

Title 182 WAC

HEALTH CARE AUTHORITY

Chapters

182-08	Procedures.
182-12	Eligible and noneligible employees.
182-16	Practice and procedure.
182-25	Washington basic health plan.
182-50	Prescription drug programs.

Chapter 182-08 WAC PROCEDURES

WAC

182-08-010	Declaration of purpose.
182-08-015	Definitions.
182-08-120	Employer contribution.
182-08-180	Premium payments and refunds.
182-08-190	The employer contribution is set by the HCA and paid to the HCA for all eligible employees.
182-08-196	What happens if my health plan becomes unavailable?
182-08-197	Employees must select insurance coverages within thirty-one days of the date they become eligible for PEBB benefits.
182-08-198	When may a subscriber change health plans?
182-08-200	Which employing agency is responsible to pay the employer contribution for eligible employees changing agency employment?
182-08-220	Advertising or promotion of PEBB benefit plans.
182-08-230	Participation in PEBB benefits by employer groups, K-12 school districts and educational service districts.

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:

"Administrator" means the administrator of the health care authority (HCA) or designee.

"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.

"Creditable coverage" means coverage that meets the definition of "creditable coverage" under RCW 48.66.020 (13)(a) and includes payment of medical and hospital benefits.

"Defer" means to postpone enrollment or interrupt enrollment in PEBB medical insurance by a retiree or eligible survivor.

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

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

"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.

"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.

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

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

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

"Open enrollment" means a time period designated by the administrator when subscribers may apply to transfer their enrollment from one health plan to another, enroll in medical if the subscriber had previously waived such insurance coverage, or add dependents.

"PEBB" means the public employees benefits board.

"PEBB benefits" means one or more insurance coverage or other employee benefit administered by the PEBB benefits services program within the HCA.

"PEBB benefits services program" means the program within the health care authority which administers insurance and other benefits to eligible employees of the state (as defined in WAC 182-12-115), eligible retired and disabled employees of the state (as defined in WAC 182-12-171), and others as defined in RCW 41.05.011.

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

"Waive" means to interrupt enrollment or postpone enrollment in a PEBB health plan by an employee (as defined in WAC 182-12-115) or a dependent who meets eligibility requirements in WAC 182-12-260.

[Statutory Authority: RCW 41.05.160. 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, a basic long-term disability benefit, medical, and dental, and to establish a

reserve for any remaining balance. There is no employer contribution available for any other insurance coverage.

[Statutory Authority: RCW 41.05.160. 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 refunds.

PEBB premium payments for retiree, COBRA or an extension of PEBB insurance coverage begin to accrue the first of the month of PEBB insurance coverage. The effective date of health plan enrollment will be retroactive to the loss of other coverage.

Premium is due for the entire month of insurance coverage and will not be prorated during the month of death or loss of eligibility of the enrollee except when eligible for life insurance conversion.

PEBB premiums will be refunded using the following method:

(1) When a PEBB subscriber submits an enrollment change affecting eligibility, such as for example: Death, divorce, or when no longer a dependent as defined at WAC 182-12-260 no more than three months of accounting adjustments and any excess premium paid will be refunded to any individual or agency except as indicated in WAC 182-12-148(3).

(2) Notwithstanding subsection (1) of this section, the PEBB assistant administrator or designee may approve a refund which does not exceed twelve months of premium if both of the following occur:

(a) The PEBB subscriber or a dependent or beneficiary of a subscriber submits a written appeal to the HCA; and

(b) Proof is provided that 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.

(3) Errors resulting in an underpayment to HCA must be reimbursed by the employer or subscriber to the HCA. Upon request of an employer, subscriber, or beneficiary, as appropriate, the HCA will develop a repayment plan designed not to create undue hardship on the employer or subscriber.

(4) HCA errors will be adjusted by returning the excess premium paid, if any, to the employer, subscriber, or beneficiary, as appropriate.

[Statutory Authority: RCW 41.05.160. 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. Every department, division, or agency of state government, and such county, municipal or other political subdivision, K-12 school district or educational service district that are covered under PEBB insurance coverage, must pay pre-

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

(1) Employer contributions are set by the HCA and are subject to the approval of the governor.

(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 eligible employee in pay status eight or more hours during a calendar month or each eligible employee 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) PEBB insurance coverage for any county, municipality or other political subdivision or any K-12 school district or educational service district may be canceled by HCA if the premium contributions are delinquent more than ninety days.

(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 182-12-115.

[Statutory Authority: RCW 41.05.160. 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? Employees and retirees for whom the chosen health plan becomes unavailable due to a change in contracting service area, or the retiree's entitlement to Medicare must select a new health plan within sixty days after notification by the PEBB benefits services program.

(1) Employees who fail to select a new medical or dental plan within the prescribed time period will be enrolled in a successor plan if one is available or will be enrolled in the Uniform Medical Plan Preferred Provider Organization or the Uniform Dental Plan with existing dependent enrollment.

(2) Retirees and survivors eligible under WAC 182-12-250 or 182-12-265 who fail to select a new health plan within the prescribed time period will be enrolled in a successor plan if one is available or will be enrolled in the Uniform Medical Plan Preferred Provider Organization and the Uniform Dental Plan. However, retirees enrolled in Medicare Parts A and B, and who enroll in Medicare Part D may be assigned to a PEBB Medicare plan that does not include a pharmacy benefit.

Any subscriber assigned to a health plan as described in this rule may not change health plans until the next open enrollment except as allowed in WAC 182-08-198.

(3) Enrollees continuing PEBB health plan enrollment under WAC 182-12-133, 182-12-148 or 182-12-270 (2) or (3) must select a new health plan no later than sixty days after notification by the PEBB benefits services program or their

health plan enrollment will end as of the last day of the month in which the plan is no longer available.

[Statutory Authority: RCW 41.05.160. 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 Employees must select insurance coverages within thirty-one days of the date they become eligible for PEBB benefits. (1) Employees who are newly eligible for PEBB benefits must complete an enrollment form indicating their health plan choice and return it to their employing agency no later than thirty-one days after they become eligible for PEBB benefits, as stated in WAC 182-12-115. Newly eligible employees who do not return an enrollment form to their employing agency indicating their medical and dental choice within thirty-one days will be enrolled in a health plan as follows:

(a) Medical enrollment will be Uniform Medical Plan Preferred Provider Organization; and

(b) Dental enrollment (if the employing agency participates in PEBB dental) will be Uniform Dental Plan.

(2) Newly eligible employees may enroll in optional insurance coverage (except for employees of agencies 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 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 agency no later than thirty-one days after becoming eligible for PEBB benefits.

(c) To enroll in long-term care insurance with limited health underwriting, employees must return a completed long-term care enrollment form to the contracted vendor no later than thirty-one days after becoming eligible for PEBB benefits.

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

(3) When an employee's employment ends, insurance coverage ends (WAC 182-12-131). Employees who are later reemployed and become newly eligible for PEBB benefits 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 agency to another agency without a break in state service. This includes movement of employees between any agencies described as eligible groups 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-based enrollment in PEBB insurance coverage.

(c) When employees continue insurance coverage under WAC 182-12-133 (1) or (2) and are reemployed into a benefits eligible position before the end of the maximum number of months allowed for continuing PEBB health plan enrollment. Employees who are eligible to continue optional life or optional long-term disability but discontinue that insurance coverage are subject to the insurance underwriting requirements if they apply for the insurance when they return to employment.

[Statutory Authority: RCW 41.05.160. 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? (1) Subscribers may change health plans during the annual open enrollment. The subscriber must request the health plan change no later than the end of the open enrollment period. Enrollment in the new health plan will begin the first day of January after open enrollment.

(2) Subscribers may change health plans outside of the annual open enrollment period under the circumstances indicated below. To make a health plan change, the subscriber must send a completed enrollment form (and a completed disenrollment form, if required) to the PEBB benefits services program no later than sixty days after the event occurs. Enrollment in the new health plan will begin the first day of the month after the PEBB benefits services program receives the form(s). These are the circumstances:

(a) Enrollees move and their current health plan is not available in their new location. If the subscriber does not select a new health plan, the PEBB benefits services program may enroll them in the Uniform Medical Plan Preferred Provider Organization or Uniform Dental Plan.

(b) Enrollees move and a health plan that was not available to them before is available to them in the new location. The subscriber may only choose a newly available health plan.

(c) Subscribers may change health plans if a court order requires the subscriber to provide insurance coverage for an eligible spouse, qualified domestic partner, or child and the subscriber adds the dependent to their insurance coverage.

(d) Seasonal employees whose off-season is during the annual open enrollment period may select a new health plan upon their return to work.

(e) Subscribers may change health plans when they enroll in PEBB retiree insurance coverage.

(f) Subscribers may change health plans when they or an eligible dependent becomes entitled to Medicare or enrolls in a Medicare Part D plan.

(g) Subscribers may not change their health plan if their or an enrolled dependent's physician stops participation with the subscriber's health plan unless the PEBB appeals manager determines that a continuity of care issue exists. However, 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. The PEBB appeals manager will use criteria that include but are not limited to the following in determining if a continuity of care issue exists:

- (i) Active cancer treatment; or
- (ii) Recent transplant (within the last twelve months); or
- (iii) Scheduled surgery within the next sixty days; or
- (iv) Major surgery within the previous sixty days; or
- (v) Third trimester of pregnancy; or
- (vi) Language barrier.

[Statutory Authority: RCW 41.05.160. 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 182-08-200 Which employing agency is responsible to pay the employer contribution for eligible employees changing agency employment? When an eligible employee's employment ceases 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.

[Statutory Authority: RCW 41.05.160. 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 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 182-08-230 Participation in PEBB benefits by employer groups, K-12 school districts and educational service districts. This section applies to all employer groups, K-12 school districts and educational service districts participating in PEBB insurance coverage.

(1) For purposes of this section, "employer group" means those employee organizations representing state civil

service employees, blind vendors, county, municipality, and political subdivisions that meet the participation requirements of WAC 182-12-111 (2), (3) and (4) and that participate in PEBB insurance coverage.

(2)(a) Each employer group must determine an employee's eligibility for PEBB insurance coverage in accordance with the applicable sections of chapter 182-12 WAC, RCW 41.04.205, and chapter 41.05 RCW.

(b) Each employer group, K-12 school district and educational service district applying for participation in PEBB insurance coverage must submit required documentation and meet all participation requirements in the then-current *Introduction to PEBB Coverage K-12 and Employer Groups* booklet(s).

(3)(a) Each employer group, K-12 school district or educational service district applying for participation in PEBB insurance coverage must sign an interlocal agreement with the HCA.

(b) Each interlocal agreement must be renewed no less frequently than once in every two-year period.

(4) At least twenty days before the premium due date, the HCA will cause each employer group, K-12 school district or educational service district to be sent a monthly billing statement. The statement of premium due will be based upon the enrollment information provided by the employer group, K-12 school district or educational service district.

(a) Changes in enrollment status must be submitted to the HCA before the twentieth day of the month when the change occurs. Changes submitted after the twentieth day of each month may not be reflected on the billing statement until the following month.

(b) Changes submitted more than one month late must be accompanied by a full explanation of the circumstances of the late notification.

(5) An employer group, K-12 school district or educational service district must remit the monthly premium as billed or as reconciled by it.

(a) If an employer group, K-12 school district or educational service district determines that the invoiced amount requires one or more changes, they may adjust the remittance only if an insurance eligibility adjustment form detailing the adjustment accompanies the remittance. The proper form for reporting adjustments will be attached to the interlocal agreement as Exhibit A.

(b) Each employer group, K-12 school district or educational service district is solely responsible for the accuracy of the amount remitted and the completeness and accuracy of the insurance eligibility adjustment form.

(6) Each employer group, K-12 school district or educational service district must remit the entire monthly premium due including the employee share, if any. The employer group, K-12 school district or educational service district is solely responsible for the collection of any employee share of the premium. The employer must not withhold portions of the monthly premium due because it has failed to collect the entire employee share.

(7) Nonpayment of the full premium when due will subject the employer group, K-12 school district or educational service district to disenrollment and termination of each employee of the group.

Chapter 182-12 WAC

ELIGIBLE AND NONELIGIBLE EMPLOYEES

WAC

182-12-108	Purpose.
182-12-109	Definitions.
182-12-111	Eligible entities and individuals.
182-12-112	Insurance eligibility for higher education.
182-12-115	Eligible employees.
182-12-116	Who is eligible for the PEBB flexible spending account plan?
182-12-123	Dual enrollment is prohibited.
182-12-128	When may an employee waive health plan enrollment for their self or their eligible dependent?
182-12-131	When does employer paid insurance coverage end?
182-12-133	What options for continuing coverage are available to employees when they are no longer eligible for PEBB insurance coverage paid for by their employer?
182-12-136	May an employee on approved educational leave waive PEBB health plan coverage?
182-12-138	If an employee is approved for family and medical leave, what insurance coverage may be continued?
182-12-141	If I revert from an eligible position to an ineligible position what happens to my insurance coverage?
182-12-146	Continuing health plan coverage under COBRA.
182-12-148	May an employee continue PEBB insurance coverage during their appeal of dismissal?
182-12-171	When are retiring employees eligible to enroll in retiree insurance?
182-12-175	May a local government entity applying for participation in PEBB insurance coverage include their retirees in the transfer unit?
182-12-200	May a retiree who is enrolled as a dependent in a PEBB health plan or a Washington state K-12 school district sponsored health plan defer enrollment in a PEBB retiree health plan?
182-12-205	May a retiree defer enrollment in a PEBB health plan at or after retirement?
182-12-207	When can a retiree or eligible dependent's insurance coverage be canceled by HCA?
182-12-208	May a retiree enroll only in dental?
182-12-209	Who is eligible for retiree life insurance?
182-12-211	If department of retirement systems makes a formal determination of retroactive eligibility, may the retiree enroll in PEBB retiree insurance coverage?
182-12-250	Insurance coverage eligibility for survivors of emergency service personnel killed in the line of duty.
182-12-260	Who are eligible dependents?
182-12-265	What options for continuing health plan enrollment are available to widows, widowers and dependent children if the employee or retiree dies?
182-12-270	What options are available to dependents who cease to meet the eligibility criteria in WAC 182-12-260?

