

Chapter 182-08 WAC

PROCEDURES

WAC

182-08-010	Declaration of purpose.		18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.
182-08-015	Definitions.	182-08-110	Open enrollments. [Order 7228, § 182-08-110, filed 12/8/76.] Repealed by 96-08-042, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.
182-08-120	Employer contribution.		
182-08-180	Premium payments and premium refunds.		
182-08-190	The employer contribution is set by the HCA and paid to the HCA for all eligible employees.	182-08-111	Medical plan options between open enrollments. [Statutory Authority: Chapter 41.05 RCW. 81-03-014 (Order 1-81), § 182-08-111, filed 1/9/81; 79-11-064 (Order 2-79), § 182-08-111, filed 10/18/79.] Repealed by 91-20-163, filed 10/2/91, effective 11/2/91. Statutory Authority: Chapter 41.05 RCW.
182-08-196	What happens if my health plan becomes unavailable?		
182-08-197	When must newly eligible employees, or employees who regain eligibility for the employer contribution, select public employees benefits board (PEBB) benefits and complete enrollment forms?	182-08-125	PEBB-sponsored medical and dental benefit is limited to one enrollment per individual member. [Statutory Authority: RCW 41.05.160 and 41.05.165. 03-17-031 (Order 02-07), § 182-08-125, filed 8/14/03, effective 9/14/03. Statutory Authority: RCW 41.05.160 and 41.05.065. 01-24-048 (Order 01-05), § 182-08-125, filed 11/29/01, effective 12/30/01.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.
182-08-198	When may a subscriber change health plans?		
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)?		
182-08-200	Which employing agency is responsible to pay the employer contribution for eligible employees changing agency employment or for faculty employed by more than one institution of higher education?	182-08-130	New dependents' medical coverage after enrollment. [Order 7228, § 182-08-130, filed 12/8/76.] Repealed by Order 3-77, filed 11/17/77.
182-08-220	Advertising or promotion of PEBB benefit plans.		
182-08-235	Employer group application process.	182-08-140	New dependents' life coverage after enrollment. [Order 7228, § 182-08-140, filed 12/8/76.] Repealed by 84-09-043 (Resolution No. 2-84), filed 4/16/84. Statutory Authority: Chapter 41.05 RCW.
182-08-237	May a local government entity or tribal government entity applying for participation in public employees benefits board (PEBB) insurance coverage include their retirees?	182-08-150	Reduction or cancellation of optional insurance coverages. [Order 3-77, § 182-08-150, filed 11/17/77; Order 7228, § 182-08-150, filed 12/8/76.] Repealed by 84-09-043 (Resolution No. 2-84), filed 4/16/84. Statutory Authority: Chapter 41.05 RCW.
182-08-240	How will the health care authority (HCA) decide to approve or deny an employer group application?		
182-08-245	Employer group participation requirements.	182-08-160	Group coverage when not in pay status. [Statutory Authority: RCW 41.05.160. 97-21-126, § 182-08-160, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-160, filed 3/29/96, effective 4/29/96; 93-23-065, § 182-08-160, filed 11/16/93, effective 12/17/93; 86-16-061 (Resolution No. 86-3), § 182-08-160, filed 8/5/86; 83-22-042 (Resolution No. 6-83), § 182-08-160, filed 10/28/83; 80-01-082 (Order 5-79), § 182-08-160, filed 12/27/79; 78-03-021 (Order 3-78), § 182-08-160, filed 2/14/78; Order 7228, § 182-08-160, filed 12/8/76.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.
DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER			
182-08-020	Duties and responsibilities. [Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-020, filed 3/29/96, effective 4/29/96; Order 7228, § 182-08-020, filed 12/8/76.] Repealed by 03-17-031 (Order 02-07), filed 8/14/03, effective 9/14/03. Statutory Authority: RCW 41.05.160 and 41.05.165.		
182-08-030	Scope and construction of terms. [Order 7228, § 182-08-030, filed 12/8/76.] Repealed by 96-08-042, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.		
182-08-040	Definitions. [Order 7228, § 182-08-040, filed 12/8/76.] Repealed by 96-08-042, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.	182-08-165	Other group coverage option. [Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-165, filed 3/29/96, effective 4/29/96. Statutory Authority: RCW 41.05.065. 89-05-013 (Resolution No. 89-1), § 182-08-165, filed 2/9/89.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.
182-08-060	Approval of health maintenance organization plans. [Statutory Authority: RCW 41.05.010 and 41.05.025. 87-21-069 (Resolution No. 87-6), § 182-08-060, filed 10/19/87; Order 7228, § 182-08-060, filed 12/8/76.] Repealed by 96-08-042, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.	182-08-170	Insurance status for a reverted employee. [Statutory Authority: Chapter 41.05 RCW. 86-16-061 (Resolution No. 86-3), § 182-08-170, filed 8/5/86; 78-02-015 (Order 2-78), § 182-08-170, filed 1/10/78; Order 7228, § 182-08-170, filed 12/8/76.] Repealed by 96-08-042, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.
182-08-080	Employee to elect option. [Order 7228, § 182-08-080, filed 12/8/76.] Repealed by 79-11-064 (Order 2-79), filed 10/18/79. Statutory Authority: Chapter 41.05 RCW.		
182-08-090	Transferred employee. [Order 3-77, § 182-08-090, filed 11/17/77; Order 7228, § 182-08-090, filed 12/8/76.] Repealed by 79-11-064 (Order 2-79), filed 10/18/79. Statutory Authority: Chapter 41.05 RCW.	182-08-175	Group coverage while on family and medical leave. [Statutory Authority: RCW 41.05.160 and 41.05.165. 03-17-031 (Order 02-07), § 182-08-175, filed 8/14/03, effective 9/14/03. Statutory Authority: RCW 41.05.160. 97-21-126, § 182-08-175, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. 93-23-065, § 182-08-175, filed 11/16/93, effective 12/17/93.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.
182-08-095	Waiver of coverage for active employees. [Statutory Authority: RCW 41.05.160 and 41.05.165. 03-17-031 (Order 02-07), § 182-08-095, filed 8/14/03, effective 9/14/03. Statutory Authority: RCW 41.05.160 and 41.05.065. 01-24-048 (Order 01-05), § 182-08-095, filed 11/29/01, effective 12/30/01. Statutory Authority: RCW 41.05.160. 99-19-029 (Order 99-03), § 182-08-095, filed 9/8/99, effective 10/9/99; 97-21-126, § 182-08-095, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-095, filed 3/29/96, effective 4/29/96.] Repealed by 04-	182-08-195	Retroactive employer and employee contributions restricted. [Statutory Authority: Chapter 41.05 RCW. 84-09-043 (Resolution No. 2-84), § 182-08-195, filed 4/16/84.] Repealed by 96-08-042, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.

