadline—Required information. (1) Within ninety days after the hearing record is closed, the presiding officer shall mail a final order that shall be the final decision of the authority. The presiding officer shall mail 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.

NEW SECTION

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.

(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 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 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 presiding officer's notice in (c) of this subsection was mailed, or the response will not be considered.

(e) Responses to a motion for reconsideration must be mailed 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.

NEW SECTION

WAC 182-16-106 Decisions on motions for reconsideration. (1) Unless the motion for reconsideration is denied as untimely filed under WAC 182-16-105 (5)(a), the same presiding officer who entered the final order, if reasonably available, will also dispose of the motion as well as any responses received.

(2) The decision on the motion for reconsideration must be in the form of a written order denying the motion, or granting the motion and issuing a new written final order.

(3) If the presiding officer does not send an order on the motion for reconsideration within twenty calendar days of the date of the notice described in WAC 182-16-105 (5)(c), the motion is deemed denied.

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

(5) An order denying a motion for reconsideration is not subject to judicial review.

NEW SECTION

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 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 should consult RCW 34.05.510 through 34.05.598 for further details and requirements of the judicial review process.

NEW SECTION

WAC 182-16-130 Index of significant decisions. (1) A final decision may be relied upon, used, or cited as precedent by a party if the final order has been indexed in the authority's index of significant decisions in accordance with RCW 34.05.473 (1)(b).

(2) The index of significant decisions is available to the public at the health care authority (HCA) internet page. As decisions are indexed they will be linked on this page. For additional information on how to obtain a copy of the index, contact the HCA hearing representative.

(3) A final decision published in the index of significant decisions may be removed from the index when:

(a) A precedential published decision entered by the court of appeals or the supreme court reverses an indexed final decision; or

(b) HCA determines that the indexed final decision is no longer precedential due to changes in statute, rule or policy.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 182-16-060 Index of significant decisions.