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

182-12-190	May a retiree change health carriers at retirement? [Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-190, filed 8/26/04, effective 1/1/05. Statutory Authority: Chapter 41.05 RCW. 80-05-016 (Order 2-80), § 182-12-190, filed 4/10/80; Order 4-77, § 182-12-190, filed 11/17/77.] Repealed by 07-20-129 (Order 07-01), filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160.
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WAC 182-12-108 Purpose. The purpose of this chapter is to establish eligibility criteria for and effective date of enrollment in the public employees benefits board (PEBB) approved benefits.

[Statutory Authority: RCW 41.05.160. 07-20-129 (Order 07-01), § 182-12-108, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-108, filed 8/26/04, effective 1/1/05.]

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

(a) Before termination for nonpayment of premium, the HCA will send a notice of overdue premium to the employer group, K-12 school district or educational service district which notice will provide a one-month grace period for payment of all overdue premium.

(b) An employer group, K-12 school district or educational service district that does not remit the entirety of its overdue premium no later than the last day of the grace period will be disenrolled effective the last day of the last month for which premium has been paid in full.

(c) Upon disenrollment, notification will be sent to both the employer group, K-12 school district or educational service district and each affected employee.

(d) Employer groups, K-12 school districts or educational service districts disenrolled due to nonpayment of premium have the right to a dispute resolution hearing in accordance with the terms of the interlocal agreement.

(e) Employees canceled due to the nonpayment of premium by the employer group, K-12 school district or educational service district are not eligible for continuation of group health plan coverage according to the terms of the Consolidated Omnibus Budget Reconciliation Act (COBRA). Employees whose coverage is canceled have conversion rights to an individual insurance policy as provided for by the employer group, K-12 school district or educational service district.

(f) Claims incurred by employees of a disenrolled group after the effective date of disenrollment will not be covered.

(g) The employer group, K-12 school district or educational service district is solely responsible for refunding any employee share paid by the employee to the employer group, K-12 school district or educational service district and not remitted to the HCA.

(8) A disenrolled employer group, K-12 school district or educational service district may apply for reinstatement in PEBB insurance coverage under the following conditions:

(a) Reinstatement must be requested and all delinquent premium paid in full no later than ninety days after the date the delinquent premium was first due, as well as a reinstatement fee of one thousand dollars.

(b) Reinstatement requested more than ninety days after the effective date of disenrollment will be denied.

(c) Employer groups, K-12 school districts or educational service districts may be reinstated only once in any two-year period and will be subject to immediate disenrollment if, after the effective date of any such reinstatement, subsequent premiums become more than thirty days delinquent.

(9) Upon written petition by the employer group, K-12 school district or educational service district disenrollment of an employer group, K-12 school district or educational service district or denial of reinstatement may be waived by the administrator upon a showing of good cause.

[Statutory Authority: RCW 41.05.160. 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.]

"Administrator" means the administrator of the HCA or designee.

"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.

"Creditable coverage" means coverage that meets the definition of "creditable coverage" under RCW 48.66.020 (13)(a) and includes payment of medical and hospital benefits.

"Defer" means to postpone enrollment or interrupt enrollment in PEBB medical insurance by a retiree or eligible survivor.

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

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

"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.

"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.

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

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

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

"Open enrollment" means a time period designated by the administrator when subscribers may apply to transfer their enrollment from one health plan to another, enroll in medical if the enrollee had previously waived such insurance coverage or add dependents.

"PEBB" means the public employees benefits board.

"PEBB benefits" means one or more insurance coverage or other employee benefit administered by the PEBB benefits services program within HCA.

"PEBB benefits services program" means the program within the health care authority which administers insurance and other benefits to eligible employees of the state (as defined in WAC 182-12-115), eligible retired and disabled employees of the state (as defined in WAC 182-12-171), and others as defined in RCW 41.05.011.

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

"Waive" means to interrupt enrollment or postpone enrollment in a PEBB health plan by an employee (as defined in WAC 182-12-115) or a dependent who meets eligibility requirements in WAC 182-12-260.

[Statutory Authority: RCW 41.05.160, 07-20-129 (Order 07-01), § 182-12-109, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.068, 06-23-165 (Order 06-09), § 182-12-109, filed 11/22/06, effective 12/23/06. Statutory Authority: RCW 41.05.160 and 41.05.165, 04-18-039, § 182-12-109, filed 8/26/04, effective 1/1/05.]

WAC 182-12-111 Eligible entities and individuals.

The following entities and individuals shall be eligible for PEBB insurance coverage subject to the terms and conditions set forth below:

(1) State agencies. Every department, division, or separate agency of state government, including all state higher education institutions, the higher education coordinating board, and the state board for community and technical colleges is required to participate in all PEBB benefits. Insurance and health care contributions for ferry employees shall be governed by RCW 47.64.270.

(a) Employees of technical colleges previously enrolled in a benefits trust may end PEBB benefits by January 1, 1996, or the expiration of the current collective bargaining agreements, whichever is later. Employees electing to end PEBB benefits have a one-time reenrollment option after a five year wait. Employees of a bargaining unit may end PEBB benefit participation only as an entire bargaining unit. All administrative or managerial employees may end PEBB participation only as an entire unit.

(b) Community and technical colleges with employees enrolled in a benefits trust shall remit to the HCA a retiree remittance as specified in the omnibus appropriations act, for each full-time employee equivalent. The remittance may be prorated for employees receiving a prorated portion of benefits.

(2) Employee organizations. Employee organizations representing state civil service employees and, effective October 1, 1995, employees of employee organizations currently pooled with employees of school districts for purchasing insurance benefits, may participate in PEBB insurance coverages at the option of each employee organization provided all of the following requirements are met:

(a) All eligible employees of the entity must transfer to PEBB insurance coverage as a unit. If the group meets the minimum size standards established by HCA, bargaining units may elect to participate separately from the whole group, and the nonrepresented employees may elect to participate separately from the whole group provided all nonrepresented employees join as a group.

(b) PEBB health plans must be the only employer sponsored health plans available to eligible employees.

(c) The legislative authority or the board of directors of the entity must submit to the HCA an application together with employee census data and, if available, prior claims experience of the entity. The application for PEBB insurance coverage is subject to the approval of the HCA.

(d) The legislative authority or the board of directors must maintain its PEBB insurance coverage participation at least one full year, and may end participation only at the end of a plan year.

(e) The terms and conditions for the payment of the insurance premiums must be in the provisions of the bargaining agreement or terms of employment and shall comply with the employer contribution requirements specified in the appropriate governing statute. These provisions, including

eligibility, shall be subject to review and approval by the HCA at the time of application for participation. Any substantive changes must be submitted to HCA.

(f) The eligibility requirements for dependents must be the same as the requirements for dependents of the state employees and retirees as in WAC 182-12-260.

(g) The legislative authority or the board of directors must give the HCA written notice of its intent to end PEBB insurance coverage participation at least thirty days before the effective date of termination. If the employee organization ends PEBB insurance coverage, retired and disabled employees who began participating after September 15, 1991, are not eligible for PEBB insurance coverage beyond the mandatory extension requirements specified in WAC 182-12-146.

(3) 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 insurance coverage.

(a) 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.

(b) 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 insurance coverage.

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

(4) Local governments: Employees of a county, municipality, or other political subdivision of the state may participate in PEBB insurance coverage provided all of the following requirements are met:

(a) All eligible employees of the entity must transfer to PEBB insurance coverage as a unit. If the group meets the minimum size standards established by HCA, bargaining units may elect to participate separately from the whole group, and the nonrepresented employees may elect to participate separately from the whole group provided all nonrepresented employees join as a group.

(b) The PEBB health plans must be the only employer sponsored health plans available to eligible employees.

(c) The legislative authority or the board of directors of the entity must submit to the HCA an application together with employee census data and, if available, prior claims experience of the entity. The application for PEBB insurance coverage is subject to the approval of the HCA.

(d) The legislative authority or the board of directors must maintain its PEBB insurance coverage participation at least one full year, and may terminate participation only at the end of the plan year.

(e) The terms and conditions for the payment of the insurance premiums must be in the provisions of the bargaining agreement or terms of employment and shall comply with the employer contribution requirements specified in the appropriate governing statute. These provisions, including eligibility, shall be subject to review and approval by the HCA at the time of application for participation. Any substantive changes must be submitted to HCA.

(f) The eligibility requirements for dependents of local government employees must be the same as the requirements for dependents of state employees and retirees in WAC 182-12-260.

(g) The legislative authority or the board of directors must give the HCA written notice of its intent to end PEBB insurance coverage participation at least thirty days before the effective date of termination. If a county, municipality, or political subdivision ends coverage in PEBB insurance coverage, retired and disabled employees who began participating after September 15, 1991, are not eligible for PEBB insurance coverage beyond the mandatory extension requirements specified in WAC 182-12-146.

(5) K-12 school districts and educational service districts: Employees of school districts or educational service districts may participate in PEBB insurance coverage provided all of the following requirements are met:

(a) All eligible employees of the entity must transfer to PEBB insurance coverage as a unit. If the K-12 school district or educational service district meets the minimum size standards established by HCA, bargaining units may elect to participate separately from the whole group. For enrolling by bargaining unit, all nonrepresented employees will be considered a single bargaining unit.

(b) The school district or educational service district must submit an application together with employee census data and, if available, prior claims experience of the entity to the HCA. The application for the PEBB insurance coverage is subject to the approval of the HCA.

(c) The school district or educational service district must agree to participate in all PEBB insurance coverage. The PEBB health plans must be the only employer sponsored health plans available to eligible employees.

(d) The school district or educational service district must maintain its PEBB insurance coverage participation at least one full year, and may end participation only at the end of the plan year.

(e) Beginning September 1, 2003, 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. Each participating school district or educational service district must agree to collect an employee premium by health plan and family size that is not less than that paid by state employees. The eligibility requirements for employees will be the same as those for state employees as defined in WAC 182-12-115.

(f) The eligibility requirements for dependents of K-12 school district and educational service district employees must be the same as the requirements for dependents of the state employees and retirees in WAC 182-12-260.

(g) The school district or educational service district must give the HCA written notice of its intent to end PEBB insurance coverage participation at least thirty days before the effective date of termination, and may end participation only at the end of a plan year.

(6) Eligible nonemployees:

(a) 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.

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

[Statutory Authority: RCW 41.05.160. 07-20-129 (Order 07-01), § 182-12-111, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-111, filed 8/26/04, effective 1/1/05; 03-17-031 (Order 02-07), § 182-12-111, filed 8/14/03, effective 9/14/03. Statutory Authority: RCW 41.05.160. 02-18-087 (Order 02-02), § 182-12-111, filed 9/3/02, effective 10/4/02; 99-19-028 (Order 99-04), § 182-12-111, filed 9/8/99, effective 10/9/99; 97-21-127, § 182-12-111, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-111, filed 3/29/96, effective 4/29/96. Statutory Authority: RCW 41.04.205, 41.05.065, 41.05.011, 41.05.080 and chapter 41.05 RCW. 92-03-040, § 182-12-111, filed 1/10/92, effective 1/10/92. Statutory Authority: Chapter 41.05 RCW. 78-02-015 (Order 2-78), § 182-12-111, filed 1/10/78.]

WAC 182-12-112 Insurance eligibility for higher education. For insurance eligibility, the HCA considers the higher education personnel board, the council for postsecondary education, and the state board for community colleges to be higher education agencies.

[Statutory Authority: RCW 41.05.160. 07-20-129 (Order 07-01), § 182-12-112, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-112, filed 8/26/04, effective 1/1/05.]

WAC 182-12-115 Eligible employees. The following employees of state government, higher education, participating K-12 school districts, educational service districts, political subdivisions and employee organizations representing state civil service workers are eligible for PEBB insurance coverage.

A person whose employment situation can be described by more than one of the eligibility categories in subsections (1) through (7) of this section shall have his or her eligibility determined solely by the criteria of the one category that most closely describes his or her employment situation.

(1) "Permanent employees." Those who work at least half-time per month and are expected to be employed for more than six months. These employees are eligible for benefits on their date of employment. Insurance coverage begins on the first day of the month following the date of employment. If the date of employment is the first working day of a month, insurance coverage begins on the date of employment.

(2) "Nonpermanent employees." Those who work at least half-time and are expected to be employed for no more than six months. These employees are eligible for benefits on the first day of the seventh month of half-time or more employment. Insurance coverage begins on the first day of the seventh month following the date of employment.

(3) "Career seasonal employees." Those who work at least half-time per month during a designated season for a minimum of three months but less than twelve months per year and who have an understanding of continued employment season after season. These employees are eligible for benefits on their date of employment. Insurance coverage begins on the first day of the month following the date of employment. If the date of employment is the first working day of a month, insurance coverage begins on the date of employment. Career seasonal employees who work at least

half-time per month for a season that extends for nine or more months are eligible for the employer contribution during the break between seasons of employment. However, career seasonal employees who work at least half-time per month for less than nine months in a season are not eligible for the employer contribution during the break between seasons of employment but may be eligible to continue insurance coverage by self-paying premiums.