- 182-08-210 Termination of employer paid insurance benefit programs. [Statutory Authority: RCW 41.05.160 and 41.05.165. 03-17-031 (Order 02-07), § 182-08-210, filed 8/14/03, effective 9/14/03. Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-210, filed 3/29/96, effective 4/29/96; Order 3-77, § 182-08-210, filed 11/17/77.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.
- 182-08-230 Participation in PEBB benefits by employer groups, including K-12 school districts and educational service districts. [Statutory Authority: RCW 41.05.160. 09-23-102 (Order 09-02), § 182-08-230, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-08-230, filed 10/1/08, effective 1/1/09; 07-20-129 (Order 07-01), § 182-08-230, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-08-230, filed 8/26/04, effective 1/1/05.] Repealed by 12-20-022 (Order 2012-01), filed 9/25/12, effective 11/1/12. Statutory Authority: RCW 41.05.-160.
- 182-08-300 Criteria for selection of insurance company for automobile and homeowners insurance. [Statutory Authority: Chapter 41.05 RCW. 81-03-014 (Order 1-81), § 182-08-300, filed 1/9/81.] Repealed by 96-08-042, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.

WAC 182-08-010 Declaration of purpose. The general purpose of this chapter is to establish a set of rules to administer the health care authority's (HCA) public employees benefits board (PEBB) employee and retiree eligibility and PEBB benefits.

[Statutory Authority: RCW 41.05.160. 07-20-129 (Order 07-01), § 182-08-010, filed 10/3/07, effective 11/3/07. Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-010, filed 3/29/96, effective 4/29/96; Order 7228, § 182-08-010, filed 12/8/76.]

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

"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 their dependent under COBRA. It does not include an employer's retiree coverage, with the exception of a federal retiree plan.

"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 by a retiree or eligible survivor.

"Dependent" means a person who meets eligibility requirements in WAC 182-12-260.

"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.

"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, 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; 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.

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

"Health plan" or "plan" means a medical or dental plan 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, 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.

"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.

"Open enrollment" means a time period when: Subscribers may apply to transfer their enrollment from one health plan to another; a dependent may be enrolled; a dependent may be removed from coverage; or an employee who previously waived medical may enroll in medical. Open enrollment is also the time when employees may enroll in or change their election under the DCAP, the medical FSA, or the premium payment plan. An "annual" open enrollment, designated by the director, is an open enrollment when all PEBB subscribers may make enrollment changes for the

upcoming year. A "special" open enrollment is triggered by a specific life event. For special open enrollment events as they relate to specific PEBB benefits, see WAC 182-08-198, 182-08-199, 182-12-128, 182-12-262.

"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.

"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.

"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.

"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.

"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 under WAC 182-12-128, or is on approved educational leave and obtains comprehensive group health plan coverage as allowed under WAC 182-12-136.

[Statutory Authority: RCW 41.05.160, 12-20-022 (Order 2012-01), § 182-08-015, filed 9/25/12, effective 11/1/12. Statutory Authority: RCW 41.05.160 and 2011 c 8, 11-22-036 (Order 11-02), § 182-08-015, filed

(9/25/12)

10/26/11, effective 1/1/12. Statutory Authority: RCW 41.05.160, 10-20-147 (Order 10-02), § 182-08-015, filed 10/6/10, effective 1/1/11; 09-23-102 (Order 09-02), § 182-08-015, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-08-015, filed 10/1/08, effective 1/1/09; 07-20-129 (Order 07-01), § 182-08-015, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.068, 06-23-165 (Order 06-09), § 182-08-015, filed 11/22/06, effective 12/23/06. Statutory Authority: RCW 41.05.160 and 41.05.165, 04-18-039, § 182-08-015, filed 8/26/04, effective 1/1/05; 03-17-031 (Order 02-07), § 182-08-015, filed 8/14/03, effective 9/14/03. Statutory Authority: Chapter 41.05 RCW, 96-08-042, § 182-08-015, filed 3/29/96, effective 4/29/96.]

WAC 182-08-120 Employer contribution. The employers' contribution must be used to provide insurance coverage for the basic life insurance benefit, the basic long-term disability insurance benefit, medical, and dental, and to establish a reserve for any remaining balance. There is no employer contribution available for any other insurance coverage for employees employed by state agencies.

[Statutory Authority: RCW 41.05.160, 12-20-022 (Order 2012-01), § 182-08-120, filed 9/25/12, effective 11/1/12; 09-23-102 (Order 09-02), § 182-08-120, filed 11/17/09, effective 1/1/10; 07-20-129 (Order 07-01), § 182-08-120, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.165, 03-17-031 (Order 02-07), § 182-08-120, filed 8/14/03, effective 9/14/03. Statutory Authority: Chapter 41.05 RCW, 96-08-042, § 182-08-120, filed 3/29/96, effective 4/29/96; 86-16-061 (Resolution No. 86-3), § 182-08-120, filed 8/5/86; 83-22-042 (Resolution No. 6-83), § 182-08-120, filed 10/28/83; Order 3-77, § 182-08-120, filed 11/17/77; Order 7228, § 182-08-120, filed 12/8/76.]

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

Premium payments. Public employees benefits board (PEBB) premiums begin to accrue the first of the month in which PEBB insurance coverage is effective.

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

(1) A newly eligible employee must complete the appropriate enrollment forms to enroll or waive coverage within thirty-one days after becoming eligible as described in WAC 182-08-197.

(a) If an employing agency does not notify an employee of his or her eligibility for benefits, as required in WAC 182-12-113, until after the thirty-one-day period has expired, the employing agency must:

(i) Notify the employee of his or her eligibility for PEBB benefits as described in WAC 182-08-197(3); and

(ii) Remit both the employer contribution and the employee contribution for medical premiums from the date benefits begin as described in WAC 182-12-114 to the health care authority (HCA). A state agency may not collect from the employee any portion of the medical premium for months prior to the state agency's notification to the employee.