(4) "Instructional year employees." Employees who work half-time or more on an instructional year (school year) or equivalent nine-month basis. These employees are eligible for benefits on their date of employment. Insurance coverage begins on the first day of the month following the date of employment. If the date of employment is the first working day of the month, insurance coverage begins on the date of employment. These employees are eligible to receive the employer contribution for insurance coverage during the off-season following each instructional year period of employment. The provisions of this subsection do not apply to persons employed on a quarter-to-quarter or semester-to-semester contract basis.

(5)(a) "Part-time faculty" and "part-time academic employees." Employees who are employed on a quarter/semester to quarter/semester basis are eligible for insurance coverage starting the second consecutive quarter/semester of half-time or more employment at one or more state institutions of higher education including one or more college districts. These employees are eligible for benefits the first day of the second consecutive quarter/semester of half-time or more employment. Insurance coverage begins on the first day of the month following the beginning of the second quarter/semester of half-time or more employment. If the first day of the second consecutive quarter/semester is the first working day of the month, insurance coverage begins at the beginning of the second consecutive quarter/semester.

To determine eligibility for part-time faculty and part-time academic employees, employers must:

(i) Consider spring and fall as consecutive quarters/semesters when first establishing eligibility; and

(ii) Determine "half-time or more employment" based on each institution's definition of "full-time"; and

(iii) At the beginning of each quarter/semester notify, in writing, all current and newly hired part-time faculty and part-time academic employees of their potential right to benefits under this subsection; and

(iv) Where concurrent employment at more than one state higher education institution is used to determine total employment of half-time or more, the employing institutions will arrange to prorate the cost of the employer insurance contribution based on the employment at each institution. However, if the employee would be eligible by virtue of employment at one institution, that institution will pay the entire cost of the employer contribution regardless of other higher education employment. In cases where the cost of the contribution is prorated between institutions, one institution will forward the entire contribution monthly to HCA.

Part-time faculty and part-time academic employees employed at more than one state institution of higher education are responsible for notifying each employer quarterly, in writing, of the employee's multiple employment. In no case will retroactive insurance coverage be permitted or employer

contribution paid to HCA if an employee does not inform all of his or her employing institutions about employment at all institutions within the current quarter.

Once enrolled, if a part-time faculty or part-time academic employee does not work at least a total of half-time in one or more state institutions of higher education, eligibility for the employer contribution ceases.

(b) Part-time academic employees of community and technical colleges who have a reasonable expectation of continued employment at one or more college districts shall be eligible for the employer contribution for benefits during the period between the end of the spring quarter and the beginning of the fall quarter, or other quarter break period, if they meet the following conditions of this subsection (5)(b).

Part-time academic employees who work half-time or more in each instructional year quarter of an academic year, or equivalent nine-month season, in a single college district or multiple college districts, as determined from the payroll records of the employing community or technical college district(s), are eligible for the employer contribution for health benefits during the quarter or off season period immediately following the end of one academic year or equivalent nine-month season.

For this subsection (5)(b):

(i) "Academic employee" is defined in RCW 28B.50.489 (3).

(ii) "Academic year" means fall, winter, and spring quarters in a community or technical college, as determined from the payroll records of the employing college district or college districts.

(iii) "Equivalent nine-month seasonal basis" means a nine consecutive month period of employment at half-time or more by a single college district or multiple college districts, as determined from the payroll records of the employing college district(s).

(iv) "Health benefits" means the particular medical and/or dental coverage in place at the end of the academic year or equivalent nine-month season. Changes to health benefits may be made only as allowed in chapter 182-08 WAC or during an annual open enrollment period.

(c) Part-time academic employees who have established eligibility, as determined from the payroll records of the employing community or technical college districts, for employer contributions for benefits and who have worked an average of half-time or more in each of the two preceding academic years, through employment at one or more community or technical college districts, are eligible for continuation of employer contributions for the subsequent summer period between the end of the spring quarter and the beginning of the fall quarter.

(d) Once a part-time academic employee meets the criteria in (c) of this subsection, the employee shall continue to receive uninterrupted employer contributions for benefits if the employee works at least two quarters of the academic year with an average academic year workload of half-time or more for three quarters of the academic year. Benefits provided under this subsection (5)(d) cease if this criteria is not met. Continuous benefits shall be reinstated once the employee reestablishes eligibility under (c) of this subsection.

(e) As used in (c) and (d) of this subsection, "academic year" means the summer, fall, winter, and spring quarters. As used in this subsection, "academic employees" has the meaning provided in RCW 28B.50.489.

(f) To be eligible for maintenance of benefits through averaging pursuant to (c) and (d) of this subsection, part-time academic employees must notify their employers of their potential eligibility.

(6) "Appointed and elected officials." Legislators are eligible for benefits on the date their term begins. All other elected and full-time appointed officials of the legislative and executive branches of state government are eligible for benefits on the date their term begins or they take the oath of office, whichever occurs first. Insurance coverage for legislators begins on the first day of the month following the date their term begins. If the term begins on the first working day of the month, insurance coverage begins on the first day of their term. Insurance coverage begins for all other elected and full-time appointed officials of the legislative and executive branches of state government on the first day of the month following the date their term begins, or the first day of the month following the date they take the oath of office, whichever occurs first. If the term begins, or oath of office is taken, on the first working day of the month, insurance coverage begins on the date the term begins, or the oath of office is taken.

(7) "Judges." Justices of the supreme court and judges of courts of appeals and the superior courts become eligible for benefits on the date they take the oath of office. Insurance coverage begins on the first day of the month following the date their term begins, or the first day of the month following the date they take oath of office, whichever occurs first. If the term begins, or oath of office is taken, on the first working day of a month, insurance coverage begins on the date the term begins, or the oath of office is taken.

[Statutory Authority: RCW 41.05.160, 07-20-129 (Order 07-01), § 182-12-115, filed 10/3/07, effective 11/3/07; 06-12-002 (Order 06-01), § 182-12-115, filed 5/25/06, effective 6/25/06; 05-17-132 (Order 04-04), § 182-12-115, filed 8/19/05, effective 9/2/05. Statutory Authority: RCW 41.05.160 and 41.05.165, 03-17-031 (Order 02-07), § 182-12-115, filed 8/14/03, effective 9/14/03. Statutory Authority: Chapter 41.05 RCW, 96-08-043, § 182-12-115, filed 3/29/96, effective 4/29/96; 92-08-003, § 182-12-115, filed 3/18/92, effective 3/18/92; 91-14-084, § 182-12-115, filed 7/1/91, effective 7/1/91. Statutory Authority: RCW 41.05.065(3), 90-12-037, § 182-12-115, filed 5/31/90, effective 7/1/90. Statutory Authority: RCW 41.05.065, 89-12-045 (Resolution No. 89-2), § 182-12-115, filed 6/2/89; 89-01-053 (Resolution No. 88-6), § 182-12-115, filed 12/15/88. Statutory Authority: RCW 41.05.010, 88-19-078 (Resolution No. 88-4), § 182-12-115, filed 9/19/88; 88-12-034 (Resolution No. 88-1), § 182-12-115, filed 5/26/88, effective 7/1/88. Statutory Authority: Chapter 41.05 RCW, 86-21-042 (Resolution No. 86-6), § 182-12-115, filed 10/10/86; 83-12-007 (Order 2-83), § 182-12-115, filed 5/20/83; 80-05-016 (Order 2-80), § 182-12-115, filed 4/10/80; 78-08-071 (Order 5-78), § 182-12-115, filed 7/26/78; Order 5646, § 182-12-115, filed 2/9/76.]

WAC 182-12-116 Who is eligible for the PEBB flexible spending account plan? Beginning January 1, 2006, all employees of public four-year institutions of higher education, of the state community and technical colleges and of the state board for community and technical colleges who are eligible for PEBB benefits, as defined in WAC 182-12-115, are eligible for the PEBB medical flexible spending account plan. Beginning July 1, 2006, all employees of state agencies

who are eligible for PEBB benefits, are eligible for the PEBB medical flexible spending account plan.

If an employee terminates employment after becoming a plan participant and later on in the same plan year is hired into a new position that is eligible for PEBB benefits, the employee may not resume participation in the PEBB medical flexible spending account until the beginning of the next plan year.

[Statutory Authority: RCW 41.05.160. 07-20-129 (Order 07-01), § 182-12-116, filed 10/3/07, effective 11/3/07; 06-11-156 (Order 06-02), § 182-12-116, 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), § 182-12-116, filed 7/27/05, effective 8/27/05.]

WAC 182-12-123 Dual enrollment is prohibited. 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.

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

(3) Children eligible for medical and dental under two or more parents or stepparents, who are employed by PEBB-participating employers, may be enrolled as a dependent under the health plan of one parent or stepparent, but not more than one.

(4) An employee employed in a benefits eligible position by more than one PEBB-participating employer may enroll only under one employer. The employee may choose to enroll in PEBB benefits under the employer that:

- (a) Offers the most favorable cost-sharing arrangement;
- or
- (b) Employed the employee for the longer period of time.

[Statutory Authority: RCW 41.05.160. 07-20-129 (Order 07-01), § 182-12-123, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-123, filed 8/26/04, effective 1/1/05.]

WAC 182-12-128 When may an employee waive health plan enrollment for their self or their eligible dependent? (1) Employees may waive medical if they have other comprehensive group medical coverage. To waive medical, the employee must complete an enrollment/change form. If an employee waives medical, then medical is automatically waived for all eligible dependents.

(2) An employee may only waive medical. The employee must remain enrolled in dental, life and long-term disability.

(3) An employee may waive medical or dental, or both, for any or all eligible dependents.

(4) Once health plan enrollment is waived, enrollment is only allowed during the following times:

- (a) The next open enrollment period;
- (b) After losing other health insurance. The employee must provide evidence:
 - (i) Other health insurance was comprehensive group coverage;
 - (ii) Enrollment was continuous from the most recent PEBB open enrollment period; and

(iii) The date when coverage was lost.

Application to enroll in a PEBB health plan must be made no later than sixty days after the date the other health insurance was lost;

(c) After acquiring a new dependent. Application for enrollment must be made no later than sixty days after acquiring the new dependent through marriage, establishment of a qualified domestic partnership, birth, adoption or placement for adoption.

[Statutory Authority: RCW 41.05.160. 07-20-129 (Order 07-01), § 182-12-128, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-128, filed 8/26/04, effective 1/1/05.]

WAC 182-12-131 When does employer paid insurance coverage end? PEBB medical, dental and life insurance for a terminated employee, spouse, qualified domestic partner or child ceases at 12:00 midnight, the last day of the month in which the enrollee is eligible. Basic long-term disability insurance ceases at 12:00 midnight the date employment ends or immediately upon the death of the employee.

[Statutory Authority: RCW 41.05.160. 07-20-129 (Order 07-01), § 182-12-131, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-131, filed 8/26/04, effective 1/1/05.]

WAC 182-12-133 What options for continuing coverage are available to employees when they are no longer eligible for PEBB insurance coverage paid for by their employer? Eligible employees covered by PEBB insurance coverage have options for providing continued coverage for themselves and their dependents during temporary or permanent loss of eligibility. Except in the case of approved family and medical leave, and except as otherwise provided, only employees in pay status eight or more hours per month are eligible to receive the employer contribution.

(1) When an employee is on leave without pay due to an event described in (a) through (f) of this subsection, insurance coverage may be continued at the group rate by self-paying premiums. Employees may self-pay for a maximum of twenty-nine months. The number of months that an employee self-pays premium during a period of leave without pay will count toward the total months of continuation coverage allowed under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). Employees may continue any combination of medical, dental and life insurance; however, only employees on approved educational leave may continue long-term disability insurance. The following types of leave qualify to continue coverage under this provision:

- (a) The employee is on authorized leave without pay;
- (b) The employee is laid off because of a reduction in force (RIF);
- (c) The employee is receiving time-loss benefits under workers' compensation;
- (d) The employee is applying for disability retirement;
- (e) The employee is called to active duty in the uniformed services as defined under the Uniformed Services Employment and Reemployment Rights Act (USERRA); or
- (f) The employee is on approved educational leave.

(2) Part-time faculty and part-time academic employees may self-pay premium at the group rate between periods of eligibility for a maximum of eighteen months. These

employees may continue any combination of medical, dental and life insurance.

(3) The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) gives enrollees the right to continue medical and dental for a period of eighteen to twenty-nine months when they lose eligibility due to one of the following qualifying events.

(a) Termination of employment.

(b) The employee's hours are reduced to the extent of losing eligibility.

(4) Employees who are approved for leave under the federal Family and Medical Leave Act (FMLA) are eligible to receive the employer contribution toward premium for up to twelve weeks, as provided in WAC 182-12-138.

[Statutory Authority: RCW 41.05.160. 07-20-129 (Order 07-01), § 182-12-133, filed 10/3/07, effective 11/3/07; 06-11-156 (Order 06-02), § 182-12-133, filed 5/24/06, effective 6/24/06. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-133, filed 8/26/04, effective 1/1/05.]

WAC 182-12-136 May an employee on approved educational leave waive PEBB health plan 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 coverage provided in WAC 182-12-133 who obtain comprehensive health plan coverage under another group plan may waive continuance of such coverage for each full calendar month in which they maintain coverage under the other comprehensive group health plan. These employees have the right to reenroll in a PEBB health plan effective the first day of the month after the date the other comprehensive group health plan coverage ends, provided evidence of such other comprehensive group health plan coverage is provided to the PEBB benefits services program upon application for reenrollment.

[Statutory Authority: RCW 41.05.160. 07-20-129 (Order 07-01), § 182-12-136, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-136, filed 8/26/04, effective 1/1/05.]