(b) If an employing agency fails to enroll an employee as required in WAC 182-08-197, the employing agency must:

(i) Correct the enrollment error; and

(ii) Remit both the employer contribution and the employee contribution for medical premiums due for insurance coverage from the date PEBB benefits begin as described in WAC 182-12-114 to the HCA. A state agency may only collect the employee contribution for medical premiums for the three months prior to the month the state agency corrects the error.

(c) If an employee elects optional coverage described in WAC 182-08-197 (2)(a) or (b), the employee is responsible for premiums from the month that the optional coverage begins.

Premium refunds. PEBB premiums will be refunded using the following method:

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

(3) If a PEBB subscriber, dependent, or beneficiary submits a written appeal as described in WAC 182-16-025, the PEBB assistant director or the PEBB appeals committee may approve a refund which does not exceed twelve months of premium. The written appeal must provide proof of the following:

Extraordinary circumstances beyond the control of the subscriber, dependent or beneficiary made it virtually impossible to submit the necessary information to accomplish an enrollment change within sixty days after the event that created a change of premium.

(4) 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 assistant director or designee.

(5) Accounts reflecting an underpayment to HCA must be paid, and are due from the employing agency, subscriber or beneficiary to the HCA. Upon request, the HCA may develop a repayment plan designed to reduce hardship.

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

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

[Statutory Authority: RCW 41.05.160. 12-20-022 (Order 2012-01), § 182-08-180, filed 9/25/12, effective 11/1/12. Statutory Authority: RCW 41.05.160 and 2011 c 8. 11-22-036 (Order 11-02), § 182-08-180, filed 10/26/11, effective 1/1/12. Statutory Authority: RCW 41.05.160. 10-20-147 (Order 10-02), § 182-08-180, filed 10/6/10, effective 1/1/11; 09-23-102 (Order 09-02), § 182-08-180, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-08-180, filed 10/1/08, effective 1/1/09; 07-20-129 (Order 07-01), § 182-08-180, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-08-180, filed 8/26/04, effective 1/1/05; 03-17-031 (Order 02-07), § 182-08-180, filed 8/14/03, effective 9/14/03. Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-180, filed 3/29/96, effective 4/29/96; Order 01-77, § 182-08-180, filed 8/26/77.]

WAC 182-08-190 The employer contribution is set by the HCA and paid to the HCA for all eligible employees. State agencies and employer groups that participate in the PEBB program under contract with the 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. 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 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.

[Statutory Authority: RCW 41.05.160. 09-23-102 (Order 09-02), § 182-08-190, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-08-190, filed 10/1/08, effective 1/1/09; 07-20-129 (Order 07-01), § 182-08-190, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-08-190, filed 8/26/04, effective 1/1/05; 03-17-031 (Order 02-07), § 182-08-190, filed 8/14/03, effective 9/14/03. Statutory Authority: RCW 41.05.160. 02-18-088 (Order 02-03), § 182-08-190, filed 9/3/02, effective 10/4/02. Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-190, filed 3/29/96, effective 4/29/96; 93-23-065, § 182-08-190, filed 11/16/93, effective 12/17/93; 78-02-015 (Order 2-78), § 182-08-190, filed 1/10/78; Order 3-77, § 182-08-190, filed 11/17/77.]

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

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

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

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

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

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

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

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

[Statutory Authority: RCW 41.05.160 and 2011 c 8. 11-22-036 (Order 11-02), § 182-08-196, filed 10/26/11, effective 1/1/12. Statutory Authority: RCW 41.05.160. 10-20-147 (Order 10-02), § 182-08-196, filed 10/6/10, effective 1/1/11; 09-23-102 (Order 09-02), § 182-08-196, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-08-196, filed 10/1/08, effective 1/1/09; 07-20-129 (Order 07-01), § 182-08-196, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160, 41.05.350, and 41.05.165. 05-16-046 (Order 05-01), § 182-08-196, filed 7/27/05, effective 8/27/05. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-08-196, filed 8/26/04, effective 1/1/05; 03-17-031 (Order 02-07), § 182-08-196, filed 8/14/03, effective 9/14/03.]

WAC 182-08-197 When must newly eligible employees, or employees who regain eligibility for the employer contribution, select public employees benefits board (PEBB) benefits and complete enrollment forms? (1)

Employees who are newly eligible for PEBB benefits must complete the appropriate forms indicating enrollment and their health plan choice, or their decision to waive medical under WAC 182-12-128. Employees must return the forms to their employing agency no later than thirty-one days (sixty days for life insurance) after they become eligible for PEBB benefits under WAC 182-12-114. Newly eligible employees who do not return enrollment forms to their employing agency indicating their medical, dental and LTD choice within thirty-one days and life insurance choice within sixty days will be enrolled as follows:

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

(b) Dental enrollment (if the employer group participates in PEBB dental) will be Uniform Dental Plan;

(c) Basic life insurance (unless the employing agency does not participate in this PEBB insurance coverage);

(d) Basic long-term disability insurance (unless the employing agency does not participate in this PEBB insurance coverage); and

(e) Dependents will not be enrolled.

(2) Employees who are newly eligible may enroll in optional insurance coverage (except for employees of employer groups that do not participate in life insurance or long-term disability insurance).

(a) To enroll in the amounts of optional life insurance available without health underwriting, employees must return a completed life insurance enrollment form to their employing agency no later than sixty days after becoming eligible for PEBB benefits.

(b) To enroll in optional long-term disability insurance without health underwriting, employees must return a completed long-term disability enrollment form to their employing agency no later than thirty-one days after becoming eligible for PEBB benefits.

(c) Employees may apply for optional life and optional long-term disability insurance at any time by providing evidence of insurability and receiving approval from the contracted vendor.

(3) If an employing agency does not notify a newly eligible employee of his or her eligibility for PEBB benefits, as required in WAC 182-12-113, until after the thirty-one-day period described in subsection (1) of this section has expired, then the following must occur:

(a) The employing agency must notify the employee of his or her eligibility for PEBB benefits and his or her requirement to complete and return enrollment forms.

(b) The employee must complete and return the appropriate forms as follows:

(i) An enrollment form indicating enrollment and health plan choice (if applicable indicating a decision to waive medical) no later than thirty-one days from the date of the employing agency's notice to the employee;

(ii) To enroll in optional coverage, a life insurance enrollment form no later than sixty days from the date of the employing agency's notice to the employee and a long-term disability insurance enrollment form no later than thirty-one days from the date of the employing agency's notice to the employee.

(c) Employees who do not return the appropriate forms to their employing agency indicating their medical and dental choice will be enrolled in a health plan according to subsection (1)(a), (b), and (c) of this section.

(d) Employees who do not return the appropriate forms to their employing agency indicating optional coverage elections, are not eligible to enroll in optional coverage, except as described in subsection (2)(c) of this section.

(4) Employees who are eligible to participate in the state's salary reduction plan (see WAC 182-12-116) 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, new employees must complete the appropriate form and return it to their state agency no later than thirty-one days after they become eligible for PEBB benefits.

(5) Employees who are eligible to participate in the state's salary reduction plan may enroll in the state's medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP) or both. To enroll in these optional PEBB benefits, employees must return the appropriate enrollment forms to their state agency or PEBB designee no later than thirty-one days after becoming eligible for PEBB benefits.

(6) The employer contribution toward insurance coverage ends according to WAC 182-12-131. Employees who become newly eligible for the employer contribution enroll as described in subsections (1) and (2) of this section, with the following exceptions in which insurance coverage elections stay the same:

(a) When an employee transfers from one employing agency to another employing agency without a break in state service. This includes movement of employees between any entities described in WAC 182-12-111 and participating in PEBB benefits.

(b) When employees have a break in state service that does not interrupt their employer contribution toward PEBB insurance coverage.

(c) When employees continue insurance coverage by self-paying the full premium under WAC 182-12-133(1) or 182-12-142 and regain eligibility for the employer contribution before the end of the maximum number of months allowed for continuing PEBB health plan enrollment under those rules. Employees who are eligible to continue optional life or optional long-term disability under continuation coverage but discontinue that insurance coverage are subject to the insurance underwriting requirements if they apply for the insurance when they return to work or regain eligibility for the employer contribution.

(7) When an employee's employment ends, participation in the state's salary reduction plan ends. If the employee 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.