WAC 182-12-138 If an employee is approved for family and medical leave, what insurance coverage may be continued? Employees on leave under the federal Family and Medical Leave Act (FMLA) may continue to receive up to twelve weeks of employer-paid medical, dental, basic life, and basic long-term disability insurance while on family and medical leave and may also continue current optional life and long-term disability. All employee premium amounts associated with insurance coverage must be paid monthly as they become due. If premiums are more than sixty days delinquent, insurance coverage will end as of the last day of the month of fully paid coverage.

[Statutory Authority: RCW 41.05.160. 07-20-129 (Order 07-01), § 182-12-138, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-138, filed 8/26/04, effective 1/1/05.]

WAC 182-12-141 If I revert from an eligible position to an ineligible position what happens to my insurance coverage? Employees who revert to a position that is ineligible for employer contribution toward insurance coverage may continue enrollment in a PEBB health plan by self-paying premium for up to eighteen months (and in some cases up

to twenty-nine months) under the same terms as an employee who is granted leave without pay.

[Statutory Authority: RCW 41.05.160. 07-20-129 (Order 07-01), § 182-12-141, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-141, filed 8/26/04, effective 1/1/05.]

WAC 182-12-146 Continuing health plan coverage under COBRA. Enrollees and eligible dependents who become ineligible for coverage and who qualify for continued coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) may continue their medical and dental by self-payment of health plan premiums in accordance with COBRA statutes and regulations.

[Statutory Authority: RCW 41.05.160. 07-20-129 (Order 07-01), § 182-12-146, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-146, filed 8/26/04, effective 1/1/05.]

WAC 182-12-148 May an employee continue PEBB insurance coverage during their appeal of dismissal? (1) Employees awaiting hearing of a dismissal action before any of the following may continue their insurance coverage by self-payment of premium on the same terms as an employee who is granted leave without pay.

(a) For an appeal filed on or before June 30, 2005, the personnel appeals board or any court.

(b) For an appeal filed on or after July 1, 2005, the personnel resources board, an arbitrator, a grievance or appeals committee established under a collective bargaining agreement for union represented employees.

(2) If the dismissal is upheld, all insurance coverage will end at the end of the month in which the decision is entered, or the date to which premiums have been paid, whichever is earlier.

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

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

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

[Statutory Authority: RCW 41.05.160. 07-20-129 (Order 07-01), § 182-12-148, 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), § 182-12-148, filed 7/27/05, effective 8/27/05. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-148, filed 8/26/04, effective 1/1/05.]

WAC 182-12-171 When are retiring employees eligible to enroll in retiree insurance? (1) Procedural requirements. Retiring employees must meet these procedural requirements, as well as have substantive eligibility under subsection (2) or (3) of this section.

(a) The employee must submit an election form to enroll or defer insurance coverage within sixty days after their employer paid or COBRA coverage ends. Employees who cancel PEBB health plan coverage or do not enroll in a PEBB health plan at retirement are only eligible to enroll if they have deferred enrollment and maintained comprehensive coverage as defined in WAC 182-12-200 or 182-12-205.

(b) The employee 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, they must enroll and maintain enrollment in Medicare.

(2) **Eligibility requirements.** Eligible employees (as defined in WAC 182-12-115) who end public employment after becoming vested in a Washington state-sponsored retirement plan (as defined in subsection (4) of this section) are eligible to continue PEBB insurance coverage as a retiree if they meet procedural and eligibility requirements. To be eligible to continue PEBB insurance coverage as a retiree the employee must be eligible to retire under a Washington state-sponsored retirement plan when their employer paid or COBRA coverage ends.

Employees who do not meet their Washington state-sponsored retirement plan's age requirements 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 health care authority's appeals committee to determine eligibility (see WAC 182-16-030). Employees must meet other retiree insurance election procedural requirements.

- 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 this is required by department of retirement systems because their monthly retirement plan payment is below the minimum payment that can be paid.

- Employees who are members of a Plan 3 retirement, also called separated employees (defined in RCW 41.05.011 (13)), are eligible if they meet their retirement plan's age requirement and length of service when PEBB employee insurance coverage ends. They do not have to receive a retirement plan payment.

- 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 age requirement, or are at least age fifty-five with ten years of state service.

- Employees who are permanently and totally disabled are eligible if they start receiving or defer a monthly disability retirement plan payment.

- Employees not retiring under the public employees' retirement system must meet the same age and years of service had the person been employed as a member of either

public employees retirement system Plan 1 or Plan 2 for the same period of employment.

- Employees who retire from a local government that participates in PEBB insurance coverage for their employees are eligible to continue PEBB insurance coverage as a retiree.

(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. These employees may continue PEBB health plan enrollment under COBRA (see WAC 182-12-146).

(b) **Washington state K-12 school district and educational service district employees for districts that do not participate in PEBB benefits.** 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 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 department of retirement systems requires this because their monthly retirement plan payment is below the minimum payment that can be paid or they enrolled before 1995.

Employees who are members of a Plan 3 retirement, also called separated employees (defined in RCW 41.05.011(13)), are eligible if they meet their retirement plan's age requirement and length of service when employer paid or COBRA coverage ends.

Employees who separate from employment due to total and permanent disability who are eligible for a deferred retirement allowance under a Washington state-sponsored retirement system (as defined in chapter 41.32, 41.35 or 41.40 RCW) are eligible if they enrolled before 1995 or within sixty days following retirement.

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

(3) **Elected state officials.** Employees who are elected state officials (as defined under WAC 182-12-115(6)) who voluntarily or involuntarily leave public office are eligible to continue PEBB insurance coverage as a retiree if they meet procedural and eligibility requirements. They do not have to receive a retirement plan payment from a state-sponsored retirement system.

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

- Higher education retirement plans;
- Law enforcement officers' and fire fighters' retirement system;
- Public employees' retirement system;
- Public safety employees' retirement system;
- School employees' retirement system;
- State judges/judicial retirement system;

- Teacher's 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.

[Statutory Authority: RCW 41.05.160. 07-20-129 (Order 07-01), § 182-12-171, filed 10/3/07, effective 11/3/07; 06-11-156 (Order 06-02), § 182-12-171, 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), § 182-12-171, filed 7/27/05, effective 8/27/05. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-171, filed 8/26/04, effective 1/1/05.]

WAC 182-12-175 May a local government entity applying for participation in PEBB insurance coverage include their retirees in the transfer unit? Local government entities applying for participation in PEBB insurance coverage under WAC 182-12-111(4), may request inclusion of retired employees who are covered under their retiree health plan at the time of application. The PEBB benefits services program will use the following criteria for approval of these requests for inclusion of retirees.

(1) The local government retiree health plan must have existed at least three years before the date of application for participation in PEBB health plans.

(2) Eligibility for coverage under the local government's retiree health plan must have required immediate enrollment in retiree health plan coverage upon termination of employee coverage.

(3) The retiree must have maintained continuous enrollment in their local government retiree health plan.

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

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

(b) May adopt a new rating methodology reflective of the cost of covering local government retirees.

(5) 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.

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

[Statutory Authority: RCW 41.05.160. 07-20-129 (Order 07-01), § 182-12-175, 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), § 182-12-175, filed 7/27/05, effective 8/27/05.]

WAC 182-12-200 May a retiree who is enrolled as a dependent in a PEBB health plan or a Washington state K-12 school district sponsored health plan defer enrollment in a PEBB retiree health plan? Retirees who are enrolled in a PEBB or Washington state K-12 school 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. 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 school district sponsored medical plan. Continuous enrollment must be from the date the retiree deferred enrollment in retiree insurance. Retirees may enroll:

(1) During any PEBB open enrollment period. (Enrollment in the PEBB health plan will begin the first day of January after the open enrollment period.); or

(2) No later than sixty days after enrollment in the PEBB or K-12 school district sponsored medical plan ends. (Enrollment in the PEBB health plan will begin the first day of the month after the PEBB or K-12 school district health plan ends.)

[Statutory Authority: RCW 41.05.160. 07-20-129 (Order 07-01), § 182-12-200, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-200, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160. 01-17-041 (Order 01-00), § 182-12-200, filed 8/9/01, effective 9/9/01; 97-21-127, § 182-12-200, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-200, filed 3/29/96, effective 4/29/96; Order 4-77, § 182-12-200, filed 11/17/77.]

WAC 182-12-205 May a retiree defer enrollment in a PEBB health plan at or after retirement? Except as stated in subsection (1)(c) of this section, if a retiree defers enrollment in a PEBB health plan, they also defer enrollment for all eligible dependents. Retirees may not defer their retiree term life insurance, even if they have other life insurance.

(1) Retirees may defer enrollment in a PEBB health plan at or after retirement if continuously enrolled in other comprehensive medical as identified below:

(a) Beginning January 1, 2001, retirees may defer enrollment if they are enrolled in comprehensive employer-sponsored medical as an employee or the dependent of an employee.

(b) Beginning January 1, 2001, retirees may defer enrollment 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 if they are enrolled in Medicare Parts A and B and a Medicaid program that provides creditable coverage as defined 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.

(2) To defer health plan enrollment, the retiree must send a completed election form to the PEBB benefits services program requesting to defer. The PEBB benefits services 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) Retirees who defer may enroll in a PEBB health plan as follows:

(a) Retirees who defer while enrolled in employer-sponsored medical may enroll in a PEBB health plan by sending a completed election form and evidence of continuous enrollment in comprehensive employer-sponsored medical to the PEBB benefits services program:

(i) During open enrollment. (Enrollment in the PEBB health plan will begin the first day of January after the open enrollment period.); or

(ii) No later than sixty days after their employer-sponsored medical ends. (Enrollment in the PEBB health plan will begin the first day of the month after the employer-sponsored medical 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 sending a completed election form and evidence of continuous enrollment in a federal retiree medical plan to the PEBB benefits services program:

(i) During open enrollment. (Enrollment in the PEBB health plan will begin the first day of January after the open enrollment period.); or

(ii) No later than sixty days after the federal retiree medical ends. (Enrollment in the PEBB health plan will begin the first day of the month after the federal retiree medical ends.)

(c) Retirees who defer enrollment while enrolled in Medicare Parts A and B and Medicaid may enroll in a PEBB health plan by sending a completed election form and evidence of continuous enrollment in creditable coverage to the PEBB benefits services program:

(i) During open enrollment. (Enrollment in the PEBB health plan will begin the first day of January after the open enrollment period.); or

(ii) No later than sixty days after their Medicaid coverage ends (Enrollment in the PEBB health plan will begin 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 USC § 1395w-114 and subsequently enrolled in a Medicare Part D plan. (Enrollment in the PEBB health plan will begin the first day of January following the end of the calendar year when the Medicaid coverage ends.)

[Statutory Authority: RCW 41.05.160. 07-20-129 (Order 07-01), § 182-12-205, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.068. 06-23-165 (Order 06-09), § 182-12-205, 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), § 182-12-205, filed 7/27/05, effective 8/27/05. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-205, filed 8/26/04, effective 1/1/05.]

WAC 182-12-207 When can a retiree or eligible dependent's insurance coverage be canceled by HCA? (1)

Failure to provide information requested by the due date or knowingly providing false information.

(2) Failure to pay the premium when due or an underpayment of premium.

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

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

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

[Statutory Authority: RCW 41.05.160. 07-20-129 (Order 07-01), § 182-12-207, filed 10/3/07, effective 11/3/07.]

WAC 182-12-208 May a retiree enroll only in dental?

If an enrollee is enrolled in retiree insurance coverage, they may not enroll in dental unless they also enroll in medical.

[Statutory Authority: RCW 41.05.160. 07-20-129 (Order 07-01), § 182-12-208, filed 10/3/07, effective 11/3/07.]

WAC 182-12-209 Who is eligible for retiree life insurance? Eligible employees who participate in 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 an election form to the PEBB benefits services program no later than sixty days after the date their PEBB employee life insurance ends. However, 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. Retirees may not defer enrollment in retiree term life insurance.

[Statutory Authority: RCW 41.05.160. 07-20-129 (Order 07-01), § 182-12-209, filed 10/3/07, effective 11/3/07.]

WAC 182-12-211 If department of retirement systems makes a formal determination of retroactive eligibility, may the retiree enroll in PEBB retiree insurance coverage?

(1) When the Washington state department of retirement systems (DRS) makes a formal determination that a person is retroactively eligible for pension benefits that person may apply for enrollment in a PEBB health plan only if application is made within sixty days after the date of notice from DRS.

(2) All premiums due from the date of eligibility established by DRS or the date of the DRS decision letter, at the option of the retiree, must be sent with the application to the PEBB benefits services program.

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

[Statutory Authority: RCW 41.05.160. 07-20-129 (Order 07-01), § 182-12-211, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-211, filed 8/26/04, effective 1/1/05.]

WAC 182-12-250 Insurance coverage eligibility for survivors of emergency service personnel killed in the line of duty. Surviving spouses 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 PEBB benefits services program within HCA.

(1) This section applies to the surviving spouse 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 fire fighters 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 fire fighters as defined in RCW 41.24.010.

(3) "Surviving spouse and children" means:

(a) A lawful spouse;

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

(c) Children. The term "children" includes the following unmarried children of the emergency service worker who are: Under the age of twenty or under the age of twenty-four if he or she is a dependent student attending high school or registered at an accredited secondary school, college, university, vocational school, or school of nursing. Children with disabilities as defined in RCW 41.26.030(7) are eligible at any age. "Children" are defined as:

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

(ii) Stepchildren; and

(iii) Legally adopted children.

(4) Surviving spouses and children who are entitled to Medicare must enroll in both parts A and B of Medicare.