[Statutory Authority: RCW 41.05.160, 12-20-022 (Order 2012-01), § 182-08-197, filed 9/25/12, effective 11/1/12. Statutory Authority: RCW 41.05.160 and 2011 c 8, 11-22-036 (Order 11-02), § 182-08-197, filed 10/26/11, effective 1/1/12. Statutory Authority: RCW 41.05.160, 10-20-147 (Order 10-02), § 182-08-197, filed 10/6/10, effective 1/1/11; 09-23-102 (Order 09-02), § 182-08-197, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-08-197, filed 10/1/08, effective 1/1/09; 07-20-129 (Order 07-01), § 182-08-197, filed 10/3/07, effective 11/3/07; 06-11-156 (Order 06-02), § 182-08-197, filed 5/24/06, effective 6/24/06. Statutory Authority: RCW 41.05.160, 41.05.350, and 41.05.165, 05-16-046 (Order 05-01), § 182-08-197, filed 7/27/05, effective 8/27/05.]

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 annual open enrollment. The subscriber must submit the appropriate enrollment forms to change health plan no later than the end 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 the event that creates the special open enrollment for either the subscriber, the subscriber's dependent or both. To make a health plan change, the subscriber must submit the appropriate enrollment forms (and a completed disenrollment form, if required) 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. Insurance coverage in the new health plan will begin the first day of the month following the later of the event date or the date the form is received. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, insurance 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 the employer contribution toward group health coverage;

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

(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 eligible for state premium assistance through 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 entitled to medicare, enrolls in or disenrolls from 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;

(h) 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;

(i) Subscriber or 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.

[Statutory Authority: RCW 41.05.160, 12-20-022 (Order 2012-01), § 182-08-198, filed 9/25/12, effective 11/1/12. Statutory Authority: RCW 41.05.160 and 2011 c 8, 11-22-036 (Order 11-02), § 182-08-198, filed 10/26/11, effective 1/1/12. Statutory Authority: RCW 41.05.160, 10-20-147 (Order 10-02), § 182-08-198, filed 10/6/10, effective 1/1/11; 09-23-102 (Order 09-02), § 182-08-198, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-08-198, filed 10/1/08, effective 1/1/09; 08-09-027 (Order 08-01), § 182-08-198, filed 4/8/08, effective 4/9/08; 07-20-129 (Order 07-01), § 182-08-198, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.068, 06-23-165 (Order 06-09), § 182-08-198, filed 11/22/06, effective 12/23/06. Statutory Authority: RCW 41.05.160, 41.05.350, and 41.05.165, 05-16-046 (Order 05-01), § 182-08-198, filed 7/27/05, effective 8/27/05.]

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 eligible employee (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 they are newly eligible under WAC 182-12-114, as described in WAC 182-08-197.

(2) **During annual open enrollment:** An eligible employee (as described in WAC 182-12-116) may enroll in or change their election under the state's premium payment plan, medical FSA or DCAP during the annual open enrollment. Employees must submit, in paper or online, the appropriate enrollment form to enroll or reenroll 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:** Employees may enroll or change their 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 enrollment 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 appropriate forms as instructed on the forms no later than sixty days after the event occurs.

For purposes of this section, an eligible dependent includes any person who qualifies as a dependent of the employee for tax purposes under IRC 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. Enrollment will be effective the first day of the month following the later of the event date or the date the form is received.

(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 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 the employer contribution toward group health coverage;

(v) Employee or an employee's dependent has a change in enrollment under another employer 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;

(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 employee's dependent becomes eligible for state premium assistance through medicaid or a state children's health insurance program (CHIP), or the employee or employee's dependent loses eligibility for coverage under medicaid or CHIP;

(x) Employee or employee's dependent gains or loses eligibility for medicare;

(xi) Employee or 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;

(xii) Employee or 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:

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

(B) Transplant within the last twelve months; or

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

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

(E) 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. Enrollment will be effective the first day of the month following approval by the FSA administrator.

(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 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 has a change in employment status that affects the employee's or a dependent's eligibility for the FSA;

(iv) 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);

(v) Employee or an employee's dependent loses eligibility for coverage under medicaid or a state children's health insurance program (CHIP);

(vi) Employee or an employee's dependent gains or loses eligibility for 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. Enrollment will be effective

the first day of the month following approval by the DCAP administrator.

(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 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 (a)(1) through (8), incorporating the rules of Section 152 (b)(1) and (2) of the IRC.

[Statutory Authority: RCW 41.05.160, 12-20-022 (Order 2012-01), § 182-08-199, filed 9/25/12, effective 11/1/12. Statutory Authority: RCW 41.05-160 and 2011 c 8, 11-22-036 (Order 11-02), § 182-08-199, filed 10/26/11, effective 1/1/12. Statutory Authority: RCW 41.05.160, 10-20-147 (Order 10-02), § 182-08-199, filed 10/6/10, effective 1/1/11; 09-23-102 (Order 09-02), § 182-08-199, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-08-199, filed 10/1/08, effective 1/1/09.]