(5) The survivor (or agent acting on their behalf) must send a completed election form (to either enroll or defer enrollment in a PEBB health plan) to PEBB benefits services program no later than one hundred eighty days after the latter 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 fire fighters 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 or child was covered under any health plan through the emergency service worker's employer; or

(d) The last day the surviving spouse 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 may choose among the following options for when their enrollment in a PEBB health plan will begin:

(a) June 1, 2006, for survivors whose election form is received by the PEBB benefits services program no later than September 1, 2006;

(b) The first of the month that is no more than sixty days before the date that the PEBB benefits services program receives the election form (for example, if the PEBB benefits services program receives the election form 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 benefits services program receives the election form.

For surviving spouses 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 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.

(iv) Dental only is not an option.

(b) Defer enrollment:

(i) Survivors may defer enrollment in a PEBB health plan if enrolled in comprehensive medical coverage through an employer.

(ii) Survivors may enroll in a PEBB health plan when they lose employer medical coverage. Survivors will need to provide evidence that they were continuously enrolled in comprehensive coverage through an employer when applying for a PEBB health plan, and apply within sixty days after the date their other coverage ended.

(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 open enrollment. In addition to open enrollment, survivors may change health plans as described in WAC 182-08-198.

(9) Survivors may not add new dependents acquired through birth, marriage, or establishment of a qualified domestic partnership.

(10) Survivors will lose their right to enroll in a PEBB health plan 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 comprehensive medical coverage through an employer during the deferral period, as provided in subsection (7)(b)(i) of this section.

[Statutory Authority: RCW 41.05.160, 07-20-129 (Order 07-01), § 182-12-250, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.080, 06-20-099 (Order 06-08), § 182-12-250, filed 10/3/06, effective 11/3/06. Statutory Authority: RCW 41.05.160 and 41.05.165, 04-18-039, § 182-12-250, filed 8/26/04, effective 1/1/05.]

WAC 182-12-260 Who are eligible dependents? The following are eligible as dependents under the PEBB eligibility rules:

(1) Lawful spouse.

(2) Domestic partner qualified by the PEBB declaration of domestic partnership that meets all of the following criteria:

(a) Partners have a close personal relationship in lieu of a lawful marriage;

(b) Partners are not married to anyone;

(c) Partners are each other's sole domestic partner and are responsible for each other's common welfare;

(d) Partners are not related by blood as close as would bar marriage; and

(e) Partners are barred from a lawful marriage.

(3) Domestic partner qualified by the certificate of state registered domestic partnership or registration card issued by the Washington secretary of state for a same-sex partnership.

(4) Children through age nineteen. Children include:

(a) The subscriber's biological children, stepchildren, legally adopted children, children for whom the subscriber has assumed a legal obligation for total or partial support of a child in anticipation of adoption of the child, children of the subscriber's qualified domestic partner, or children specified in a court order or divorce decree;

(b) Married children who qualify as dependents of the subscriber under the Internal Revenue Code;

(c) Extended dependents in the legal custody or legal guardianship of the subscriber, their spouse, or qualified domestic partner. The legal responsibility is demonstrated by

a valid court order and the child's official residence with the custodian or guardian. This 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;

(d) Children age twenty through age twenty-three who are attending high school or registered students at an accredited secondary school, college, university, vocational school, or school of nursing.

(i) Student health plan enrollment begins the first day of the month of the quarter or semester for which the child is registered begins. Health plan enrollment ends the last day of the month in which the student stops attending or in which the quarter or semester ends, whichever is first, except that dependent student eligibility continues year-round for those who attend three of the four school quarters or two semesters.

(ii) Student eligibility for enrollment in a PEBB health plan continues during the three month period following graduation provided the subscriber is covered, the child has not reached age twenty-four, and meets all other eligibility requirements.

(iii) Student recertification occurs annually.

(e) Children as defined in (a) through (d) of this subsection who have disabilities are eligible by subsection (5) of this section.

(5) Children of any age with disabilities, developmental disabilities, mental illness or mental retardation who are incapable of self-support, provided such condition occurs before age twenty or during the time the dependent was eligible as a student under subsection (4) of this section.

(a) The subscriber must provide evidence that such disability occurred as stated below:

(i) For children enrolled in PEBB insurance coverage, the subscriber must provide evidence of the disability within sixty days of the child's attainment of age twenty.

(ii) For children enrolled in PEBB insurance coverage as a student under subsection (4)(d) of this section, the subscriber must provide evidence of the disability within sixty days after the student is no longer eligible under subsection (4)(d) of this section.

(iii) To enroll a dependent child with disabilities, age twenty or older, the subscriber must provide evidence that the condition occurred before the child reached age twenty or evidence that when the condition occurred the child would have satisfied eligibility for student coverage under subsection (4) of this section. The PEBB benefits services program will request evidence of the child's disability periodically thereafter.

(b) The subscriber must notify the PEBB benefits services program, in writing, no later than sixty days after the date that a child age twenty or older no longer qualifies under this subsection.

(i) For example, children who become self-supporting are not eligible under this rule as of the last day of the month in which they become capable of self-support. The child may be eligible to continue enrollment in a PEBB health plan under provisions of WAC 182-12-270.

(ii) Children age twenty and older who become capable of self-support do not regain eligibility under subsection (5) of this section if they later become incapable of self-support.

(c) Disability recertification occurs periodically.

(6) Parents.

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

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

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

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

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

(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.

(7) The enrollee (or the subscriber on their behalf) must notify the PEBB benefits services program, in writing, no later than sixty days after the date they are no longer eligible under this section. A PEBB continuation of coverage election notice and continued health plan enrollment will only be available if the PEBB benefits services program is notified in writing within the sixty-day period.

[Statutory Authority: RCW 41.05.160. 07-20-129 (Order 07-01), § 182-12-260, 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), § 182-12-260, filed 7/27/05, effective 8/27/05. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-260, filed 8/26/04, effective 1/1/05.]

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 surviving 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 in public employees benefits board (PEBB) retiree insurance coverage as a surviving dependent. An eligible surviving spouse, qualified domestic partner, or child must enroll in or defer enrollment in a PEBB health plan no later than sixty days after the date of the employee or retiree's death.

(1) Dependents who lose eligibility due to the death of an eligible employee may continue enrollment in a PEBB health plan 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 qualified domestic partner may continue health plan enrollment until death.

(b) Children may continue health plan enrollment until they lose eligibility under PEBB rules.

(c) If a surviving spouse, qualified domestic partner, or child of an eligible employee is not eligible for a monthly retirement benefit (or a lump-sum payment because the monthly pension payment would be less than the minimum amount established by the department of retirement systems) the dependent is not eligible for PEBB retiree insurance as a survivor. However, the dependent may continue health plan enrollment under provisions of the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) or WAC 182-12-270.

(d) The two federal retirement systems, Civil Service Retirement System and Federal Employees Retirement Sys-

tem, shall be considered a Washington sponsored retirement system for Washington State University extension service employees who were covered under PEBB insurance coverage at the time of death.

(2) Dependents who lose eligibility due to the death of a PEBB eligible retiree may continue health plan enrollment under retiree insurance.

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

(b) Children may continue health plan enrollment until they lose eligibility under PEBB rules.

(c) Dependents who are waiving enrollment in a PEBB health plan at the time of the retiree's death are eligible to enroll or defer enrollment in PEBB retiree insurance. A form to enroll or defer PEBB health plan enrollment must be hand-delivered or mailed to the PEBB benefits services program no later than sixty days after the retiree's death. To enroll in a PEBB health plan, the dependent must provide satisfactory evidence of continuous enrollment in other medical coverage from the most recent open enrollment for which enrollment in PEBB was waived.

(3) Surviving spouses or eligible children of a deceased school district or educational service district employee who were not enrolled in PEBB insurance coverage at the time of the subscriber's death may enroll in a PEBB health plan provided the employee died on or after October 1, 1993, and the dependent(s) immediately began receiving a retirement benefit allowance under chapter 41.32, 41.35 or 41.40 RCW.

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

(b) Children may continue health plan enrollment until they lose eligibility under PEBB rules.

(4) Surviving dependents must notify the PEBB benefits services program of their decision to enroll or defer enrollment in a PEBB health plan no later than sixty days after the date of death of the employee or retiree. If PEBB health plan enrollment ended due to the death of the employee or retiree, PEBB will reinstate health plan enrollment without a gap subject to payment of premium. 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. To notify the PEBB benefits services program of their intent to enroll or defer enrollment in a PEBB health plan the surviving dependent must send a completed election form to the PEBB benefits services program no later than sixty days after the date of death of the employee or retiree.

[Statutory Authority: RCW 41.05.160. 07-20-129 (Order 07-01), § 182-12-265, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.068. 06-23-165 (Order 06-09), § 182-12-265, 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), § 182-12-265, filed 7/27/05, effective 8/27/05. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-265, filed 8/26/04, effective 1/1/05.]

WAC 182-12-270 What options 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 options in subsection (1), (2), or (3) of this section by self-paying premiums following their loss of eligibility. The PEBB benefits services program must receive a timely election form as out-

lined 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, qualified 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.

(2) Dependents of a lawful marriage 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); or

(3) Dependents of a qualified domestic partnership who lose eligibility because they no longer meet the eligibility criteria in WAC 182-12-260 may continue health plan enrollment under an extension of PEBB insurance coverage for a maximum of thirty-six months.

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

[Statutory Authority: RCW 41.05.160. 07-20-129 (Order 07-01), § 182-12-270, 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), § 182-12-270, filed 7/27/05, effective 8/27/05. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-270, filed 8/26/04, effective 1/1/05.]

Chapter 182-16 WAC PRACTICE AND PROCEDURE

WAC

182-16-020	Definitions.
182-16-030	Appeals of decisions of the agency or its agent—Applicability.
182-16-040	Appeals—Notice of appeal contents.
182-16-050	Appeals—Hearings.

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

"Administrator" means the administrator of the health care authority (HCA) or designee;

"Agency" means the health care authority;

"Agent" means a person, association, or corporation acting on behalf of the health care authority pursuant to a contract between the health care authority and the person, association, or corporation.

"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.

"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.

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

"PEBB" means the public employees benefits board.

"PEBB benefits services program" means the program within the health care authority which administers insurance

and other benefits to eligible employees of the state (as defined in WAC 182-12-115), eligible retired and disabled employees of the state (as defined in WAC 182-12-171), and others as defined in RCW 41.05.011.

[Statutory Authority: RCW 41.05.160. 07-20-129 (Order 07-01), § 182-16-020, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.010 and 34.05.250. 91-14-025, § 182-16-020, filed 6/25/91, effective 7/26/91.]

WAC 182-16-030 Appeals of decisions of the agency or its agent—Applicability. Except as provided by RCW 48.43.530 and 48.43.535, any person aggrieved by a decision of the health care authority or its agent may appeal that decision.

(1) **Eligibility appeals.** Decisions concerning eligibility determinations are reviewable by the health care authority. The PEBB appeals manager must receive the appeal within ninety days from the date of the denial notice.

(2) **Noneligibility appeals.** Appeals of decisions made by the agency's self-insured medical plans, managed health care plans, and other agency contractors are governed by the appeal provisions of those plans. Those appeals are not subject to this chapter, except for eligibility determinations.

(3) **Dental plan appeals.** Any enrollee of the health care authority's self-administered dental plan aggrieved by a decision of the agency or its agent may appeal to the PEBB appeals manager. The PEBB appeals manager must receive the appeal within ninety days from the date of the denial notice.

(4) **Retirement plan age appeals.** Employees who do not meet their Washington state-sponsored retirement plan's age requirements when their employer paid or COBRA coverage ends, but who meet the age requirement within sixty days of coverage ending, may appeal the denial of their retiree insurance eligibility. The PEBB appeals manager must receive the appeal within ninety days from the date of the denial notice. Employees must meet other retiree insurance election procedural requirements. Eligibility denials caused by these circumstances may be reversed:

(a) Misleading or incorrect written information provided by employees of the health care authority or employers;

(b) Loss of COBRA coverage due to Medicare eligibility;

(c) Other related miscalculations of the duration of COBRA coverage; or

(d) Administrative errors or delays attributable to the state that have material impact on eligibility.

(5) **Limited retiree insurance coverage reinstatement.** Reinstatement of a retiree's insurance coverage may be approved when coverage was terminated because of late payment or late paperwork, or in extraordinary circumstances such as the retiree's impaired decision-making which adversely affects eligibility. No retiree's insurance coverage may be reinstated more than three times. Reinstatement may be approved only if:

(a) The retiree or a representative acting on their behalf submits a written appeal within sixty days after the notice of termination was mailed; and

(b) The retiree agrees to make payment in accordance with the terms of an agreement with the HCA.

[Statutory Authority: RCW 41.05.160. 07-20-129 (Order 07-01), § 182-16-030, filed 10/3/07, effective 11/3/07; 97-21-128, § 182-16-030, filed

10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.010 and 34.05.250. 91-14-025, § 182-16-030, filed 6/25/91, effective 7/26/91.]

WAC 182-16-040 Appeals—Notice of appeal contents. Except as provided by RCW 48.43.530 and 48.43.535 and WAC 182-16-030(2), any person aggrieved by a decision of the health care authority or its agent may appeal that decision by filing a notice of appeal with the PEBB appeals manager. The notice of appeal must contain:

(1) The name and mailing address of the enrollee;

(2) The name and mailing address of the appealing party;

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

(4) A statement identifying the specific portion of the decision being appealed making it clear what is believed to be unlawful or unjust;

(5) A clear and concise statement of facts in support of appealing party's position;

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

(7) A copy of the health care authority's or its agent's response to the issue the appealing party has raised;

(8) The type of relief sought;

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

(10) The appealing party's signature and the signature of his or her representative, if any;

(11) The appealing party shall file the original notice of appeal with the PEBB benefits services program using hand delivery, electronic mail or United States Postal Service mail. The notice of appeal must be received by the PEBB benefits services program within ninety days after the decision of the PEBB staff was mailed to the appealing party. The PEBB appeals manager shall acknowledge receipt of the copies filed with the PEBB benefits services program;

(12) The health care authority's appeals committee will render a written decision within thirty working days after receipt of the complete notice of appeal.

[Statutory Authority: RCW 41.05.160. 07-20-129 (Order 07-01), § 182-16-040, 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), § 182-16-040, filed 7/27/05, effective 8/27/05. Statutory Authority: RCW 41.05.160. 97-21-128, § 182-16-040, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.010 and 34.05.250. 91-14-025, § 182-16-040, filed 6/25/91, effective 7/26/91.]

WAC 182-16-050 Appeals—Hearings. (1) If the appealing party is not satisfied with the decision of the health care authority's appeals committee, the appealing party may request an administrative hearing. The request must be made in writing to the PEBB appeals manager. The appeal is not effective unless the PEBB appeals manager receives the written request for a hearing within thirty days of the date the appeals decision was mailed to the appealing party.

(2) The agency shall set the time and place of the hearing and give not less than twenty days notice to all parties and persons who have filed written petitions to intervene.

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

(4) All hearings must be conducted in compliance with these rules, chapter 34.05 RCW and chapter 10-08 WAC as applicable.

(5) Within ninety days after the hearing record is closed, the administrator or his or her designee shall render a decision which shall be the final decision of the agency. A copy of that decision accompanied by a written statement of the reasons for the decision shall be served on all parties and persons who have intervened.

[Statutory Authority: RCW 41.05.160. 07-20-129 (Order 07-01), § 182-16-050, 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), § 182-16-050, filed 7/27/05, effective 8/27/05. Statutory Authority: RCW 41.05.160. 97-21-128, § 182-16-050, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.010 and 34.05.250. 91-14-025, § 182-16-050, filed 6/25/91, effective 7/26/91.]

Chapter 182-25 WAC

WASHINGTON BASIC HEALTH PLAN

WAC

182-25-010	Definitions.
182-25-030	Eligibility.
182-25-040	Enrollment in the plan.
182-25-080	Premiums and co-payments.

WAC 182-25-010 Definitions. The following definitions apply throughout these rules.

(1) "Administrator" means the administrator of the Washington state health care authority (HCA) or designee.

(2) "Appeal procedure" means a formal written procedure for resolution of problems or concerns raised by enrollees which cannot be resolved in an informal manner to the enrollee's satisfaction.

(3) "Basic health plan" (or "BHP") means the system of enrollment and payment for basic health care services administered by the administrator through managed health care systems.

(4) "BHP Plus" means the program of expanded benefits available to children through coordination between the department of social and health services (DSHS) and basic health plan. Eligibility for BHP Plus is determined by the department of social and health services, based on Medicaid eligibility criteria. To be eligible for the program children must be under age nineteen, with a family income at or below two hundred percent of federal poverty level, as defined by the United States Department of Health and Human Services. They must be Washington state residents, not eligible for Medicare, and may be required to meet additional DSHS eligibility requirements.

(5) "Co-payment" means a payment indicated in the schedule of benefits which is made by an enrollee to a health care provider or to the MHCS.

(6) "Covered services" means those services and benefits in the BHP schedule of benefits (as outlined in the member handbook issued to the enrollee, or to a subscriber on behalf of the enrollee), which an enrollee shall be entitled to receive from a managed health care system in exchange for payment

of premium and applicable co-payments, coinsurance and deductible.

(7) "Disenrollment" means the termination of coverage for a BHP enrollee.

(8) "Effective date of enrollment" means the first date, as established by BHP, on which an enrollee is entitled to receive covered services from the enrollee's respective managed health care system.

(9) "Dependent," as it applies to the subsidized or non-subsidized programs, means:

(a) The subscriber's lawful spouse, not legally separated, who resides with the subscriber; or

(b) The unmarried child of the subscriber or the subscriber's dependent spouse, whether by birth, adoption, legal guardianship, or placement pending adoption, who is:

(i) Younger than age nineteen, and who has not been relinquished for adoption by the subscriber or the subscriber's dependent spouse; or

(ii) Younger than age twenty-three, and a registered student at an accredited secondary school, college, university, technical college, or school of nursing, attending full time, other than during holidays, summer and scheduled breaks; or

(c) A person of any age who is incapable of self-support due to disability, and who is the unmarried child of the subscriber or the subscriber's dependent spouse, whether by birth, adoption, or legal guardianship; or

(d) An unmarried child younger than age nineteen who is residing with the subscriber under an informal guardianship agreement. For a child to be considered a dependent of the subscriber under this provision:

(i) The guardianship agreement must be signed by the child's parent;

(ii) The guardianship agreement must authorize the subscriber to obtain medical care for the child;

(iii) The subscriber must be providing at least fifty percent of the child's support; and

(iv) The child must be on the account for BHP coverage.

(10) "Eligible full-time employee" means an employee who meets all eligibility requirements in WAC 182-25-030 and who is regularly scheduled to work thirty or more hours per week for an employer. The term includes a self-employed individual (including a sole proprietor or a partner of a partnership, and may include an independent contractor) if the individual:

(a) Is regularly scheduled to work thirty hours or more per week; and

(b) Derives at least seventy-five percent of his or her income from a trade or business that is licensed to do business in Washington.

Persons covered under a health benefit plan pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 shall not be considered eligible employees for purposes of minimum participation requirements.

(11) "Eligible part-time employee" means an employee who meets all the criteria in subsection (10) of this section, but who is regularly scheduled to work fewer than thirty hours per week for an employer.

(12) "Employee" means one who is in the employment of an employer, as defined by RCW 50.04.080.

(13) "Employer" means an enterprise licensed to do business in Washington state, as defined by RCW 50.04.080,

with employees in addition to the employer, whose wages or salaries are paid by the employer.

(14) "Enrollee" means a person who meets all applicable eligibility requirements, who is enrolled in BHP, and for whom applicable premium payments have been made.

(15) "Family" means an individual or an individual and eligible spouse and dependents. For purposes of eligibility determination and enrollment in BHP, an individual cannot be a member of more than one family.

(16) "Financial sponsor" means a person, organization or other entity, approved by the administrator, that is responsible for payment of all or a designated portion of the monthly premiums on behalf of a subscriber and any dependents.

(17) "Gross family income" means total cash receipts, as defined in (a) of this subsection, before taxes, from all sources, for subscriber and dependents whether or not they are enrolled in BHP, with the exceptions noted in (b) of this subsection. An average of documented income received over a period of several months will be used for purposes of eligibility determination, unless documentation submitted confirms a change in circumstances so that an average would not be an accurate reflection of current income. A twelve-month average will be used when calculating gambling income, lump-sum payments, and income from capital gains. A twelve-month history of receipts and expenses will be required for calculating self-employment or rental income unless the applicant or enrollee has not owned the business for at least twelve months.

(a) Income includes:

(i) Wages, tips and salaries before any deductions;

(ii) Net receipts from nonfarm self-employment (receipts from a person's own business, professional enterprise, or partnership, after deductions for business expenses). A net loss from self-employment will not be used to offset other income sources. In calculating net self-employment income, deductions will not be allowed for noncash-flow items such as depreciation, amortization, or business use of home, except that:

(A) A deduction for business use of the home may be allowed in cases where the enrollee has documented that more than fifty percent of their home is used for the business for the majority of the year; or

(B) A deduction for business use of the home may be allowed in cases where the enrollee has documented that they maintain a separate building located on the same property as their home that is used exclusively for the business;

(iii) Net receipts from farm self-employment (receipts from a farm which one operates as an owner, renter, or share-cropper, after deductions for farm operating expenses). In calculating net self-employment income, deductions will not be allowed for noncash-flow items such as depreciation, amortization, or business use of home, and a net loss from self-employment will not be used to offset other income sources;

(iv) Periodic payments from Social Security, railroad retirement, military pension or retirement pay, military disability pensions, military disability payments, government employee pensions, private pensions, unemployment compensation, workers' compensation, and strike benefits from union funds;

(v) Payments for punitive damages;

(vi) Public assistance, alimony, child support, and military family allotments;

(vii) Work study, assistantships, or training stipends;

(viii) Dividends and interest accessible to the enrollee without a penalty for early withdrawal;

(ix) Net rental income, net royalties, and net gambling or lottery winnings;

(x) Lump sum inheritances and periodic receipts from estates or trusts; and

(xi) Short-term capital gains, such as from the sale of stock or real estate.

(b) Income does not include the following types of money received:

(i) Any assets drawn down as withdrawals from a bank, the sale of property, a house or a car;

(ii) Tax refunds, gifts, loans, one-time insurance payments, other than for punitive damages, and one-time payments or winnings received more than one month prior to application;

(iii) Noncash receipts, such as the employer-paid or union-paid portion of health insurance or other employee fringe benefits, food or housing received in lieu of wages, the value of food and fuel produced and consumed on farms, the imputed value of rent from owner-occupied nonfarm or farm housing, goods or services received due to payments a trust makes to a third party, and such noncash benefit programs as Medicare, Medicaid, food stamps, school lunches, state supplementary payment income that is specifically dedicated to reimburse for services received, and housing assistance;

(iv) Income earned by dependent children with the exception of distributions from a corporation, partnership, or business;

(v) Income of a family member who resides in another household when such income is not available to the subscriber or dependents seeking enrollment in BHP;

(vi) College or university scholarships, grants, and fellowships;

(vii) Payments from the department of social and health services adoption support program authorized under RCW 26.33.320 and 74.13.100 through 74.13.145;

(viii) Long-term capital gains;

(ix) Crime victims' compensation;

(x) Documented child care expenses for the care of a dependent child of a subscriber may be deducted (at a rate set by the administrator and consistent with Internal Revenue Service requirements) when calculating gross family income. To qualify for this deduction:

(A) The subscriber and the spouse listed as a dependent on the account, if any, must be employed or attending school full-time during the time the child care expenses were paid; and

(B) Payment may not be paid to a parent or stepparent of the child or to a dependent child of the subscriber or his/her spouse.

(18) "Home care agency" means a private or public agency or organization that administers or provides home care services directly or through a contract arrangement to ill, disabled, or infirm persons in places of temporary or permanent residence, and is licensed by the department of social and health services (DSHS) as a home care agency. In order to qualify, the agency must be under contract with one of the

following DSHS programs: Chore, Medicaid Personal Care, Community Options Program Entry System (COPES) or Respite Care (up to level three).

(19) "Institution" means a federal, state, county, city or other government correctional or detention facility or government-funded facility where health care historically has been provided and funded through the budget of the operating agency, and includes, but is not limited to: Washington state department of corrections institutions; federal, county and municipal government jail and detention institutions; Washington state department of veterans affairs soldiers' and veterans' homes; department of social and health services state hospitals and facilities and juvenile rehabilitation institutions and group homes. An institution does not include: Educational institutions; government-funded acute health care or mental health facilities except as provided above; chemical dependency facilities; and nursing homes.

(20) "Institutionalized" means to be confined, voluntarily or involuntarily, by court order or health status, in an institution, as defined in subsection (19) of this section. This does not include persons on work release or who are residents of higher education institutions, acute health care facilities, alcohol and chemical dependency facilities, or nursing homes.

(21) "Insurance broker" or "agent" means a person who is currently licensed as a disability insurance broker or agent, according to the laws administered by the office of the insurance commissioner under chapter 48.17 RCW.

(22) "Managed health care system" (or "MHCS") means:

(a) Any health care organization (including health care providers, insurers, health care service contractors, health maintenance organizations, or any combination thereof) which has entered into a contract with the HCA to provide basic health care services; or

(b) A self-funded or self-insured method of providing insurance coverage to subsidized enrollees provided under RCW 41.05.140 and subject to the limitations under RCW 70.47.100(7).

(23) "Maternity benefits through medical assistance," also known as S-Medical, means the coordinated program between BHP and DSHS for eligible pregnant women. This program includes all Medicaid benefits, including maternity coverage. Eligible members must be at or below one hundred eighty-five percent of the federal poverty level. Eligibility for this program is determined by DSHS, based on Medicaid eligibility criteria.

(24) "Medicaid" means the Title XIX Medicaid program administered by the department of social and health services, and includes the medical care programs provided to the "categorically needy" and the "medically needy" as defined in chapter 388-503 WAC.

(25) "Medicare" means programs established by Title XVIII of Public Law 89-97, as amended, "Health Insurance for the Aged and Disabled."

(26) "Nonsubsidized enrollee" or "full premium enrollee" means an individual who enrolls in BHP, as the subscriber or dependent, and who pays or on whose behalf is paid the full costs for participation in BHP, without subsidy from the HCA.

(27) "Open enrollment" means a time period designated by the administrator during which enrollees may enroll addi-

tional dependents or apply to transfer their enrollment from one managed health care system to another.

(28) "Participating employee" means an employee of a participating employer or home care agency who has met all the eligibility requirements and has been enrolled for coverage under BHP.

(29) "Participating employer" means an employer who has been approved for enrollment in BHP as an employer group.

(30) "Preexisting condition" means any illness, injury or condition for which, in the six months immediately preceding an enrollee's effective date of enrollment in BHP:

(a) Treatment, consultation or a diagnostic test was recommended for or received by the enrollee; or

(b) Medication was prescribed or recommended for the enrollee; or

(c) Symptoms existed which would ordinarily cause a reasonably prudent individual to seek medical diagnosis, care or treatment.

(31) "Premium" means a periodic payment, determined under RCW 70.47.060(2), which an individual, an employer, a financial sponsor, or other entity makes to BHP for enrollment in BHP.