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 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 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 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 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 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.

[Statutory Authority: RCW 41.05.160. 09-23-102 (Order 09-02), § 182-08-200, filed 11/17/09, effective 1/1/10; 07-20-129 (Order 07-01), § 182-08-200, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-08-200, filed 8/26/04, effective 1/1/05. Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-200, filed 3/29/96, effective 4/29/96; Order 3-77, § 182-08-200, filed 11/17/77.]

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

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

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

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

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

[Statutory Authority: RCW 41.05.160. 07-20-129 (Order 07-01), § 182-08-220, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160

(9/25/12)

and 41.05.165. 03-17-031 (Order 02-07), § 182-08-220, filed 8/14/03, effective 9/14/03. Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-220, filed 3/29/96, effective 4/29/96; 91-20-163, § 182-08-220, filed 10/2/91, effective 11/2/91; 86-16-061 (Resolution No. 86-3), § 182-08-220, filed 8/5/86.]

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). The authority will approve or deny the application through the evaluation criteria described in WAC 182-08-240. To apply, the employer group 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.

(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 insurance or medical, dental, life and LTD insurance.

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

(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. 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 greater than three hundred but less than twenty-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 twenty-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.

[Statutory Authority: RCW 41.05.160, 12-20-022 (Order 2012-01), § 182-08-235, filed 9/25/12, effective 11/1/12.]

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

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

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

(b) Eligibility for coverage under the local government's or tribal government's retiree health plan must have required

immediate enrollment in retiree health plan coverage upon termination of employee coverage; and

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

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

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

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

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

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

[Statutory Authority: RCW 41.05.160, 12-20-022 (Order 2012-01), § 182-08-237, filed 9/25/12, effective 11/1/12.]

WAC 182-08-240 How will the health care authority (HCA) decide to approve or deny an employer group application? Employer group applications for participation in insurance coverage provided through the public employees benefits board (PEBB) program are approved or denied by the health care authority (HCA) based upon the information and documents submitted by the employer group and the employer group evaluation (EGE) criteria described in this rule. The authority may automatically deny an employer group application if the employer group fails to provide the required information and documents described in WAC 182-08-235.

(1) Employer groups are evaluated as a single unit. To support this requirement the employer group must provide census data for all employees eligible to participate under the employer group's current health plan.

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

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

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

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

(ii) The member level census file demographic data must indicate a relative underwriting factor that is equal to or better than the relative underwriting factor for the nonmedicare PEBB risk pool as determined by the authority.

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

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

(i) The member level census file demographic data must indicate a relative underwriting factor that is equal to or better than the relative underwriting factor for the nonmedicare PEBB risk pool as determined by the authority;

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

- The frequency of large claims must be less than or equal to the historical benchmark frequency for the PEBB nonmedicare population; and

- The ongoing large claims management report must demonstrate that the frequency of ongoing large claims is less than or equal to the recurring benchmark frequency for the PEBB nonmedicare population.

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

(i) The member level census file demographic data must indicate a relative underwriting factor that is equal to or better than the relative underwriting factor for the nonmedicare PEBB risk pool as determined by the authority;

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

- The frequency of large claims must be less than or equal to the PEBB historical benchmark frequency for the PEBB nonmedicare population;

- The ongoing large claims management report must demonstrate that the frequency of ongoing large claims is less than or equal to the recurring benchmark frequency for the PEBB nonmedicare population;

(iii) Provide an executive summary of benefits;

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

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

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

(4) The group evaluation for a jumbo group is valid for two years after approval by the authority. If an employer group applies to add additional bargaining units after two years the group must be reevaluated.

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

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

[Statutory Authority: RCW 41.05.160, 12-20-022 (Order 2012-01), § 182-08-240, filed 9/25/12, effective 11/1/12.]

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 PEBB 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.

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.

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 COBRA 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 cease to be eligible under WAC 182-12-171, but may continue health plan enrollment under COBRA (see WAC 182-12-146).

[Statutory Authority: RCW 41.05.160. 12-20-022 (Order 2012-01), § 182-08-245, filed 9/25/12, effective 11/1/12.]