(32) "Program" means subsidized BHP, nonsubsidized BHP, BHP Plus, maternity benefits through medical assistance, or other such category of enrollment specified within this chapter.

(33) "Provider" or "health care provider" means a health care professional or institution duly licensed and accredited to provide covered services in the state of Washington.

(34) "Rate" means the amount, including administrative charges and any applicable premium and prepayment tax imposed under RCW 48.14.0201, negotiated by the administrator with and paid to a managed health care system, to provide BHP health care benefits to enrollees.

(35) "Schedule of benefits" means the basic health care services adopted and from time to time amended by the administrator, which an enrollee shall be entitled to receive from a managed health care system in exchange for payment of premium and applicable co-payments, as described in the member handbook.

(36) "Service area" means the geographic area served by a managed health care system as defined in its contract with HCA.

(37) "Subscriber" is a person who applies to BHP on his/her own behalf or on behalf of his/her dependents, if any, who is responsible for payment of premiums and to whom BHP sends notices and communications. The subscriber may be a BHP enrollee or the spouse, parent, or guardian of an enrolled dependent and may or may not be enrolled for coverage. Notices to a subscriber and, if applicable, a financial sponsor or employer shall be considered notice to the subscriber and his/her enrolled dependents.

(38) "Subsidized enrollee" or "reduced premium enrollee" means an individual who is not a full-time student who has received a temporary visa to study in the United States and who otherwise meets the criteria in (a), (b), or (c) of this subsection.

(a) An individual who enrolls in BHP, either as the subscriber or an eligible dependent, whose current gross family income does not exceed twice the federal poverty level as

adjusted for family size and determined annually by the federal Department of Health and Human Services, and who receives a premium subsidy from the HCA.

(b) An individual who enrolls in BHP, either as the subscriber or an eligible dependent, and who is a foster parent licensed under chapter 74.15 RCW and whose current gross family income does not exceed three hundred percent of the federal poverty level as adjusted for family size and determined annually by the federal Department of Health and Human Services, and who receives a premium subsidy from the HCA.

(c) To the extent that state funds are specifically appropriated for this purpose, with a corresponding federal match, "subsidized enrollee" also means an individual who enrolls in BHP, either as the subscriber or an eligible dependent, whose current gross family income is more than two hundred percent, but less than two hundred fifty-one percent, of the federal poverty level as adjusted for family size and determined annually by the federal Department of Health and Human Services, and who receives a premium subsidy from the HCA.

(39) "Subsidy" means the difference between the amount of periodic payment the HCA makes to a managed health care system on behalf of a subsidized enrollee, and the amount determined to be the subsidized enrollee's responsibility under RCW 70.47.060(2).

(40) "Washington state resident" or "resident," for purposes of this chapter, means a person who physically resides and maintains a residence in the state of Washington.

(a) To be considered a Washington resident, enrollees who are temporarily out of Washington state for any reason:

(i) May be required to demonstrate their intent to return to Washington state; and

(ii) May not be out of Washington state for more than three consecutive calendar months.

(b) Dependent children who meet the requirements of subsection (9)(b)(ii) of this section and are attending school out-of-state may be considered to be residents if they are out-of-state during the school year, provided their primary residence is in Washington state and they return to Washington state during breaks. Dependent children attending school out-of-state may also be required to provide proof that they pay out-of-state tuition, vote in Washington state and file their federal income taxes using a Washington state address.

(c) "Residence" may include, but is not limited to:

(i) A home the person owns or is purchasing or renting;

(ii) A shelter or other physical location where the person is staying in lieu of a home; or

(iii) Another person's home.

[Statutory Authority: RCW 70.47.050, 07-20-079 (Order 07-04), § 182-25-010, filed 10/1/07, effective 11/1/07; 06-11-158 (Order 05-06), § 182-25-010, filed 5/24/06, effective 7/1/06. Statutory Authority: RCW 70.47.050 and 2005 c 188, 05-17-078 (Order 05-03), § 182-25-010, filed 8/12/05, effective 9/12/05. Statutory Authority: RCW 70.47.050 and 2004 c 192, 04-23-012 (Order 04-03), § 182-25-010, filed 11/5/04, effective 1/1/05. Statutory Authority: RCW 70.47.050, 70.47.020(4) and 70.47.060 (5) and (9), 03-18-039 (Order 02-01), § 182-25-010, filed 8/27/03, effective 10/1/03. Statutory Authority: RCW 70.47.050, 70.47.020 (4) and (5), 70.47.060 (9) and (10), 74.08A.100 and 2002 c 371, 02-24-051 (Order 02-06), § 182-25-010, filed 12/3/02, effective 1/1/03. Statutory Authority: RCW 70.47.050, 01-09-001 (Order 00-08), § 182-25-010, filed 4/4/01, effective 5/5/01. Statutory Authority: RCW 70.47.050 and 70.47.020 as revised by E2SSB 6067, 01-01-134 (Order 00-04), § 182-25-010, filed 12/20/00, effective 1/20/01.]

Statutory Authority: RCW 70.47.050, 70.47.060 and 70.47.100, 99-24-005 (Order 99-06), § 182-25-010, filed 11/18/99, effective 12/19/99. Statutory Authority: RCW 70.47.050, 70.47.060(9) and SHB 2556, 98-15-018, § 182-25-010, filed 7/6/98, effective 8/6/98. Statutory Authority: RCW 70.47.050, 98-07-002, § 182-25-010, filed 3/5/98, effective 4/5/98; 97-15-003, § 182-25-010, filed 7/3/97, effective 8/3/97; 96-15-024, § 182-25-010, filed 7/9/96, effective 8/9/96.]

WAC 182-25-030 Eligibility. (1) To be eligible for enrollment in BHP, unless otherwise specified elsewhere in this chapter, an individual must be a Washington state resident who is not:

(a) Eligible for free Medicare coverage or eligible to buy Medicare coverage; or

(b) Institutionalized at the time of enrollment.

(2) Persons not meeting these criteria, as evidenced by information submitted on the application for enrollment or otherwise obtained by BHP, will not be enrolled. An enrollee who is no longer a Washington resident, who becomes eligible for free or purchased Medicare, or who is later determined to have failed to meet BHP's eligibility criteria at the time of enrollment, will be disenrolled from the plan as provided in WAC 182-25-090. An enrollee who was not confined to an institution at the time of enrollment, who is subsequently confined to an institution, will not be disenrolled, provided he or she remains otherwise eligible and continues to make all premium payments when due.

(3) Eligibility for BHP Plus and maternity benefits through medical assistance is determined by DSHS, based on Medicaid eligibility criteria.

(4) For subsidized enrollment in BHP, an individual must meet the eligibility criteria in subsection (1) of this section and the definition of "subsidized enrollee" in WAC 182-25-010(38), and must pay, or have paid on his or her behalf, the monthly BHP premium.

(5) To be eligible for nonsubsidized enrollment in BHP, an individual may have any income level, must meet the eligibility criteria in subsection (1) of this section, and must pay, or have paid on their behalf, the full costs for participation in BHP, including the cost of administration, without subsidy from the HCA.

(6)(a) An individual otherwise eligible for enrollment in BHP as a subsidized enrollee may be denied enrollment if the administrator has determined that acceptance of additional enrollment would exceed limits established by the legislature, would jeopardize the orderly development of BHP, or would result in an overexpenditure of BHP funds. An individual otherwise eligible for enrollment in either the subsidized or nonsubsidized program may also be denied enrollment if no MHCS is accepting new enrollment in that program or from the geographic area where the applicant lives.

(b) If the administrator closes or limits subsidized enrollment, to the extent funding is available, BHP will continue to accept and process applications for subsidized enrollment from:

(i) Children eligible for subsidized BHP, who were referred to DSHS for BHP Plus coverage, but were found ineligible for BHP Plus for reasons other than noncompliance;

(ii) Employees of a home care agency group enrolled or applying for coverage under WAC 182-25-060;

(iii) Eligible individual home care providers;

- (iv) Licensed foster care workers;
- (v) Persons who disenrolled from basic health in order to enroll in Medicaid, and subsequently became ineligible for Medicaid;
- (vi) Limited enrollment of new employer groups;
- (vii) Members of the Washington National Guard and Reserves who served in Operation Enduring Freedom, Operation Iraqi Freedom, or Operation Noble Eagle, and their spouses and dependents; and
- (viii) Subject to availability of funding, additional space for enrollment may be reserved for other applicants as determined by the administrator, in order to ensure continuous coverage and service for current individual and group accounts. (For example: Within established guidelines, processing routine income changes that may affect subsidy eligibility for current enrollees; adding new family members to an existing account; transferring enrollees between group and individual accounts; restoring coverage for enrollees who are otherwise eligible for continued enrollment under WAC 182-25-090 after a limited suspension of coverage due to late payment or other health care coverage; adding newly hired employees to an existing employer group; or adding new or returning members of federally recognized native American tribes to that tribe's currently approved financial sponsor group.)

(c) If the administrator has closed or limited subsidized enrollment, applicants for subsidized BHP who are not in any of the categories in (b) of this subsection may reserve space on a waiting list to be processed according to the date the waiting list request or application is received by BHP. When enrollment is reopened by the administrator, applicants whose names appear on the waiting list will be notified by BHP of the opportunity to enroll. BHP may require new application forms and documentation from applicants on the waiting list, or may contact applicants to verify continued interest in applying, prior to determining their eligibility.

[Statutory Authority: RCW 70.47.050, 07-23-109 (Order 07-07), § 182-25-030, filed 11/21/07, effective 11/21/07. Statutory Authority: RCW 70.47.050 and 2006 c 343, 06-18-055 (Order 06-05), § 182-25-030, filed 8/31/06, effective 10/1/06. Statutory Authority: RCW 70.47.050 and 2004 c 192, 04-23-012 (Order 04-03), § 182-25-030, filed 11/5/04, effective 1/1/05. Statutory Authority: RCW 70.47.050 and 70.47.020 as revised by E2SSB 6067, 01-01-134 (Order 00-04), § 182-25-030, filed 12/20/00, effective 1/20/01. Statutory Authority: RCW 70.47.050, 70.47.060 and 70.47.100, 99-24-005 (Order 99-06), § 182-25-030, filed 11/18/99, effective 12/19/99. Statutory Authority: RCW 70.47.050 and 70.47.060, 99-16-022 (Order 99-02), § 182-25-030, filed 7/26/99, effective 8/26/99. Statutory Authority: RCW 70.47.050, 98-07-002, § 182-25-030, filed 3/5/98, effective 4/5/98; 97-15-003, § 182-25-030, filed 7/3/97, effective 8/3/97; 96-15-024, § 182-25-030, filed 7/9/96, effective 8/9/96.]

WAC 182-25-040 Enrollment in the plan. (1) Any individual applying for enrollment in BHP must submit a signed, completed BHP application for enrollment. Applications for enrollment of children under the age of eighteen must be signed by the child's parent or guardian, who shall also be held responsible for payment of premiums due on behalf of the child. If an applicant is accepted for enrollment, the applicant's signature acknowledges the applicant's obligation to pay the monthly premium in accordance with the terms and conditions identified in the member handbook. Applications for BHP Plus enrollment on behalf of children under the age of nineteen will be referred to the department of

social and health services for Medicaid eligibility determination.

(2) Each applicant for subsidized enrollment or BHP Plus must list all eligible dependents, whether or not the dependents will be enrolled, and must supply other information and documentation as required by BHP and, where applicable, DSHS medical assistance.

(a) Applicants for subsidized enrollment must provide documentation showing the amount and sources of their gross family income. Income documentation must include a copy of the applicant's most recently filed federal income tax form or verification of nonfiling status, and copies of pay stubs or other documents showing income for the most recent thirty days or complete calendar month as of the date of application. Applicants who were not required to file a federal income tax return may be required to provide other documentation showing year-to-date income. As described in WAC 182-25-010(17), BHP may use an average of documented income when determining eligibility.

(b) Applicants for subsidized or nonsubsidized enrollment must provide documentation of Washington state residence, displaying the applicant's name and current address, for example, a copy of a current utility bill or rent receipt. Other documentation may be accepted if the applicant does not have a physical residence, for example, a signed statement from a person or other entity who is providing temporary shelter.

(c) BHP may request additional information from applicants for purposes of establishing or verifying eligibility, premium responsibility or MHCS selection.

(d) Submission of incomplete or inaccurate information may delay or prevent an applicant's enrollment in BHP. Intentional submission of false information will result in disenrollment of the subscriber and all enrolled dependents.

(3) Each member may be enrolled in only one BHP account. Each family applying for enrollment must designate a MHCS from which the applicant and all enrolled dependents will receive covered services. All applicants from the same family who are covered under the same account must receive covered services from the same MHCS (with the exception of cases in which a subscriber who is paying for BHP coverage for his/her dependent who lives in a different service area). No applicant will be enrolled for whom designation of a MHCS has not been made as part of the application for enrollment. Procedures for the selection of MHCS are set forth in the BHP member handbook. Generally, enrollees may change from one MHCS to another only during open enrollment or if they are able to show good cause for the transfer, for example, when enrollees move to an area served by a different MHCS or where they would be billed a higher premium for their current MHCS.

(4) When a MHCS assists BHP applicants in the enrollment process, it must provide them with the toll-free number for BHP and information on all MHCS available within the applicant's county of residence and the estimated premiums for each available MHCS.

(5) If specific funding has been appropriated for that purpose, insurance brokers or agents who have met all statutory and regulatory requirements of the office of the insurance commissioner, are currently licensed through the office of the insurance commissioner, and who have completed BHP's

training program, will be paid a commission for assisting eligible applicants to enroll in BHP.

(a) Individual policy commission: Subject to availability of funds, and as a pilot program, BHP will pay a one-time fee to any currently licensed insurance broker or agent who sells BHP to an eligible individual applicant if that applicant has not been a BHP member within the previous five years.

(b) Group policy commission: Subject to availability of funds, and as a pilot program, fees paid for the sale of BHP group coverage to an eligible employer will be based on the number of employees in the group for the first and second months of the group's enrollment.

(c) Insurance brokers or agents must provide the prospective applicant with the BHP toll-free information number and inform them of BHP benefits, limitations, exclusions, waiting periods, co-payments, all MHCSs available to the applicant within his/her county of residence and the estimated premium for each of them.

(d) All statutes and regulations of the office of the insurance commissioner will apply to brokers or agents who sell BHP, except they will not be required to be appointed by the MHCS.

(e) BHP will not pay renewal commissions.

(6) Except as provided in WAC 182-25-030 (6)(c), applications for enrollment will be reviewed by BHP within thirty days of receipt and those applicants satisfying the eligibility criteria and who have provided all required information, documentation and premium payments will be notified of their effective date of enrollment.

(7)(a) Eligible applicants will be enrolled in BHP in the order in which their completed applications, including all required documentation, have been received by BHP, provided that:

(i) At least one MHCS is accepting new enrollment in the program for which the applicant is applying and from the geographic area where the applicant lives; and

(ii) The applicant also remits full payment of the first premium bill to BHP by the due date specified by BHP.

(b) In the event a waiting list is implemented, eligible applicants will be enrolled in accordance with WAC 182-25-030(6).

(8) An open enrollment period of at least twenty consecutive days will be held annually. During this open enrollment period, enrollees may apply to enroll additional family members or to transfer their enrollment to a different MHCS, provided the MHCS selected is accepting new enrollment for the enrollee's program in the geographic area where the enrollee lives.

(9) Not all family members are required to apply for enrollment in BHP; however, any family member for whom application for enrollment is not made at the same time that other family members apply, may not subsequently enroll as a family member until the next open enrollment period, unless the subscriber has experienced a "qualifying change in family status." "Qualifying changes in family status" include:

(a) The loss of other health care coverage, for a family member who has previously waived coverage, provided BHP receives the family member's application within thirty days of the loss of other coverage, along with proof of the family member's continuous medical coverage from the date the subscriber enrolled in BHP;

(b) Marriage or assuming custody or dependency of a child or adult dependent (other than newborn or newly adopted children), provided BHP receives the new family member's application within thirty days of the change in family status;

(c) Addition of an eligible newborn child or a child newly placed for adoption provided BHP receives the child's application for enrollment within sixty days of the date of birth or placement for adoption. These children may be enrolled effective from the date of birth or placement for adoption; or

(d) Addition of a family member who was not previously eligible for coverage, and who has become eligible.

(10) Subscribers must notify BHP of any changes that could affect their eligibility or subsidy or their dependents' eligibility or subsidy:

(a) Within thirty days of the end of the first month of receiving an increased income; or

(b) Within thirty days of a change other than an income change (for example, a change in family size or address).

(11) BHP will verify the continuing eligibility of subsidized enrollees through the recertification process at least once every twelve months. Upon request of BHP, subsidized enrollees must submit evidence satisfactory to BHP, proving their continued eligibility for enrollment and for the premium subsidy they are receiving.

(a) BHP will verify income of subsidized enrollees through comparison with other state and federal agency records or other third-party sources.

(b) If the enrollee's income on record with other agencies or third-party source differs from the income the enrollee has reported to BHP, or if questions arise concerning the documentation submitted, BHP will require updated documentation from the enrollee to prove continued eligibility for the subsidy they are receiving. At that time, BHP may also require updated documentation of residence to complete the recertification process.

(c) Subsidized enrollees who have been enrolled in BHP six months or more and have not provided updated income documentation for at least six months will be required to submit new income documentation if their wage or salary income cannot be compared to an independent source for verification.

(d) Enrollees who have documented that they are not required to file a federal income tax return for previous years will not be required to provide additional verification of non-filing unless their circumstances appear to have changed or other information received indicates they have filed a federal income tax return.

(12) In addition to verification of income, subsidized and nonsubsidized enrollees must annually submit documentation satisfactory to BHP of the following:

(a) Washington state residence;

(b) Full-time student status for dependent students age nineteen through twenty-two; and

(c) Medicare ineligibility for enrollees age sixty-five or over.

(13) When determining eligibility for subsidized enrollment, noncitizens may be required to provide proof of immigration status, to verify whether they are here on a temporary visa to study in the United States.

(14) For good cause such as, but not limited to, when information received indicates a change in income or a source of income the enrollee has not reported, BHP may require enrollees to provide verification required in subsections (11) and (12) of this section more frequently, regardless of the length of time since their last recertification.

(15) Enrollees who fail to comply with a recertification request will be disenrolled, according to the provisions of WAC 182-25-090 (2)(e).

(16) If, as a result of recertification, BHP determines that an enrollee has not reported income or income changes accurately, the enrollee will be subject to the provisions of WAC 182-25-085.

[Statutory Authority: RCW 70.47.050. 07-23-109 (Order 07-07), § 182-25-040, filed 11/21/07, effective 11/21/07; 06-11-158 (Order 05-06), § 182-25-040, filed 5/24/06, effective 7/1/06. Statutory Authority: RCW 70.47.050 and 2005 c 188. 05-17-078 (Order 05-03), § 182-25-040, filed 8/12/05, effective 9/12/05. Statutory Authority: RCW 70.47.050 and 2004 c 192. 04-23-012 (Order 04-03), § 182-25-040, filed 11/5/04, effective 1/1/05. Statutory Authority: RCW 70.47.050. 04-15-109 (Order 04-05), § 182-25-040, filed 7/20/04, effective 8/20/04. Statutory Authority: RCW 70.47.050, 70.47.060(9), and 2002 c 371 § 212(5). 02-19-054 (Order 01-07), § 182-25-040, filed 9/12/02, effective 10/13/02. Statutory Authority: RCW 70.47.050, 70.47.060 and 70.47.100. 99-24-005 (Order 99-06), § 182-25-040, filed 11/18/99, effective 12/19/99. Statutory Authority: RCW 70.47.050 and 70.47.060. 99-16-022 (Order 99-02), § 182-25-040, filed 7/26/99, effective 8/26/99. Statutory Authority: RCW 70.47.050. 98-07-002, § 182-25-040, filed 3/5/98, effective 4/5/98; 97-15-003, § 182-25-040, filed 7/3/97, effective 8/3/97; 96-15-024, § 182-25-040, filed 7/9/96, effective 8/9/96.]

WAC 182-25-080 Premiums and co-payments. (1)

Subscribers or their employer or financial sponsor shall be responsible for paying the full monthly premium to BHP, on behalf of the subscriber and all enrolled dependents, according to the most current premium schedule. A third party may, with the approval of the administrator, become a financial sponsor and pay all or a designated portion of the premium on behalf of a subscriber and dependents, if any.

(2) The amount of premium due from or on behalf of a subsidized enrollee will be based upon the subscriber's gross family income, the managed health care system selected by the subscriber, rates payable to managed health care systems, and the number and ages of individuals in the subscriber's family.

(3) Once BHP has determined that an applicant and his/her dependents (if any) are eligible for enrollment, the applicant or employer or financial sponsor will be informed of the amount of the first month's premium for the applicant and his/her enrolled dependents. New enrollees will not be eligible to receive covered services on the effective date of enrollment specified by BHP unless the premium has been paid by the due date given. Thereafter, BHP will bill each subscriber or employer or financial sponsor monthly.

(4) Full payment for premiums due must be received by BHP by the date specified on the premium statement. If BHP does not receive full payment of a premium by the date specified on the premium statement, BHP shall issue a notice of delinquency to the subscriber, at the subscriber's last address on file with BHP or, in the case of group or financial sponsor coverage, to the employer or financial sponsor. If full payment is not received by the date specified in the delinquency notice, the subscriber and enrolled family members will be suspended from coverage for one month. If payment is not

received by the due date on the notice of suspension, the subscriber and enrolled family members will be disenrolled effective the date of the initial suspension. If an enrollee's coverage is suspended more than two times in a twelve-month period, the enrollee will be disenrolled for nonpayment under the provisions of WAC 182-25-090(2). Partial payment of premiums due, payment which for any reason cannot be applied to the correct BHP enrollee's account, or payment by check which is not signed, cannot be processed, or is returned due to nonsufficient funds will be regarded as nonpayment.

(5) Enrollees shall be responsible for paying any required co-payment, coinsurance, or deductible directly to the provider of a covered service or directly to the MHCS. Repeated failure to pay co-payments, coinsurance, or other cost-sharing in full on a timely basis may result in disenrollment, as provided in WAC 182-25-090(2).

(6) Monthly premiums due for foster parents with gross family income up to two hundred percent of the federal poverty level will be set at the minimum premium amount charged to enrollees with income below sixty-five percent of the federal poverty level. Monthly premiums due for foster parents with gross family income between two hundred percent and three hundred percent of the federal poverty level will not exceed one hundred dollars per month.

[Statutory Authority: RCW 70.47.050. 07-20-079 (Order 07-04), § 182-25-080, filed 10/1/07, effective 11/1/07. Statutory Authority: RCW 70.47.050 and 2004 c 192. 04-23-012 (Order 04-03), § 182-25-080, filed 11/5/04, effective 1/1/05. Statutory Authority: RCW 70.47.050 and 70.47.090. 02-19-053 (Order 01-08), § 182-25-080, filed 9/12/02, effective 10/13/02. Statutory Authority: RCW 70.47.050. 98-07-002, § 182-25-080, filed 3/5/98, effective 4/5/98; 96-15-024, § 182-25-080, filed 7/9/96, effective 8/9/96.]

Chapter 182-50 WAC

PRESCRIPTION DRUG PROGRAMS

WAC

182-50-005	Definitions.
182-50-200	Endorsing practitioner therapeutic interchange program; effect of practitioner's endorsing status; dispense as written instructions.

WAC 182-50-005 Definitions. When used in this chapter:

(1) "Appointing authority" shall mean the following persons acting jointly: The administrator of the health care authority, the secretary of the department of social and health services, and the director of the department of labor and industries.

(2) "Committee" means the independent Washington state pharmacy and therapeutics committee created by RCW 41.05.021 (1)(a)(iii) and 70.14.050. At the election of the department of social and health services, the committee may serve as the drug use review board provided for in WAC 388-530-1850.

(3) "Drug" means the term as it is defined in RCW 69.41.010 (9) and (12).

(4) "Endorsing practitioner" means a practitioner who has reviewed the preferred drug list and has notified the health care authority that he or she has agreed to allow therapeutic interchange of a preferred drug for any nonpreferred drug in a given therapeutic class.

(5) "Practitioner" means a health care provider, except a veterinarian, as defined at RCW 18.64.011(9).

(6) "Preferred drug" means a drug selected by the appointing authority for inclusion in the preferred drug list used by applicable state agencies for state purchased health care programs.

(7) "Preferred drug list" or "PDL" means the list of drugs selected by the appointing authority to be used by applicable state agencies as the basis for the purchase of drugs in state purchased health care programs.

(8) "Prescription" has the meaning set forth in RCW 18.64.011(8).

(9) "Refill" means the continuation of therapy with the same drug (including the renewal of a previous prescription or adjustments in dosage) when a prescription is for an antipsychotic, antidepressant, chemotherapy, antiretroviral, or immunosuppressive drug, or for the refill of an immunomodulator/antiviral treatment for hepatitis C for which an established, fixed duration of therapy is prescribed for at least twenty-four weeks but no more than forty-eight weeks.

(10) "State purchased health care" has the meaning set forth in RCW 41.05.011(2).

(11) "Therapeutic alternatives" are drug products of different chemical structure within the same pharmacologic or therapeutic class and that are expected to have similar therapeutic effects and safety profiles when administered in therapeutically equivalent doses.

(12) "Therapeutic interchange" means to dispense, with the endorsing practitioner's authorization, a therapeutic alternative to the prescribed drug.

[Statutory Authority: RCW 41.05.160 and 69.41.180. 07-19-031 (Order 07-03), § 182-50-005, filed 9/12/07, effective 10/13/07. Statutory Authority: RCW 41.05.160; 2004 1st sp.s. c 29 § 10. 04-06-021 (Order 03-02), § 182-50-005, filed 2/23/04, effective 3/25/04.]

WAC 182-50-200 Endorsing practitioner therapeutic interchange program; effect of practitioner's endorsing status; dispense as written instructions. (1) When filling prescriptions for participating state purchased health care programs, pharmacists shall dispense a preferred drug in place of a drug not included in the preferred drug list in a given therapeutic class whenever pharmacists receive a prescription from an endorsing practitioner except:

(a) If the endorsing practitioner determines the nonpreferred drug is medically necessary by indicating "dispense as written" on the prescription; or

(b) If the prescription is a refill of an antipsychotic, antidepressant, chemotherapy, antiretroviral, or immunosuppressive drug, or for the refill of an immunomodulator/antiviral treatment for hepatitis C for which an established, fixed duration of therapy is prescribed for at least twenty-four weeks but no more than forty-eight weeks.

(2) When a therapeutic interchange is made, the pharmacist shall notify the endorsing practitioner of the specific drug and dose dispensed.

(3) When a nonendorsing practitioner issues a prescription for a drug not included in the preferred drug list, the pharmacist shall dispense the prescribed drug in accordance with the requirements of RCW 69.41.100 through 69.41.180.

[Statutory Authority: RCW 41.05.160 and 69.41.180. 07-19-031 (Order 07-03), § 182-50-200, filed 9/12/07, effective 10/13/07. Statutory Authority: