

Title 182 WAC

HEALTH CARE AUTHORITY

Chapters

- 182-04** Public records.
- 182-08** Procedures.
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- 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
- 182-18-110 Kidney transplant program. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-110, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
- 182-18-120 Kidney transplant team training and experience. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-120, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
- 182-18-130 Pancreas transplant program. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-130, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
- 182-18-140 Pancreas transplant team training and experience. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-140, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
- 182-18-150 Heart and/or heart-lung transplant program. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-150, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
- 182-18-160 Heart and/or heart-lung transplant team training and experience. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-160, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.

DISPOSITION OF CHAPTERS FORMERLY CODIFIED IN THIS TITLE

Chapter 182-18

GENERAL REQUIREMENTS FOR ALL ORGAN TRANSPLANT PROGRAMS

- 182-18-005 Purpose. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-005, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
- 182-18-010 Transplant program. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-010, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
- 182-18-020 New programs. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-020, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
- 182-18-030 Pediatric programs. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-030, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
- 182-18-040 Transplant team training and experience. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-040, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
- 182-18-050 Multiple organ transplants. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-050, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
- 182-18-060 Institutional commitment. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-060, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
- 182-18-070 Patient management. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-070, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
- 182-18-080 General recipient selection criteria for all organs. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-080, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
- 182-18-090 Liver transplant program. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-090, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
- 182-18-100 Liver transplant team training and experience. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-100, filed 8/20/91, effective 9/20/91.] Repealed by

**Chapter 182-04 WAC
PUBLIC RECORDS**

WAC

- 182-04-010 Purpose.
- 182-04-015 Definitions.
- 182-04-025 Public records.
- 182-04-035 Office hours.
- 182-04-040 Request for public records.
- 182-04-041 Preserving requested records.
- 182-04-045 Copying.
- 182-04-050 Exemptions.
- 182-04-055 Review of denials of public records request.
- 182-04-060 Protection of public records.
- 182-04-070 Request for inspection of records.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

- 182-04-030 Public records officer. [Order 01-77, § 182-04-030, filed 8/26/77.] Repealed by 97-21-125, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.
- 182-04-065 Communication with the board. [Order 01-77, § 182-04-065, filed 8/26/77.] Repealed by 97-21-125, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.

WAC 182-04-010 Purpose. The purpose of this chapter shall be to insure compliance by the Washington state health care authority (HCA) with the provisions of chapter 42.17 RCW dealing with public records.

[Statutory Authority: RCW 41.05.160. 97-21-125, § 182-04-010, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-010, filed 8/26/77.]

WAC 182-04-015 Definitions. The following definitions shall apply:

(1) "HCA" means the Washington state health care authority, created pursuant to chapter 41.05 RCW.

(2) "Public record" includes any writing containing information relating to the conduct of government or the performance of any governmental agency or the performance of any governmental or proprietary information.

(3) "Writing" means all means of recording any form of communication or representation as defined in RCW 42.17-020(28).

[Statutory Authority: RCW 41.05.160, 97-21-125, § 182-04-015, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-015, filed 8/26/77.]

WAC 182-04-025 Public records. (1) All public records of the HCA as defined in WAC 182-04-015(2) shall be made available upon public request for inspection and copying pursuant to these rules, except however as provided by law.

(2) The public disclosure officer, or designee, shall respond promptly to requests for disclosure. Within five business days, the public disclosure officer, or designee shall respond by:

(a) Providing the record;

(b) Acknowledging the request and providing a reasonable estimate of the time it will take to respond to the request; or

(c) Denying the public record request.

(3) In acknowledging receipt of a public record request that is unclear, the public disclosure officer may ask the requestor to clarify what information the requestor is seeking. If the requestor fails to clarify the request, the public disclosure officer need not respond to it.

[Statutory Authority: RCW 41.05.160, 97-21-125, § 182-04-025, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-025, filed 8/26/77.]

WAC 182-04-035 Office hours. Public records shall be made available upon request only during working hours of the HCA. For the purpose of this chapter, the working hours shall be from 9:00 a.m. until noon, and from 1:00 p.m. until 4:00 p.m., Monday through Friday, excluding legal holidays.

[Statutory Authority: RCW 41.05.160, 97-21-125, § 182-04-035, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-035, filed 8/26/77.]

WAC 182-04-040 Request for public records. In accordance with the requirements of chapter 42.17 RCW that agencies prevent unreasonable invasion of privacy, and to protect public records from damage or disorganization, and to prevent excessive interference with essential functions of the agency, public records may be inspected or copied, or copies of such records may be obtained by the public, upon compliance with the following procedures:

(1) A request shall be made in writing or upon the form prescribed in WAC 182-04-070, which shall be available at the HCA. The form shall be presented to the public disclosure officer; or to any member of the agency's staff, if the public disclosure officer is not available, at the office of the agency during customary office hours. A request need merely identify with reasonable certainty the record sought to be disclosed. If the matter requested is referred to within the current index maintained by the public disclosure officer, a reference

to the requested record as it is described in such current index is desirable.

(2) In all cases in which a member of the public is making a request, it shall be the obligation of the public disclosure officer or staff member to assist the member of the public in appropriately identifying the public record requested.

(3) When the law makes a record disclosable to a specific person, a requestor may be required to provide personal identification.

[Statutory Authority: RCW 41.05.160, 97-21-125, § 182-04-040, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-040, filed 8/26/77.]

WAC 182-04-041 Preserving requested records. If a public record request is made at a time when such record exists but is scheduled for destruction in the near future, the public disclosure officer shall retain possession of the record, and may not destroy or erase the record until the request is resolved.

[Statutory Authority: RCW 41.05.160, 97-21-125, § 182-04-041, filed 10/21/97, effective 11/21/97.]

WAC 182-04-045 Copying. (1) No fee shall be charged for the inspection of public records.

(2) The agency shall collect the following fees to reimburse the agency for its actual costs incident to providing copies of public records:

(a) Fifteen cents per page for black and white photocopies, plus sales tax; and

(b) The cost of postage, if any.

(3) The public disclosure officer is authorized to waive the foregoing costs. Factors considered in deciding whether to waive costs include, but are not limited to: Providing the copy will facilitate administering the program, and/or the expense of processing the payment exceeds the copying and postage cost.

[Statutory Authority: RCW 41.05.160, 97-21-125, § 182-04-045, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-045, filed 8/26/77.]

WAC 182-04-050 Exemptions. (1) The HCA reserves the right to determine whether a public record requested in accordance with the procedures outlined in WAC 182-04-040 is exempted under statutory provisions.

(2) Pursuant to RCW 42.17.260, the HCA reserves the right to delete identifying details when it makes available or publishes any public record, in any case where there is reason to believe that disclosure of such details would be an invasion of personal privacy or vital governmental interest protected by chapter 42.17 RCW. The public disclosure officer will fully justify such deletion in writing in such a way so that the nature of the deleted information is made known.

(3) If disclosure is denied, the requestor is entitled to a written explanation of the denial which cites the relevant exemption and an explanation of how it applies to the record being denied.

[Statutory Authority: RCW 41.05.160, 97-21-125, § 182-04-050, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-050, filed 8/26/77.]

WAC 182-04-055 Review of denials of public records request. (1) Any person who objects to the denial of request for public record may petition for prompt review of such

decision by tendering a written request for review. The written request shall specifically refer to the written statement by the public disclosure officer or other staff member which constituted or accompanied the denial.

(2) Following receipt of a written request for review of a decision denying a public record, the disclosure officer shall immediately consider the matter and either affirm or reverse such denial. Such review shall be deemed completed at the end of the second business day following the receipt by the disclosure officer of the request for review. This shall constitute final agency action for the purposes of judicial review, pursuant to RCW 42.17.320.

[Statutory Authority: RCW 41.05.160, 97-21-125, § 182-04-055, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-055, filed 8/26/77.]

WAC 182-04-060 Protection of public records. Following are guidelines which shall be adhered to by any person inspecting such public records:

(1) Inspection of any public records shall be conducted only during working hours as specified in WAC 182-04-035 with the presence of an HCA employee;

(2) No public record shall be removed from the main office without the approval of the public disclosure officer or his/her designee;

(3) Public records shall not be marked, torn, or otherwise damaged;

(4) Public records must be maintained as they are in file or in a chronological order, and shall not be dismantled except for purposes of copying and then only by an HCA employee;

(5) Access to file cabinets and other places where public records are kept is restricted, and shall be used by employees of the HCA.

[Statutory Authority: RCW 41.05.160, 97-21-125, § 182-04-060, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-060, filed 8/26/77.]

WAC 182-04-070 Request for inspection of records. The HCA hereby adopts for use by all persons requesting inspection and/or copying of its records, the form set out below, entitled "Request for Inspection of Records."

The information requested in Blocks 4 through 6 is not mandatory, however, the completion of these blocks will enable this office to expedite your request and contact you should the record you seek not be immediately available.

1. Name	4. Phone Number
2. Address	5. Representing (if applicable)
3. Zip Code	6. If urgent - date needed

Below please state what record(s) you wish to inspect and be as specific as possible. If you are uncertain as to the type or identification of specific record or records we will assist you.

I certify that the information requested from the above record(s) will not be part of a list of individuals to be used for commercial purposes.

(Signed)

Date

Return the request for inspection of records to:

Public Disclosure Office
Health Care Authority
676 Woodland Square Loop S.E.
Post Office Box 42705
Olympia, Washington 98504-2705

[Statutory Authority: RCW 41.05.160 and chapter 41.05 RCW, 98-17-063, § 182-04-070, filed 8/17/98, effective 9/17/98. Statutory Authority: RCW 41.05.160, 97-21-125, § 182-04-070, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-070, filed 8/26/77.]

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 PEBB benefits and complete enrollment forms within thirty-one days of the date they become eligible for PEBB benefits.
- 182-08-198 When may a subscriber change health plans?
- 182-08-199 When may an employee enroll in or change their election under the premium payment plan, medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP)?
- 182-08-200 Which employing agency is responsible to pay the employer contribution for eligible employees changing agency employment?
- 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.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

- 182-08-020 Duties and responsibilities. [Statutory Authority: Chapter 41.05 RCW, 96-08-042, § 182-08-020, filed 3/29/96, effective 4/29/96; Order 7228, § 182-08-020, filed 12/8/76.] Repealed by 03-17-031 (Order 02-07), filed 8/14/03, effective 9/14/03. Statutory Authority: RCW 41.05.160 and 41.05.165.
- 182-08-030 Scope and construction of terms. [Order 7228, § 182-08-030, filed 12/8/76.] Repealed by 96-08-042, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.
- 182-08-040 Definitions. [Order 7228, § 182-08-040, filed 12/8/76.] Repealed by 96-08-042, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.
- 182-08-060 Approval of health maintenance organization plans. [Statutory Authority: RCW 41.05.010 and 41.05.025, 87-21-069 (Resolution No. 87-6), § 182-08-060, filed 10/19/87; Order 7228, § 182-08-060, filed 12/8/76.] Repealed by 96-08-042, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.
- 182-08-080 Employee to elect option. [Order 7228, § 182-08-080, filed 12/8/76.] Repealed by 79-11-064 (Order 2-79), filed 10/18/79. Statutory Authority: Chapter 41.05 RCW.
- 182-08-090 Transferred employee. [Order 3-77, § 182-08-090, filed 11/17/77; Order 7228, § 182-08-090, filed 12/8/76.] Repealed by 79-11-064 (Order 2-79), filed 10/18/79. Statutory Authority: Chapter 41.05 RCW.
- 182-08-095 Waiver of coverage for active employees. [Statutory Authority: RCW 41.05.160 and 41.05.165, 03-17-031 (Order 02-07), § 182-08-095, filed 8/14/03, effective 9/14/03. Statutory Authority: RCW 41.05.160 and 41.05.065, 01-24-048 (Order 01-05), § 182-08-095,

filed 11/29/01, effective 12/30/01. Statutory Authority: RCW 41.05.160. 99-19-029 (Order 99-03), § 182-08-095, filed 9/8/99, effective 10/9/99; 97-21-126, § 182-08-095, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-095, filed 3/29/96, effective 4/29/96.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.

182-08-110 Open enrollments. [Order 7228, § 182-08-110, filed 12/8/76.] Repealed by 96-08-042, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.

182-08-111 Medical plan options between open enrollments. [Statutory Authority: Chapter 41.05 RCW. 81-03-014 (Order 1-81), § 182-08-111, filed 1/9/81; 79-11-064 (Order 2-79), § 182-08-111, filed 10/18/79.] Repealed by 91-20-163, filed 10/2/91, effective 11/2/91. Statutory Authority: Chapter 41.05 RCW.

182-08-125 PEBB-sponsored medical and dental benefit is limited to one enrollment per individual member. [Statutory Authority: RCW 41.05.160 and 41.05.165. 03-17-031 (Order 02-07), § 182-08-125, filed 8/14/03, effective 9/14/03. Statutory Authority: RCW 41.05.160 and 41.05.065. 01-24-048 (Order 01-05), § 182-08-125, filed 11/29/01, effective 12/30/01.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.

182-08-130 New dependents' medical coverage after enrollment. [Order 7228, § 182-08-130, filed 12/8/76.] Repealed by Order 3-77, filed 11/17/77.

182-08-140 New dependents' life coverage after enrollment. [Order 7228, § 182-08-140, filed 12/8/76.] Repealed by 84-09-043 (Resolution No. 2-84), filed 4/16/84. Statutory Authority: Chapter 41.05 RCW.

182-08-150 Reduction or cancellation of optional insurance coverages. [Order 3-77, § 182-08-150, filed 11/17/77; Order 7228, § 182-08-150, filed 12/8/76.] Repealed by 84-09-043 (Resolution No. 2-84), filed 4/16/84. Statutory Authority: Chapter 41.05 RCW.

182-08-160 Group coverage when not in pay status. [Statutory Authority: RCW 41.05.160. 97-21-126, § 182-08-160, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-160, filed 3/29/96, effective 4/29/96; 93-23-065, § 182-08-160, filed 11/16/93, effective 12/17/93; 86-16-061 (Resolution No. 86-3), § 182-08-160, filed 8/5/86; 83-22-042 (Resolution No. 6-83), § 182-08-160, filed 10/28/83; 80-01-082 (Order 5-79), § 182-08-160, filed 12/27/79; 78-03-021 (Order 3-78), § 182-08-160, filed 2/14/78; Order 7228, § 182-08-160, filed 12/8/76.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.

182-08-165 Other group coverage option. [Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-165, filed 3/29/96, effective 4/29/96. Statutory Authority: RCW 41.05.065. 89-05-013 (Resolution No. 89-1), § 182-08-165, filed 2/9/89.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.

182-08-170 Insurance status for a reverted employee. [Statutory Authority: Chapter 41.05 RCW. 86-16-061 (Resolution No. 86-3), § 182-08-170, filed 8/5/86; 78-02-015 (Order 2-78), § 182-08-170, filed 1/10/78; Order 7228, § 182-08-170, filed 12/8/76.] Repealed by 96-08-042, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.

182-08-175 Group coverage while on family and medical leave. [Statutory Authority: RCW 41.05.160 and 41.05.165. 03-17-031 (Order 02-07), § 182-08-175, filed 8/14/03, effective 9/14/03. Statutory Authority: RCW 41.05.160. 97-21-126, § 182-08-175, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. 93-23-065, § 182-08-175, filed 11/16/93, effective 12/17/93.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.

182-08-195 Retroactive employer and employee contributions restricted. [Statutory Authority: Chapter 41.05 RCW. 84-09-043 (Resolution No. 2-84), § 182-08-195, filed 4/16/84.] Repealed by 96-08-042, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.

182-08-210 Termination of employer paid insurance benefit programs. [Statutory Authority: RCW 41.05.160 and 41.05.165. 03-17-031 (Order 02-07), § 182-08-210, filed 8/14/03, effective 9/14/03. Statutory Authority:

Chapter 41.05 RCW. 96-08-042, § 182-08-210, filed 3/29/96, effective 4/29/96; Order 3-77, § 182-08-210, filed 11/17/77.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.

182-08-300 Criteria for selection of insurance company for automobile and homeowners insurance. [Statutory Authority: Chapter 41.05 RCW. 81-03-014 (Order 1-81), § 182-08-300, filed 1/9/81.] Repealed by 96-08-042, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.

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

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

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

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

"Agency" means the health care authority.

"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.

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

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

"Employer group" means those employee organizations representing state civil service employees, blind vendors, counties, municipalities, political subdivisions, and tribal governments participating in PEBB insurance coverage under contractual agreement as described in WAC 182-08-230.

"Employing agency" means a division, department, or separate agency of state government; a county, municipality, school district, educational service district, or other political subdivision; or a tribal government covered by chapter 41.05 RCW.

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

"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.

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

"Open enrollment" means a time period when: Subscribers may apply to transfer their enrollment from one health plan to another; a dependent may be enrolled; a dependent's enrollment may be waived; or an employee who previously waived medical may enroll in medical. Open enrollment is also the time when employees may enroll in or change their election under the DCAP, the medical FSA, or the premium payment plan. An "annual" open enrollment, designated by the administrator, is an open enrollment when all PEBB subscribers may make enrollment changes for the upcoming year. A "special" open enrollment is triggered by a specific life event. For special open enrollment events as they relate to specific PEBB benefits, see WAC 182-08-198, 182-08-199, 182-12-128, 182-12-262.

"PEBB" means the public employees benefits board.

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

"PEBB benefits" means one or more insurance 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 for 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), eligible dependents (as defined in WAC 182-12-250 and 182-12-260) and others as defined in RCW 41.05.011.

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

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

"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

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

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

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

WAC 182-08-120 Employer contribution. The employers' contribution must be used to provide insurance coverage for the basic life insurance benefit, 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.

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 employing agency except as indicated in WAC 182-12-148(3).

(2) Notwithstanding subsection (1) of this section, the PEBB assistant administrator or the PEBB appeals committee 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 PEBB appeals committee; 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 employing agency, subscriber, or beneficiary, as appropriate.

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

WAC 182-08-190 The employer contribution is set by the HCA and paid to the HCA for all eligible employees. Every department, division, or agency of state government, and such county, municipal or other political subdivision, tribal government, or an agency or instrumentality of a tribal government, K-12 school district or educational service district that are covered under PEBB insurance coverage, must pay premium 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, tribal government, or an agency or instrumentality of a tribal government, 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. 08-20-128 (Order 08-03), § 182-08-190, filed 10/1/08, effective 1/1/09; 07-20-129 (Order 07-01), § 182-08-190, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-08-190, filed 8/26/04, effective 1/1/05; 03-17-031 (Order 02-07), § 182-08-190, filed 8/14/03, effective 9/14/03. Statutory Authority: RCW 41.05.160. 02-18-088 (Order 02-03), § 182-08-190, filed 9/3/02, effective 10/4/02. Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-190, filed 3/29/96, effective 4/29/96; 93-23-065, § 182-08-190, filed 11/16/93, effective 12/17/93; 78-02-015 (Order 2-78), § 182-08-190, filed 1/10/78; Order 3-77, § 182-08-190, filed 11/17/77.]

WAC 182-08-196 What happens if my health plan becomes unavailable? 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) 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. 08-20-128 (Order 08-03), § 182-08-196, filed 10/1/08, effective 1/1/09; 07-20-129 (Order 07-01), § 182-08-196, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160, 41.05.350, and 41.05.165. 05-16-046 (Order 05-01), § 182-08-196, filed 7/27/05, effective 8/27/05. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-08-196, filed 8/26/04, effective 1/1/05; 03-17-031 (Order 02-07), § 182-08-196, filed 8/14/03, effective 9/14/03.]

WAC 182-08-197 Employees must select PEBB benefits and complete enrollment forms within thirty-one days of the date they become eligible for PEBB benefits.

(1) Employees who are newly eligible for PEBB benefits must complete the appropriate forms indicating enrollment and their health plan choice, or their decision to waive medical under WAC 182-12-128. Employees must return the forms to their employing agency no later than thirty-one days 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 employ-

ing agency no later than sixty days after becoming eligible for PEBB benefits.

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

(c) 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) Employees who are eligible to participate in the state's salary reduction plan (see WAC 182-12-116) will be automatically enrolled in the premium payment plan upon enrollment in medical so employee medical premiums are taken on a pretax basis. To opt out of the premium payment plan, new employees must complete the appropriate form and return it to their employing agency no later than thirty-one days after they become eligible for PEBB benefits.

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

(5) 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 employing agency to another employing 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.

(6) When an employee's employment ends, participation in the state's salary reduction plan ends. If the employee is hired into a new position that is eligible for PEBB benefits in the same year, the employee may not resume participation in DCAP or medical FSA until the beginning of the next plan year, unless the time between employments is less than thirty days.

[Statutory Authority: RCW 41.05.160. 08-20-128 (Order 08-03), § 182-08-197, filed 10/1/08, effective 1/1/09; 07-20-129 (Order 07-01), § 182-08-197, filed 10/3/07, effective 11/3/07; 06-11-156 (Order 06-02), § 182-08-197, filed 5/24/06, effective 6/24/06. Statutory Authority: RCW 41.05.160, 41.05.350, and 41.05.165. 05-16-046 (Order 05-01), § 182-08-197, filed 7/27/05, effective 8/27/05.]

WAC 182-08-198 When may a subscriber change health plans? (1) Subscribers may change health plans during the annual open enrollment. The subscriber must submit the appropriate enrollment forms to change health plan no later than the end of the annual open enrollment. Enrollment in the new health plan will begin January of the following year.

(2) Subscribers may change health plans outside of the annual open enrollment if a special open enrollment event occurs. The change in enrollment must correspond to the event that creates the special open enrollment for either the subscriber or the subscriber's dependents or both. To make a health plan change, the subscriber must submit the appropriate enrollment forms (and a completed disenrollment form, if required) no later than sixty days after the event occurs. Employees submit the enrollment forms to their employing agency. All other subscribers submit the enrollment forms to the PEBB benefits services program. Enrollment in the new health plan will begin the first day of the month following the event that created the special open enrollment; or in cases where the event occurs on the first day of the month, enrollment will begin on that date. If the special open enrollment is due to the birth or adoption of a child, enrollment will begin the month in which the event occurs. The following events create a special open enrollment:

(a) Subscriber acquires a new eligible dependent through marriage, domestic partnership, birth, adoption or placement for adoption, legal custody or legal guardianship;

(b) Subscriber's dependent child becomes eligible by fulfilling PEBB dependent eligibility criteria;

(c) Subscriber loses an eligible dependent or a dependent no longer meets PEBB eligibility criteria;

(d) Subscriber has a change in marital status, including legal separation documented by a court order;

(e) Subscriber or a dependent loses comprehensive group health coverage;

(f) Subscriber or a dependent has a change in employment status that affects the subscriber's or a dependent's eligibility, level of benefits, or cost of insurance coverage.

(g) Subscriber or a dependent has a change in residence that affects health plan availability, benefits, or cost of insurance coverage. If the subscriber moves and the subscriber's current health plan is not available in the new location but the subscriber does not select a new health plan, the PEBB benefits services program may enroll the subscriber in the Uniform Medical Plan Preferred Provider Organization or Uniform Dental Plan.

(h) Subscriber receives a court order or medical support order requiring the subscriber, the subscriber's spouse, or the subscriber's qualified domestic partner to provide insurance coverage for an eligible dependent.

(i) Subscriber receives formal notice that the department of social and health services has determined it is more cost-effective to enroll the eligible subscriber or eligible dependent in PEBB medical than a medical assistance program.

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

(k) Subscriber enrolls in PEBB retiree insurance coverage.

(l) Subscriber or an eligible dependent becomes entitled to medicare, enrolls in or disenrolls from a medicare Part D plan.

(m) Subscriber experiences a disruption that could function as a reduction in benefits for the subscriber or the subscriber's dependent(s) due to a specific condition or ongoing course of treatment. A subscriber may not change their health plan if the subscriber's 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. 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.

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

[Statutory Authority: RCW 41.05.160. 08-20-128 (Order 08-03), § 182-08-198, filed 10/1/08, effective 1/1/09; 08-09-027 (Order 08-01), § 182-08-198, filed 4/8/08, effective 4/9/08; 07-20-129 (Order 07-01), § 182-08-198, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.-068. 06-23-165 (Order 06-09), § 182-08-198, filed 11/22/06, effective 12/23/06. Statutory Authority: RCW 41.05.160, 41.05.350, and 41.05.165. 05-16-046 (Order 05-01), § 182-08-198, filed 7/27/05, effective 8/27/05.]

WAC 182-08-199 When may an employee enroll in or change their election under the premium payment plan, medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP)? (1) An eligible employee may enroll in or change their election under the state's premium payment plan, medical FSA or DCAP during the annual open enrollment. Employees must submit the appropriate enrollment form, or complete the appropriate online enrollment process, to reenroll no later than the end of the annual open enrollment. The enrollment or new election will begin January of the following year.

(2) Employees may enroll or change their election under the state's premium payment plan, medical FSA or DCAP outside of the annual open enrollment if a special open enrollment event occurs. The enrollment or change in enrollment must be allowable under Internal Revenue Code (IRC) and correspond to the event that creates the special open enrollment. To make a change or enroll, the employee must submit the appropriate forms as instructed on the forms no later than sixty days after the event occurs. Enrollment will begin the first day of the month following approval by the plan administrator. For purposes of this section, an eligible dependent includes the employee's opposite sex spouse and any other person who qualifies as the employee's dependent under Section 152 of the IRC without regard to the income limitations of that section. It does not include a domestic partner who is

the same sex as the subscriber unless the domestic partner otherwise qualifies as a dependent under Section 152 of the IRC. The following changes are events that create a special open enrollment for purposes of an eligible employee making a change:

- (a) Employee acquires a new eligible dependent;
- (b) Employee's dependent child becomes eligible by fulfilling PEBB dependent eligibility criteria;
- (c) Employee loses an eligible dependent or a dependent no longer meets PEBB eligibility criteria;
- (d) Employee has a change in marital status, including legal separation documented by a court order;
- (e) Employee or a dependent has a change in employment status that affects the employee's or a dependent's eligibility, level of benefits, or cost of insurance coverage under a plan provided by the employee's employer or the dependent's employer;
- (f) Employee's or a dependent's residence changes that affects health plan availability, level of benefits, or cost of insurance coverage;
- (g) Employee receives a court order or medical support order requiring the employee or the employee's spouse to provide insurance coverage for an eligible dependent;
- (h) Employee receives formal notice that the department of social and health services has determined it is more cost-effective to enroll the eligible employee or eligible dependent in PEBB medical than in a medical assistance program;
- (i) Seasonal employees whose off-season occurs during the annual open enrollment may enroll in the plan upon their return to work;

(j) Employee or an eligible dependent gains or loses eligibility for medicare or medicaid;

(k) Employees who change dependent care providers may make a change in their DCAP to reflect the cost of the new provider;

(l) If an employee's dependent care provider imposes a change in the cost of dependent care, the employee may make a change in the DCAP to reflect the new cost if the dependent care provider is not a relative as defined in Section 152 (a)(1) through (8), incorporating the rules of Section 152 (b)(1) and (2) of the IRC;

(m) The employee or the employee's spouse experiences a change in the number of qualifying individuals as defined in IRC Section 21 (b)(1).

[Statutory Authority: RCW 41.05.160. 08-20-128 (Order 08-03), § 182-08-199, filed 10/1/08, effective 1/1/09.]

WAC 182-08-200 Which employing agency is responsible to pay the employer contribution for eligible employees changing agency employment? 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)(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).

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

(3) 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.

(4) 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 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.

(5) 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.

(6) 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.

(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 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.

(7) 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.

(8) 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. 08-20-128 (Order 08-03), § 182-08-230, filed 10/1/08, effective 1/1/09; 07-20-129 (Order 07-01), § 182-08-230, filed 10/3/07, effective 11/3/07. Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-08-230, filed 8/26/04, effective 1/1/05.]

Chapter 182-12 WAC

ELIGIBLE AND NONELIGIBLE EMPLOYEES

WAC

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182-12-128	May an employee waive health plan enrollment?
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 or tribal 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?
182-12-262	When may subscribers enroll, waive or remove 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

182-12-110	Purpose. [Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-110, filed 3/29/96, effective 4/29/96; Order 5646, § 182-12-110, filed 2/9/76.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.
182-12-117	Eligible retirees. [Statutory Authority: RCW 41.05.160 and 41.05.165. 03-17-031 (Order 02-07), § 182-12-117, filed 8/14/03, effective 9/14/03. Statutory Authority: RCW 41.05.160. 01-17-042 (Order 01-01), § 182-12-117, filed 8/9/01, effective 9/9/01; 97-21-127, § 182-12-117, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-117, filed 3/29/96, effective 4/29/96.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.
182-12-118	Insurance eligibility for surviving dependents of emergency service personnel killed in the line of duty. [Statutory Authority: RCW 41.05.160 and 41.05.065. 01-24-047 (Order 01-04), § 182-12-118, filed 11/29/01, effective 12/30/01.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.
182-12-119	Eligible dependents. [Statutory Authority: RCW 41.05.160 and 41.05.165. 03-17-031 (Order 02-07), § 182-12-119, filed 8/14/03, effective 9/14/03. Statutory Authority: RCW 41.05.160. 02-18-087 (Order 02-02), § 182-12-119, filed 9/3/02, effective 10/4/02; 01-01-126 (Order 00-02), § 182-12-119, filed 12/19/00, effective 1/19/01; 99-19-028 (Order 99-04), § 182-12-119, filed 9/8/99, effective 10/9/99; 97-21-127, § 182-12-119, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-119, filed 3/29/96, effective 4/29/96.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.
182-12-120	Noneligible employees. [Order 5646, § 182-12-120, filed 2/9/76.] Repealed by 88-12-034 (Resolution No. 88-1), filed 5/26/88, effective 7/1/88. Statutory Authority: RCW 41.05.010.
182-12-122	Surviving dependents eligibility. [Statutory Authority: Chapter 41.05 RCW. 86-16-061 (Resolution No. 86-3), § 182-12-122, filed 8/5/86; 80-05-016 (Order 2-80), § 182-12-122, filed 4/10/80; 78-08-071 (Order 5-78), § 182-12-122, filed 7/26/78.] Repealed by 96-08-043, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.
182-12-124	Determination by department of retirement systems of retroactive eligibility for PEBB pension. [Statutory Authority: RCW 41.05.160 and 41.05.165. 03-17-031 (Order 02-07), § 182-12-124, filed 8/14/03, effective 9/14/03.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.
182-12-125	Employee or dependents become ineligible for state group coverage. [Statutory Authority: Chapter 41.05 RCW. 84-09-043 (Resolution No. 2-84), § 182-12-125, filed 4/16/84; Order 5646, § 182-12-125, filed 2/9/76.] Repealed by 84-14-058 (Order 5-84), filed 6/29/84. Statutory Authority: Chapter 41.05 RCW.
182-12-126	Extension of retiree dependents' eligibility. [Statutory Authority: Chapter 41.05 RCW. 86-16-061 (Resolution No. 86-3), § 182-12-126, filed 8/5/86.] Repealed by 87-21-069 (Resolution No. 87-6), filed 10/19/87. Statutory Authority: RCW 41.05.010 and 41.05.025.
182-12-127	Extension of retiree dependents' eligibility. [Statutory Authority: RCW 41.05.065. 89-12-045 (Resolution No. 89-2), § 182-12-127, filed 6/2/89. Statutory Authority: RCW 41.05.010. 88-19-078 (Resolution No. 88-4), § 182-12-127, filed 9/19/88. Statutory Authority: RCW 41.05.010 and 41.05.025. 87-21-069 (Resolution No. 87-6), § 182-12-127, filed 10/19/87.] Repealed by 91-

- 11-010, filed 5/3/91, effective 6/3/91. Statutory Authority: RCW 41.05.010 and 41.05.025.
- 182-12-130 Retirees eligible for medicare. [Statutory Authority: Chapter 41.05 RCW. 91-14-084, § 182-12-130, filed 7/1/91, effective 7/1/91; 80-05-016 (Order 2-80), § 182-12-130, filed 4/10/80; Order 4-77, § 182-12-130, filed 11/17/77; Order 5646, § 182-12-130, filed 2/9/76.] Repealed by 96-08-043, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.
- 182-12-132 Deferring coverage at or following retirement. [Statutory Authority: RCW 41.05.160 and 41.05.165. 03-17-031 (Order 02-07), § 182-12-132, filed 8/14/03, effective 9/14/03. Statutory Authority: RCW 41.05.160. 02-18-087 (Order 02-02), § 182-12-132, filed 9/3/02, effective 10/4/02; 01-01-126 (Order 00-02), § 182-12-132, filed 12/19/00, effective 1/19/01; 97-21-127, § 182-12-132, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-132, filed 3/29/96, effective 4/29/96; 80-05-016 (Order 2-80), § 182-12-132, filed 4/10/80.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.
- 182-12-135 Eligibility for employees on leave without pay. [Order 4-77, § 182-12-135, filed 11/17/77; Order 5646, § 182-12-135, filed 2/9/76.] Repealed by 80-05-016 (Order 2-80), filed 4/10/80. Statutory Authority: Chapter 41.05 RCW.
- 182-12-140 New eligible employees. [Order 4-77, § 182-12-140, filed 11/17/77; Order 5646, § 182-12-140, filed 2/9/76.] Repealed by 89-05-013 (Resolution No. 89-1), filed 2/9/89. Statutory Authority: RCW 41.05.065.
- 182-12-145 Insurance eligibility for higher education. [Statutory Authority: RCW 41.05.160 and 41.05.165. 03-17-031 (Order 02-07), § 182-12-145, filed 8/14/03, effective 9/14/03. Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-145, filed 3/29/96, effective 4/29/96; Order 5646, § 182-12-145, filed 2/9/76.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.
- 182-12-150 Husband and wife are eligible employees. [Order 5646, § 182-12-150, filed 2/9/76.] Repealed by Order 4-77, filed 11/17/77.
- 182-12-151 Dependent life insurance. [Order 01-77, § 182-12-151, filed 8/26/77.] Repealed by 96-08-043, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.
- 182-12-155 Classified employee eligible for employer contribution. [Order 5646, § 182-12-155, filed 2/9/76.] Repealed by Order 4-77, filed 11/17/77.
- 182-12-160 Elected officials. [Statutory Authority: Chapter 41.05 RCW. 86-06-003 (Resolution No. 86-1), § 182-12-160, filed 2/20/86; Order 5646, § 182-12-160, filed 2/9/76.] Repealed by 96-08-043, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.
- 182-12-165 State contribution for permanent employees appointed to instructional year or seasonal positions. [Statutory Authority: RCW 41.05.010. 88-12-034 (Resolution No. 88-1), § 182-12-165, filed 5/26/88, effective 7/1/88; Order 7228, § 182-12-165, filed 12/8/76.] Repealed by 96-08-043, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.
- 182-12-170 State contributions for medicare for actively employed. [Order 7228, § 182-12-170, filed 12/8/76.] Repealed by 83-22-042 (Resolution No. 6-83), filed 10/28/83. Statutory Authority: Chapter 41.05 RCW.
- 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.
- 182-12-210 Extended self-pay medical and dental coverage. [Statutory Authority: RCW 41.05.065. 89-12-045 (Resolution No. 89-2), § 182-12-210, filed 6/2/89. Statutory Authority: RCW 41.05.010. 88-19-078 (Resolution No. 88-4), § 182-12-210, filed 9/19/88. Statutory Authority: Chapter 41.05 RCW. 87-07-034 (Resolution No. 87-2), § 182-12-210, filed 3/13/87; 86-16-061 (Resolution No. 86-3), § 182-12-210, filed 8/5/86.] Repealed by 91-11-010, filed 5/3/91, effective 6/3/91. Statutory Authority: RCW 41.05.010 and 41.05.025.
- 182-12-215 Continued PEBB medical/dental coverage under COBRA. [Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-215, filed 3/29/96, effective 4/29/96. Statutory Authority: RCW 41.05.010 and 41.05.025. 91-11-010, § 182-12-215, filed 5/3/91, effective 6/3/91.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.
- 182-12-220 Eligibility during appeal of dismissal. [Statutory Authority: RCW 41.05.160 and 41.05.165. 03-17-031 (Order 02-07), § 182-12-220, filed 8/14/03, effective 9/14/03. Statutory Authority: RCW 41.05.160. 02-18-088 (Order 02-03), § 182-12-220, filed 9/3/02, effective 10/4/02. Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-220, filed 3/29/96, effective 4/29/96; 86-16-061 (Resolution No. 86-3), § 182-12-220, filed 8/5/86.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.
- 182-12-230 Employer groups. [Statutory Authority: RCW 41.05.160. 02-18-087 (Order 02-02), § 182-12-230, filed 9/3/02, effective 10/4/02. Statutory Authority: RCW 41.05.160, 41.05.021 (1)(h). 02-08-047 (Order 01-09), § 182-12-230, filed 3/29/02, effective 4/29/02.] Repealed by 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.

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:

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

"Agency" means the health care authority.

"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.

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

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

"Employing agency" means a division, department, or separate agency of state government; a county, municipality, school district, educational service district, or other political subdivision; or a tribal government covered by chapter 41.05 RCW.

"Employer group" means those employee organizations representing state civil service employees, blind vendors, counties, municipalities, political subdivisions, and tribal governments participating in PEBB insurance coverage under contractual agreement as described in WAC 182-08-230.

"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.

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

"Open enrollment" means a time period when: Subscribers may transfer their enrollment from one health plan to another; a dependent may be enrolled; a dependent's enrollment may be waived; or an employee who previously waived medical may enroll in medical. Open enrollment is also the time when employees may enroll in or change their election under the DCAP, the medical FSA, or the premium payment plan. An "annual" open enrollment, designated by the administrator, is an open enrollment when all PEBB subscribers may make enrollment changes for the upcoming year. A "special" open enrollment is triggered by a specific life event. For special open enrollment events as they relate to specific PEBB benefits, see WAC 182-08-198, 182-08-199, 182-12-128, 182-12-262.

"PEBB" means the public employees benefits board.

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

"PEBB benefits" means one or more insurance 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 for eligible employees of the state (as defined in WAC 182-12-115), eligible retired and disabled employees (as defined in WAC 182-12-171), eligible dependents (as defined in WAC 182-12-250 and 182-12-260) and others as defined in RCW 41.05.011.

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

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

"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 contracted vendors will issue all notices, information, requests and premium bills on behalf of enrollees.

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

"Waive" means to interrupt 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. 08-20-128 (Order 08-03), § 182-12-109, filed 10/1/08, effective 1/1/09; 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 with the following exceptions:

- Bargaining units may elect to participate separately from the whole group; and
- 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 a 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 sixty 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.

(h) Employees eligible for PEBB participation include only those employees whose services are substantially all in the performance of essential governmental functions but not in the performance of commercial activities, whether or not those activities qualify as essential governmental functions. Employers shall determine eligibility in order to ensure PEBB's continued status as a governmental plan under Section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA) as amended.

(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 with the following exception:

- Bargaining units may elect to participate separately from the whole group; and
- 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 a 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 sixty days before the effective date of termination. If a county, municipality, or political subdivision 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.

(h) Employees eligible for PEBB participation include only those employees whose services are substantially all in the performance of essential governmental functions but not in the performance of commercial activities, whether or not those activities qualify as essential governmental functions. Employers shall determine eligibility in order to ensure PEBB's continued status as a governmental plan under Section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA) as amended.

(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 K-12 school district or educational service district must transfer to PEBB insurance coverage as a unit with the following exceptions:

- Bargaining units may elect to participate separately from the whole group; and
- Nonrepresented employees may elect to participate separately from the whole group provided all nonrepresented employees join as a group.

(b) The school district or educational service district must submit an application together with an estimate of the number of employees and dependents to be enrolled. The application for the PEBB insurance coverage is subject to review for compliance with PEBB terms and conditions of participation.

(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 sixty days before the effective date of termination, and may end participation only at the end of a plan year.

(h) Employees eligible for PEBB participation include only those employees whose services are substantially all in the performance of essential governmental functions but not in the performance of commercial activities, whether or not those activities qualify as essential governmental functions. Employers shall determine eligibility in order to ensure PEBB's continued status as a governmental plan under Section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA) as amended.

(6) Tribal governments: Employees of a tribal government, or an agency or instrumentality of a tribal government, 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 as a unit with the following exceptions:

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

- 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 tribal council 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 tribal council 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 a 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 tribal government employees must be the same as the requirements for dependents of state employees and retirees in WAC 182-12-260.

(g) The tribal council or the board of directors must give the HCA written notice of its intent to end PEBB insurance coverage participation at least sixty days before the effective date of termination. If a tribal government, or an agency or instrumentality of a tribal government, ends PEBB insurance coverage, retired and disabled employees are not eligible for PEBB insurance coverage beyond the mandatory extension requirements specified in WAC 182-12-146.

(h) Employees eligible for PEBB participation include only those employees whose services are substantially all in the performance of essential governmental functions but not in the performance of commercial activities, whether or not those activities qualify as essential governmental functions. Employers shall determine eligibility in order to ensure PEBB's continued status as a governmental plan under Section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA) as amended.

(7) 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. 08-20-128 (Order 08-03), § 182-12-111, filed 10/1/08, effective 1/1/09; 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 and technical colleges to be higher education agencies.

[Statutory Authority: RCW 41.05.160. 08-20-128 (Order 08-03), § 182-12-112, filed 10/1/08, effective 1/1/09; 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 begin-

ning 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 to participate in the state's salary reduction plan? (1) The following employees are eligible to participate in the state's salary reduction plan provided they are eligible for PEBB benefits as defined in WAC 182-12-115 and they elect to participate within the time frames described in WAC 182-08-197 or 182-08-199.

(a) Employees of public four-year institutions of higher education.

(b) Employees of the state community and technical colleges and of the state board for community and technical colleges.

(c) Employees of state agencies.

(2) Employees of employer groups, K-12 school districts and educational service districts are not eligible to participate in the state's salary reduction plan.

[Statutory Authority: RCW 41.05.160. 08-20-128 (Order 08-03), § 182-12-116, filed 10/1/08, effective 1/1/09; 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 182-12-121 Does a change in position or job affect eligibility status? Employees who voluntarily move from an eligible to an otherwise noneligible position shall retain their eligibility for the employer contribution each month in which they are in pay status eight or more hours, provided, (1) the new position is one in which the employee is scheduled to work half time or more, and (2) the employee did not terminate state service before taking the new position. Layoff because of reduction in force is not considered termination of state service. Proviso (1) above does not apply to employees who are on reduction in force status.

[Statutory Authority: RCW 41.05.160 and 41.05.165. 04-18-039, § 182-12-121, filed 8/26/04, effective 1/1/05. Statutory Authority: Chapter 41.05 RCW. 80-01-082 (Order 5-79), § 182-12-121, filed 12/27/79.]

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 May an employee waive health plan enrollment? (1) Employees must enroll in dental, life and long-term disability insurance (unless the employing agency does not participate in these PEBB insurance coverages). However, employees may waive PEBB medical if they have other comprehensive group medical coverage. Employees may waive enrollment in PEBB medical by submitting the appropriate enrollment form to their employing agency during the following times:

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

(b) Employees may waive medical during the annual open enrollment if they submit the appropriate enrollment form to their employing agency before the end of the annual

open enrollment. Medical will be waived beginning January of the following year.

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

(2) If an employee waives medical, medical is automatically waived for all eligible dependents, with the exception of adult dependents who may enroll in a health plan if the employee has waived medical coverage.

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

(a) The annual open enrollment period;

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

(4) Employees may waive enrollment in medical or enroll in medical if one of these special open enrollment events occur. The change in enrollment must correspond to the event that creates the special open enrollment. The following changes are events that create a special open enrollment:

(a) Employee acquires a new eligible dependent through marriage, domestic partnership, birth, adoption or placement for adoption, legal custody or legal guardianship;

(b) Employee's dependent child becomes eligible by fulfilling PEBB dependent eligibility criteria;

(c) Employee loses an eligible dependent or a dependent no longer meets PEBB eligibility criteria;

(d) Employee has a change in marital status, including legal separation documented by a court order;

(e) Employee or a dependent loses comprehensive group insurance coverage;

(f) Employee or a dependent has a change in employment status that affects the employee's or a dependent's eligibility, level of benefits, or cost of insurance coverage;

(g) Employee or a dependent has a change in place of residence that affects the employee's or a dependent's eligibility, level of benefits, or cost of insurance coverage;

(h) Employee receives a court order or medical support enforcement order requiring the employee, spouse, or qualified domestic partner to enroll an eligible dependent;

(i) Employee receives formal notice that the department of social and health services has determined it is more cost-effective to enroll the employee or an eligible dependent in PEBB medical than a medical assistance program.

To change enrollment during a special open enrollment, the employee must submit the appropriate forms to their employing agency no later than sixty days after the event that creates the special open enrollment.

Enrollment in insurance coverage will begin the first of the month following the event that created the special open enrollment; or in cases where the event occurs on the first day of a month, enrollment will begin on that date. If the special open enrollment is due to the birth or adoption of a child, insurance coverage will begin the month in which the event occurs.

[Statutory Authority: RCW 41.05.160. 08-20-128 (Order 08-03), § 182-12-128, filed 10/1/08, effective 1/1/09; 08-09-027 (Order 08-01), § 182-12-128,

filed 4/8/08, effective 4/9/08; 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 twenty-six weeks, as provided in WAC 182-12-138.

[Statutory Authority: RCW 41.05.160. 08-20-128 (Order 08-03), § 182-12-133, filed 10/1/08, effective 1/1/09; 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 approved leave under the federal Family and Medical Leave Act (FMLA) may continue to receive up to twenty-six weeks of employer-paid medical, dental, basic life, and basic long-term disability insurance. These employees may also continue current optional life and long-term disability. The employee's employing agency is responsible for determining if the employee is eligible for leave under FMLA and the duration of such leave. The employee must pay the premium amounts associated with insurance coverage monthly as premiums become due. If premiums are more than sixty days delinquent, insurance coverage will end as of the last day of the month for which a full premium is paid.

[Statutory Authority: RCW 41.05.160. 08-20-128 (Order 08-03), § 182-12-138, filed 10/1/08, effective 1/1/09; 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.

(2009 Ed.)

(a) The employee must submit the appropriate forms to enroll or defer insurance coverage within sixty days after the employee's employer paid or COBRA coverage ends. The effective date of health plan enrollment will be the first day of the month following the loss of other coverage.

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

Employees who do not enroll in a PEBB health plan at retirement are only eligible to enroll if they have deferred enrollment and maintained comprehensive coverage as identified 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 the employee's 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 PEBB appeals committee to determine eligibility (see WAC 182-16-032). 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 a Washington state-sponsored retirement plan 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 or tribal government that participates in PEBB insurance coverage for their employees are eligible to continue PEBB insurance coverage as retirees if the employees meet the procedural and eligibility requirements under this section.

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

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

(c) **Washington state K-12 school district and educational service district employees for districts that do not participate in PEBB 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 annual 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. 08-20-128 (Order 08-03), § 182-12-171, filed 10/1/08, effective 1/1/09; 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 or tribal government entity applying for participation in PEBB insurance coverage include their retirees in the transfer unit?

Local government or tribal government entities applying for participation in PEBB insurance coverage under WAC 182-12-111 (4) and (6), 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 or tribal 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 or tribal 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 or tribal government retiree health plan.

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

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

(b) May adopt a new rating methodology reflective of the cost of covering local government or tribal 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 or tribal government transferring to PEBB health plan coverage must meet retiree eligibility as outlined in chapter 182-12 WAC.

[Statutory Authority: RCW 41.05.160. 08-20-128 (Order 08-03), § 182-12-175, filed 10/1/08, effective 1/1/09; 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 annual open enrollment period. (Enrollment in the PEBB health plan will begin the first day of January after the annual 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. 08-20-128 (Order 08-03), § 182-12-200, filed 10/1/08, effective 1/1/09; 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 and for adult dependents as defined in WAC 182-12-260 (4)(d), if retirees defer 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 submit the appropriate forms 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 submitting the appropriate forms and evidence of continuous enrollment in comprehensive employer-sponsored medical to the PEBB benefits services program:

(i) During annual open enrollment. (Enrollment in the PEBB health plan will begin the first day of January after the annual open enrollment.); 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 submitting the appropriate forms and evidence of continuous enrollment in a federal retiree medical plan to the PEBB benefits services program:

(i) During annual open enrollment. (Enrollment in the PEBB health plan will begin the first day of January after the annual open enrollment.); 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 submitting the appropriate forms and evidence of continuous enrollment in creditable coverage to the PEBB benefits services program:

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

(d) Retirees who defer enrollment may enroll in a PEBB health plan if the retiree receives formal notice that the department of social and health services has determined it is more cost-effective to enroll the retiree or the retiree's eligible dependent(s) in PEBB medical than a medical assistance program.

[Statutory Authority: RCW 41.05.160. 08-20-128 (Order 08-03), § 182-12-205, filed 10/1/08, effective 1/1/09; 08-09-027 (Order 08-01), § 182-12-205, filed 4/8/08, effective 4/9/08; 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 the appropriate forms 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. 08-20-128 (Order 08-03), § 182-12-209, filed 10/1/08, effective 1/1/09; 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 unmarried children of the emergency service worker who are under the age of twenty-five. Children with disabilities as defined in RCW 41.26.030(7) are eligible at any age. "Children" is 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 submit the appropriate forms (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 appropriate forms are received by the PEBB benefits services program no later than September 1, 2006;

(b) The first of the month that is not earlier than sixty days before the date that the PEBB benefits services program

receives the appropriate forms (for example, if the PEBB benefits services program receives the appropriate forms on August 29, the survivor may request health plan enrollment to begin on July 1); or

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

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). For children age twenty through age twenty-four who enroll and are not students under the age of twenty-four attending high school or registered at an accredited secondary school, college, university, vocational school, or school of nursing: The adult dependent premium 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 medical 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 annual open enrollment. In addition to annual 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. 08-20-128 (Order 08-03), § 182-12-250, filed 10/1/08, effective 1/1/09; 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.]

(2009 Ed.)

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 in Washington state.

(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. Children are defined as the subscriber's biological children, stepchildren, legally adopted children, children for whom the subscriber has assumed a legal obligation for total or partial support 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. In addition, children include extended dependents in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or subscriber's qualified domestic partner. The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. "Children" does not include foster children for whom support payments are made to the subscriber through the state department of social and health services foster care program.

Eligible children include:

(a) Unmarried children through age nineteen.

(b) Married children through age nineteen who qualify as dependents of the subscriber under the Internal Revenue Code.

(c) Unmarried children age twenty through age twenty-three who are attending high school or are registered students at an accredited secondary school, college, university, vocational school, or school of nursing (students). A married child is eligible as a student if the child is a dependent of the subscriber under the Internal Revenue Code.

(i) A child is eligible as a student or can maintain eligibility as a student when not registered for courses through the summer or off quarter/semester as long as the child meets all other eligibility requirements and is in any one of the following circumstances:

- The child attended the three consecutive quarters or two consecutive semesters before the off quarter/semester.

- The child is an enrolled dependent turning age twenty or renewing annual student certification and the child is expected to register for three consecutive quarters or two consecutive semesters after the off quarter/semester.

- The child recently graduated. Graduation is defined as the successful completion of studies to earn a degree or certificate, not the date of the graduation ceremony. The child is eligible for the three month period following graduation.

(ii) For student dependents who are not eligible for the summer or off quarter/semester according to (c)(i) of this subsection, student eligibility begins the first day of the month of the quarter or semester for which the child is registered, and eligibility ends the last day of the month in which the student stops attending or in which the quarter or semester ends, whichever is first.

The PEBB benefits services program certifies students annually. Health plan enrollment ends the last day of the month in which certification ends or the student ceases to meet eligibility criteria, whichever comes first. See WAC 182-12-262 (3)(g) and (7) for enrollment requirements.

(d) Unmarried children age twenty through age twenty-four (adult dependents).

Subscriber must pay the adult dependent premium for adult dependents whom the subscriber has enrolled. Nonpayment of premium will result in termination of coverage back to the end of the month for which the last full month premium was paid.

Adult dependents must enroll in the same health plan as the subscriber.

Exception: The adult dependent may enroll in a different health plan than the subscriber if the dependent does not reside within the subscriber's plan service area or the subscriber has waived or deferred medical.

(e) 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 (c) of this subsection.

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

(i) For a child 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 a child enrolled in PEBB insurance coverage as a student under (c) of this subsection, the subscriber must provide evidence of the disability within sixty days after the student is no longer eligible under (c) of this subsection.

(iii) For a child, age twenty or older, who is a new dependent or for a child, age twenty or older, who is a dependent of a newly eligible subscriber, the child may be enrolled as a dependent child with disabilities if the subscriber provides evidence that the condition occurred before the child reached age twenty or evidence that when the condition occurred the child would have satisfied PEBB eligibility for student coverage under (c) of this subsection had the subscriber been eligible for PEBB benefits at the time.

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.

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 as an adult dependent, as per (d) of this subsection, or in a PEBB health plan under provisions of WAC 182-12-270.

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

The PEBB benefits services program will recertify the eligibility of children with disabilities periodically.

(5) Parents.

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

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

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

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

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

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

(6) 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. 08-20-128 (Order 08-03), § 182-12-260, filed 10/1/08, effective 1/1/09; 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 182-12-262 When may subscribers enroll, waive or remove eligible dependents? (1) Subscribers may enroll or waive eligible dependents when the subscriber becomes eligible and enrolls in PEBB insurance coverage. If enrolled, the dependent's effective date will be the same as the subscriber's effective date. Unless a dependent is independently eligible for PEBB health plan coverage, the subscriber must be enrolled to enroll their dependent.

Exceptions:

- Adult dependents may enroll in a health plan if the employee has waived medical coverage or the retiree has deferred enrollment in PEBB retiree insurance in accordance with PEBB rule;
- OR
- Eligible dependents of a retiree may enroll in a health plan if the retiree deferred PEBB retiree insurance coverage due to the retiree's enrollment in medicare and creditable medicaid under WAC 182-12-205 (1)(c).

(2) Subscribers may enroll eligible dependents during the annual open enrollment with health plan coverage beginning January of the following year.

(3) Subscribers may enroll a newly acquired dependent or a dependent that becomes eligible during a special open enrollment.

(a) A spouse may be enrolled upon marriage. If the date of marriage is the first day of the month, health plan coverage will begin on that date; otherwise, it will begin the first of the following month.

(b) A qualified domestic partner may be enrolled upon declaration or registration of the domestic partnership (see WAC 182-12-260). If the date of declaration or registration is the first day of the month, health plan coverage will begin on

that date; otherwise, it will begin the first of the following month.

(c) Newborn children may be enrolled upon birth and adopted children may be enrolled when the subscriber assumes legal responsibility for the child in anticipation of adoption. The child's health plan coverage will begin on the date of birth or the date the subscriber assumes legal responsibility for the child in anticipation of adoption. The subscriber must submit the appropriate forms as described in subsection (7) of this section no later than sixty days after birth or assuming legal responsibility for the child.

(d) Children acquired through marriage or a qualified domestic partnership may be enrolled upon marriage or declaration or registration of the domestic partnership as described in (a) or (b) of this subsection.

(e) Extended dependents acquired through legal guardianship or legal custody (see WAC 182-12-260(4)) may be enrolled upon issuance of a court order granting such responsibility to the subscriber, spouse, or qualified domestic partner. If legal guardianship or legal custody begins on the first day of the month, health plan coverage will begin on that date; otherwise, it will begin the first of the following month.

(f) Children age twenty through age twenty-four (adult dependents) may be enrolled when they become eligible (see WAC 182-12-260 (4)(d)). If they become eligible on the first day of the month, health plan coverage will begin on that date; otherwise, it will begin the first of the month following the date they become eligible. For enrollment requirements, see subsection (7) of this section.

(g) Children who become eligible as students may be enrolled provided the child's eligibility is certified by the PEBB benefits services program. If enrolled, the child's insurance coverage will begin or continue on the first day of the month the child becomes eligible as a student according to WAC 182-12-260 (4)(c).

(h) A child twenty years or older who becomes eligible as a child with disabilities under WAC 182-12-260 (4)(e) may be enrolled after the child's eligibility is certified by the PEBB benefits services program.

Health plan coverage will begin on the first day of the month that eligibility is certified by the PEBB benefits services program.

(4) Subscribers may change the enrollment (enroll, waive or remove) of their dependents outside of the annual open enrollment if a special open enrollment event occurs. The change in enrollment must correspond to the event that creates the special open enrollment for either the subscriber or the subscriber's dependents or both. Enrollment in health plan coverage will begin the first of the month following the event that created the special open enrollment; or in cases where the event occurs on the first day of a month, enrollment will begin on that date. If the special open enrollment is due to the birth or adoption of a child, health plan coverage will begin the month in which the event occurs. The following changes are events that create a special open enrollment for medical and dental:

(a) Subscriber acquires an eligible dependent through marriage, domestic partnership, birth, adoption or placement for adoption, legal custody or legal guardianship;

(b) Subscriber loses an eligible dependent or a dependent no longer meets PEBB eligibility criteria;

(c) Subscriber has a change in marital status, including legal separation documented by a court order;

(d) Subscriber or a dependent loses comprehensive group health insurance coverage;

(e) Subscriber or a dependent has a change in employment status that affects the subscriber's or a dependent's eligibility, level of benefits, or cost of insurance coverage;

(f) Subscriber or a dependent has a change in place of residence that affects the subscriber's or a dependent's eligibility, level of benefits, or cost of insurance coverage;

(g) Subscriber receives a court order or medical support enforcement order requiring the subscriber, their spouse, or qualified domestic partner to provide insurance coverage for an eligible dependent. (A former spouse is not an eligible dependent.);

(h) Subscriber receives formal notice that the department of social and health services has determined it is more cost-effective to enroll an eligible dependent in PEBB medical than a medical assistance program.

(5) Subscribers may waive (interrupt or postpone) enrollment of an eligible dependent.

(a) Employees may only waive dependents if those dependents are enrolled in another comprehensive group health plan. Employees may only waive an eligible dependent's enrollment at the following times:

(i) When the employee is first eligible and enrolls in PEBB benefits. (The dependent's enrollment will be waived beginning with the employee's effective date.);

(ii) During the annual open enrollment. (The dependent's enrollment will be waived beginning January of the following year.);

(iii) No later than sixty days after the dependent becomes eligible as described in subsection (3) of this section. (The dependent's enrollment will be waived beginning the date enrollment would have begun.); or

(iv) During a special open enrollment as described in subsection (4) of this section. (The dependent's enrollment will be waived as of the date corresponding to the event that creates the special open enrollment.)

(b) Retirees, survivors or individuals continuing PEBB insurance coverage under WAC 182-12-133 or 182-12-270 may waive enrollment of an eligible dependent outside of the annual open enrollment or a special open enrollment. Unless otherwise approved by the PEBB benefits services program, enrollment will be waived prospectively.

(c) Subscribers may enroll eligible dependents that were waived as stated in subsections (2) and (4) of this section.

(6) Subscribers must remove dependents from the subscriber's insurance coverage within sixty days of the date the dependent no longer meets eligibility criteria in WAC 182-12-250 or 182-12-260. Insurance coverage enrollment ends the last day of the month in which the dependent is eligible.

Subscribers may remove a lawful spouse from PEBB insurance coverage in the event of legal separation documented by a court order, provided the court did not order the subscriber to maintain the spouse's health plan enrollment. Subscribers must remove former spouses and former qualified domestic partners upon finalization of a divorce, annulment, or termination of a partnership, even if a court order

requires the subscriber to provide health insurance for the former spouse or partner.

Consequences for not submitting notice as described in subsection (7) of this section within sixty days of any dependent ceasing to be eligible may include:

(a) The dependent's loss of eligibility to continue health plan enrollment under one of the continuation options described in WAC 182-12-270;

(b) The subscriber being billed for claims paid by the health plan for services after the dependent lost eligibility; and

(c) The subscriber being responsible for premiums paid by the state for the dependent's health plan enrollment after the dependent lost eligibility.

(7) **Subscribers must submit the appropriate forms within the time frames described in this subsection.** Employees submit the appropriate forms to their employing agency. All other subscribers submit the appropriate forms to the PEBB benefits services program. In addition to the appropriate forms indicating dependent enrollment, the PEBB benefits services program may require the subscriber to provide evidence of eligibility or evidence of the event that created the special open enrollment.

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

(b) If a subscriber wants to enroll eligible dependents during the annual open enrollment, the subscriber must submit the appropriate forms no later than the end of the annual open enrollment.

(c) If a subscriber wants to enroll newly eligible dependents, the subscriber must submit the appropriate enrollment forms no later than sixty days after the dependent becomes eligible.

(d) If the subscriber wants to enroll a child age twenty or older as a child with disabilities, the subscriber must submit the appropriate enrollment form(s) required to certify the dependent's eligibility within the relevant time frame described in WAC 182-12-250(3) or 182-12-260(4).

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

(f) If the subscriber wants to waive a dependent's enrollment, the subscriber must submit the appropriate forms. Unless otherwise approved by the PEBB benefits services program, enrollment will be waived prospectively.

[Statutory Authority: RCW 41.05.160, 08-20-128 (Order 08-03), § 182-12-262, filed 10/1/08, effective 1/1/09; 08-09-027 (Order 08-01), § 182-12-262, filed 4/8/08, effective 4/9/08.]

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 medical plan no later than sixty days after the date of the employee's 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 enrollment as a survivor under retiree insurance coverage provided they immediately begin receiving a monthly retirement benefit from any state of Washington sponsored retirement system.

(a) The employee's spouse or 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 System, 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, whose enrollment in a PEBB health plan is waived 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 submit the appropriate forms 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. 08-20-128 (Order 08-03), § 182-12-265, filed 10/1/08, effective 1/1/09; 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) or (2) of this section by self-paying premiums following their loss of eligibility. The PEBB benefits services program must receive the appropriate forms as outlined in the *PEBB Initial Notice of COBRA and Continuation Coverage Rights*. Options for continuing health plan enrollment are based on the reason that eligibility was lost.

(1) Spouses, 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; or

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

Exception: A qualified domestic partner who loses eligibility because he or she no longer meets 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. 08-20-128 (Order 08-03), § 182-12-270, filed 10/1/08, effective 1/1/09; 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 182-13 WAC

STATE RESIDENT—MEDICARE SUPPLEMENT

WAC

182-13-010	Purpose.
182-13-020	Definitions.
182-13-030	Eligibility.

(2009 Ed.)

182-13-040

Application for medicare supplement coverage.

WAC 182-13-010 Purpose. The purpose of this chapter is to establish criteria for state residents for participation in medicare supplement coverage available through the HCA.

[Statutory Authority: RCW 41.05.197. 95-07-011, § 182-13-010, filed 3/3/95, effective 4/3/95.]

WAC 182-13-020 Definitions. Unless otherwise specifically provided, the definitions contained in this section apply throughout this chapter.

(1) "HCA" means the Washington state health care authority.

(2) "Health plan," or "plan" means any individual or group: Policy, agreement, or other contract providing coverage for medical, surgical, hospital, or emergency care services, whether issued, or issued for delivery, in Washington or any other state. "Health Plan" or "plan" also includes self-insured coverage governed by the federal Employee Retirement Income Security Act, coverage through the Health Insurance Access Act as described in chapter 48.41 RCW, coverage through the Basic Health Plan as described in chapter 70.47 RCW, and coverage through the medicaid program as described in Title 74 RCW. "Health plan" or "plan" does not mean or include: Hospital confinement indemnity coverage as described in WAC 284-50-345; disability income protection coverage as described in WAC 284-50-355; accident only coverage as described in WAC 284-50-360; specified disease and specified accident coverage as described in WAC 284-50-365; limited benefit health insurance coverage as described in WAC 284-50-370; long-term care benefits as described in chapter 48.84 RCW; or limited health care coverage such as dental only, vision only, or chiropractic only.

(3) "Lapse in coverage" means a period of time greater than ninety continuous days without coverage by a health plan.

(4) "Resident" means a person who demonstrates that he/she lives in the state of Washington at the time of application for, and issuance of coverage.

[Statutory Authority: RCW 41.05.197. 95-07-011, § 182-13-020, filed 3/3/95, effective 4/3/95.]

WAC 182-13-030 Eligibility. Residents are eligible to apply for medicare supplement coverage arranged by the HCA when they are:

- (1) Eligible for Parts A and B of medicare, and
- (2) Actually enrolled in both Parts A and B of medicare not later than the effective date of medicare supplement coverage.

[Statutory Authority: RCW 41.05.197. 95-07-011, § 182-13-030, filed 3/3/95, effective 4/3/95.]

WAC 182-13-040 Application for medicare supplement coverage. Residents meeting eligibility requirements may apply for medicare supplement coverage arranged by the HCA:

- (1) During the initial open enrollment period of January 1 through June 30, 1995, or
- (2) Within sixty days after becoming a resident, or
- (3) In the thirty day period before the resident becomes eligible for medicare, or

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- (4) Within sixty days of retirement, or
- (5) During any open enrollment period established by federal or state law, or
- (6) During any open enrollment period established by the HCA subsequent to the initial open enrollment period provided that the applicant is replacing a health plan with no lapse in coverage.

[Statutory Authority: RCW 41.05.197, 95-07-011, § 182-13-040, filed 3/3/95, effective 4/3/95.]

**Chapter 182-16 WAC
PRACTICE AND PROCEDURE**

WAC

182-16-010	Adoption of model rules of procedure.
182-16-020	Definitions.
182-16-030	How can an employee or an employee's dependent appeal a decision made by an employing agency about eligibility or enrollment in benefits?
182-16-032	How can a retiree or self-pay enrollee appeal a decision made by the PEBB benefits services program regarding eligibility, enrollment or premium payments?
182-16-034	How can a PEBB enrollee appeal a decision regarding the administration of a PEBB medical plan, insured dental plan, life insurance, long-term care insurance, long-term disability insurance, or property or casualty insurance?
182-16-036	How can an enrollee appeal a decision regarding the administration of benefits offered under the state's salary reduction plan?
182-16-037	How can an enrollee appeal a decision by the agency's self-insured dental plan?
182-16-038	How can an entity or organization appeal a decision to deny its participation in PEBB?
182-16-040	What should the request for review or notice of appeal contain?
182-16-050	How can an enrollee or entity get a hearing if aggrieved by a decision made by the PEBB appeals committee?

WAC 182-16-010 Adoption of model rules of procedure. The model rules of procedure adopted by the chief administrative law judge pursuant to RCW 34.05.250, as now or hereafter amended, are hereby adopted for use by this agency in PEBB benefits related proceedings. Those rules may be found in chapter 10-08 WAC. Other procedural rules adopted in this title are supplementary to the model rules of procedure. In the case of a conflict between the model rules of procedure and the procedural rules adopted in this title, the procedural rules adopted in this title shall govern.

[Statutory Authority: RCW 41.05.160, 08-20-128 (Order 08-03), § 182-16-010, filed 10/1/08, effective 1/1/09. Statutory Authority: RCW 41.05.010 and 34.05.250, 91-14-025, § 182-16-010, filed 6/25/91, effective 7/26/91.]

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;

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

"Employing agency" means a division, department, or separate agency of state government; a county, municipality, school district, educational service district, or other political

subdivision; or a tribal government covered by chapter 41.05 RCW.

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

"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.

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

"PEBB" means the public employees benefits board.

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

"PEBB benefits" means one or more insurance 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 for eligible employees (as defined in WAC 182-12-115), eligible retired and disabled employees of the state (as defined in WAC 182-12-171), eligible dependents (as defined in WAC 182-12-250 and 182-12-260), and others as defined in RCW 41.05.011.

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

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

[Statutory Authority: RCW 41.05.160, 08-20-128 (Order 08-03), § 182-16-020, filed 10/1/08, effective 1/1/09; 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 How can an employee or an employee's dependent appeal a decision made by an employing agency about eligibility or enrollment in benefits? Any employee or employee's dependent aggrieved by a decision made by an employing agency with regard to public employee benefits eligibility or enrollment may appeal that decision to the employing agency.

Note: Eligibility decisions address whether an employee or an employee's dependent is entitled to insurance coverage, as described in PEBB rules and policies. Enrollment decisions address the application for PEBB benefits as described in PEBB rules and policies, including but not limited to the submission of proper documentation and meeting enrollment deadlines.

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

(1) Any employee or employee's dependent aggrieved by an eligibility or enrollment decision made by an employing agency may appeal the decision by submitting a written request for review to the employing agency. The employing agency must receive the request for review within thirty days of the date of the initial denial notice. The contents of the request for review are to be provided in accordance with WAC 182-16-040.

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

(b) The employing agency shall render a written decision within thirty days of receiving the request for review. The written decision shall be sent to the appellant.

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

(2) Any employee or employee's dependent who disagrees with the employing agency's decision in response to a request for review, as described in subsection (1) of this section, may appeal that decision by submitting a notice of appeal to the PEBB appeals committee. The PEBB appeals manager must receive the notice of appeal within thirty days of the date of the employing agency's written decision on the request for review.

As well, any employee or employee's dependent may appeal a decision about premium payments by submitting a notice of appeal to the PEBB appeals committee. The PEBB appeals manager must receive the notice of appeal within thirty days of the date of the denial notice. The contents of the notice of appeal are to be provided in accordance with WAC 182-16-040.

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

(b) The PEBB appeals committee shall render a written decision within thirty days of receiving the notice of appeal. The written decision shall be sent to the appellant.

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

[Statutory Authority: RCW 41.05.160. 08-20-128 (Order 08-03), § 182-16-030, filed 10/1/08, effective 1/1/09; 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 182-16-032 How can a retiree or self-pay enrollee appeal a decision made by the PEBB benefits services program regarding eligibility, enrollment or premium payments? Any retiree or self-pay enrollee aggrieved by a decision made by the PEBB benefits services program with regard to public employee benefit eligibility, enroll-

ment, or premium payments may appeal the decision to the PEBB appeals committee.

Note: Eligibility decisions address whether a retiree, self-pay enrollee or their dependent is entitled to insurance coverage, as described in PEBB rules and policies. Enrollment decisions address the application for PEBB benefits as described in PEBB rules and policies, including, but not limited to the submission of proper documentation, enrollment deadlines, and premium related issues.

The PEBB appeals manager must receive the notice of appeal within sixty days of the date of the denial notice by the PEBB benefits services program. The contents of the notice of appeal are to be provided in accordance with WAC 182-16-040.

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

(2) The PEBB appeals committee shall render a written decision within thirty days of receiving the notice of appeal. The written decision shall be sent to the appellant.

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

[Statutory Authority: RCW 41.05.160. 08-20-128 (Order 08-03), § 182-16-032, filed 10/1/08, effective 1/1/09.]

WAC 182-16-034 How can a PEBB enrollee appeal a decision regarding the administration of a PEBB medical plan, insured dental plan, life insurance, long-term care insurance, long-term disability insurance, or property or casualty insurance? Any PEBB enrollee aggrieved by a decision regarding the administration of a PEBB medical plan, insured dental plan, life insurance, long-term care insurance, long-term disability insurance, or property and casualty insurance may do so by following the appeal provisions of those plans. Those appeals are not subject to this chapter, except for eligibility, enrollment and premium payment determinations. Employees and their dependents should refer to WAC 182-16-030 for eligibility, enrollment and premium payment appeals. Retirees, self-pay enrollees, and their dependents should refer to WAC 182-16-032 for eligibility, enrollment and premium payment appeals.

[Statutory Authority: RCW 41.05.160. 08-20-128 (Order 08-03), § 182-16-034, filed 10/1/08, effective 1/1/09.]

WAC 182-16-036 How can an enrollee appeal a decision regarding the administration of benefits offered under the state's salary reduction plan? (1) Any enrollee aggrieved by a decision regarding the medical FSA and DCAP offered under the state's salary reduction plan may appeal that decision to the third-party administrator contracted to administer the plan.

(2) Any enrollee who disagrees with a decision in response to an appeal filed with the third-party administrator that administers the medical FSA and DCAP under the state's salary reduction plan may appeal to the PEBB appeals committee. The PEBB appeals manager must receive the notice of appeal within thirty days of the date of the appeal decision by the third-party administrator that administers the medical FSA and DCAP offered under the state's salary reduction plan. The contents of the notice of appeal are to be provided in accordance with WAC 182-16-040.

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

(b) The PEBB appeals committee shall render a written decision within thirty days of receiving the notice of appeal. The written decision shall be sent to the appellant.

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

(3) Any enrollee aggrieved by a decision regarding the administration of the premium payment plan offered under the state's salary reduction plan may appeal that decision to the PEBB appeals committee. The PEBB appeals manager must receive the notice of appeal within thirty days of the date of the denial notice by the PEBB benefits services program. The contents of the notice of appeal are to be provided in accordance with WAC 182-16-040.

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

(b) The PEBB appeals committee shall render a written decision within thirty days of receiving the notice of appeal. The written decision shall be sent to the appellant.

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

[Statutory Authority: RCW 41.05.160. 08-20-128 (Order 08-03), § 182-16-036, filed 10/1/08, effective 1/1/09.]

WAC 182-16-037 How can an enrollee appeal a decision by the agency's self-insured dental plan? Any enrollee aggrieved by a decision by the agency's self-insured dental plan may appeal that decision to the PEBB appeals committee. The PEBB appeals manager must receive the notice of appeal within thirty days of the date of the denial notice by the agency's self-insured dental plan. The contents of the notice of appeal are to be provided in accordance with WAC 182-16-040.

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

(2) The PEBB appeals committee shall render a written decision within thirty days of receiving the notice of appeal. The written decision shall be sent to the appellant.

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

[Statutory Authority: RCW 41.05.160. 08-20-128 (Order 08-03), § 182-16-037, filed 10/1/08, effective 1/1/09.]

WAC 182-16-038 How can an entity or organization appeal a decision to deny its participation in PEBB? Any entity or organization whose application to participate in PEBB benefits has been denied may appeal the decision to the PEBB appeals committee. For rules regarding eligible entities, see WAC 182-12-111. The PEBB appeals manager must receive the notice of appeal within thirty days of the date of the denial notice. The contents of the notice of appeal are to be provided in accordance with WAC 182-16-040.

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

(2) The PEBB appeals committee shall render a written decision on the notice of appeal within thirty days of receiving the notice of appeal. The written decision shall be sent to the appealing party.

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

[Statutory Authority: RCW 41.05.160. 08-20-128 (Order 08-03), § 182-16-038, filed 10/1/08, effective 1/1/09.]

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

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

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

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

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

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

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

(7) The type of relief sought;

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

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

[Statutory Authority: RCW 41.05.160. 08-20-128 (Order 08-03), § 182-16-040, filed 10/1/08, effective 1/1/09; 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 How can an enrollee or entity get a hearing if aggrieved by a decision made by the PEBB appeals committee? (1) Any party aggrieved by a decision of the PEBB appeals committee, may request an administrative hearing.

(2) The request must be made in writing to the PEBB appeals manager. The PEBB appeals manager must receive the request for an administrative hearing within thirty days of the date of the written decision by the PEBB appeals committee.

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

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

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

(6) Within ninety days after the hearing record is closed, the administrator or his or her designee shall render a decision on the notice of appeal.

sion which shall be the final decision of the agency. A copy of that decision shall be mailed to all parties.

[Statutory Authority: RCW 41.05.160, 08-20-128 (Order 08-03), § 182-16-050, filed 10/1/08, effective 1/1/09; 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 182-20 WAC

STANDARDS FOR COMMUNITY HEALTH CLINICS

WAC

182-20-001	Purpose.
182-20-010	Definitions.
182-20-100	Administration.
182-20-130	Application for funds.
182-20-160	Eligibility.
182-20-200	Allocation of state funds.
182-20-300	Dispute resolution procedures.
182-20-320	Audit review.
182-20-400	Limitations on awards.
182-20-500	Dental residency pilot project.
182-20-600	Community health care collaborative program.
182-20-610	Administration.
182-20-620	Application process.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

182-20-250	Allocation of state noncitizen immigrant funds. [Statutory Authority: RCW 41.05.220, 02-18-089 (Order 02-04), § 182-20-250, filed 9/3/02, effective 10/1/02.] Repealed by 07-01-107 (Order 06-03), filed 12/19/06, effective 1/19/07. Statutory Authority: RCW 41.05.-220.
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WAC 182-20-001 Purpose. The purpose of this chapter is to establish procedures at the Washington state health care authority for determining eligibility and distribution of funds for:

(1) Medical, dental, and migrant services to community health clinics under section 214(3), chapter 19, Laws of 1989 1st ex. sess., including other state general fund appropriations for medical, dental, and migrant services in community health clinics since 1985; and

(2) Other grant programs assigned to the authority. The authority shall disburse grant awards to community-based organizations to develop innovative health care delivery models that address:

- Access to medical treatment;
- Efficient use of health care resources; or
- Improve quality of care.

[Statutory Authority: RCW 41.05.160, 41.05.220, 41.05.230, and 2006 c 67, 07-02-055 (Order 06-07), § 182-20-001, filed 12/28/06, effective 1/28/07. Statutory Authority: RCW 41.05.160, 01-04-080 (Order 00-06), § 182-20-001, filed 2/7/01, effective 3/10/01. Statutory Authority: RCW 43.70.040, 95-12-010, § 182-20-001, filed 5/26/95, effective 6/26/95.]

WAC 182-20-010 Definitions. For the purposes of these rules, the following words and phrases shall have these meanings unless the context clearly indicates otherwise.

(1) "Community health clinic" means a public or private nonprofit tax exempt corporation with the mission of providing primary health care to low income individuals at a charge based upon ability to pay.

(2009 Ed.)

(2) "Authority" means the Washington state health care authority.

(3) "Encounter" means a face-to-face contact between a patient and a health care provider exercising independent judgment, providing primary health care, and documenting the care in the individual's health record.

(4) "Health care provider" means any person having direct or supervisory responsibility for the delivery of health care including:

- Physicians under chapters 18.57 and 18.71 RCW;
- Dentists under chapter 18.32 RCW;
- Advanced registered nurse practitioner under chapter 18.79 RCW;
- Physician's assistant under chapters 18.71A and 18.57A RCW;
- Dental hygienist under chapter 18.29 RCW;
- Licensed midwife under chapter 18.50 RCW;
- Federal uniformed service personnel lawfully providing health care within Washington state.

(5) "Low-income individual" means a person with income at or below two hundred percent of federal poverty level. The poverty level has been established by Public Law 97-35 § 652 (codified at 42 USC 9847), § 673(2) (codified at 42 USC 9902 (2)) as amended; and the *Poverty Income Guideline* updated annually in the *Federal Register*.

(6) "Primary health care" means comprehensive care that includes a basic level of preventive and therapeutic medical and/or dental care, usually delivered in an outpatient setting, and focused on improving and maintaining the individual's general health.

(7) "Relative value unit" means a standard measure of performance based upon time to complete a clinical procedure. The formula is one unit equals ten minutes. A table is available from the authority stating the actual values.

(8) "Administrator" means the administrator of the health care authority or the administrator's designee.

(9) "User" means an individual having one or more primary health care encounters and counted only once during a calendar year.

(10) "Contractor" means the community health clinic or other entity performing services funded by chapter 182-20 WAC, and shall include all employees of the contractor.

[Statutory Authority: RCW 41.05.160, 01-04-080 (Order 00-06), § 182-20-010, filed 2/7/01, effective 3/10/01. Statutory Authority: RCW 43.70.040, 95-12-010, § 182-20-010, filed 5/26/95, effective 6/26/95.]

WAC 182-20-100 Administration. The authority shall contract with community health clinics to provide primary health care in the state of Washington by:

- Developing criteria for the selection of community health clinics to receive funding;
- Establishing statewide standards governing the granting of awards and assistance to community health clinics;
- Disbursing funds appropriated for community health clinics only to those clinics meeting the criteria in WAC 182-20-160;

(4) Distributing available state funds to community health clinics according to the following priority in the order listed:

- First, to community health clinics that are private, nonprofit corporations classified exempt under Internal Rev-

enue Service Rule 501 (c)(3) and governed by a board of directors including representatives from the populations served;

(b) Second, to local health jurisdictions with an organized primary health clinic or division;

(c) Third, to private nonprofit or public hospitals with an organized primary health clinic or department.

(5) Reviewing records and conducting on-site visits of contractors or applicants as necessary to assure compliance with these rules; and

(6) Withholding funding from a contractor or applicant until such time as satisfactory evidence of corrective action is received and approved by the authority, if the authority determines:

(a) Noncompliance with applicable state law or rule; or

(b) Noncompliance with the contract; or

(c) Failure to provide such records and data required by the authority to establish compliance with section 214(3), chapter 19, Laws of 1989 1st ex. sess., this chapter, and the contract; or

(d) The contractor or applicant provided inaccurate information in the application.

[Statutory Authority: RCW 41.05.160. 01-04-080 (Order 00-06), § 182-20-100, filed 2/7/01, effective 3/10/01. Statutory Authority: RCW 43.70.040. 95-12-010, § 182-20-100, filed 5/26/95, effective 6/26/95.]

WAC 182-20-130 Application for funds. (1) The authority shall, upon request, supply a prospective applicant with an application kit for a contract requesting information as follows:

(a) Include in the application a request for information as follows:

(i) The applicant's name, address, and telephone number;

(ii) A description of the primary health care provided;

(iii) A brief statement of intent to apply for funds;

(iv) The signature of the agency's authorized representative;

(v) Description of the nature and scope of services provided or planned;

(vi) Evidence of a current financial audit establishing financial accountability; and

(vii) A description of how the applicant meets eligibility requirements under WAC 182-20-160;

(b) Notify existing contractors at least ninety days in advance of the date a new contract application is due to the authority;

(c) Review completed application kits for evidence of compliance with this section;

(d) Develop procedures for:

(i) Awarding of funds for new contractors, special projects, and emergency needs of existing contractors; and

(ii) Notifying existing and prospective contractors of procedures and application process.

(2) The applicant shall:

(a) Complete the application on standard forms provided or approved by the authority; and

(b) Return the completed application kit to the authority by the specified due date.

[Statutory Authority: RCW 43.70.040. 95-12-010, § 182-20-130, filed 5/26/95, effective 6/26/95.]

WAC 182-20-160 Eligibility. Applicants shall:

(1) Demonstrate private, nonprofit, tax exempt status incorporated in Washington state or public agency status under the jurisdiction of a local or county government;

(2) Receive other funds from at least one of the following sources:

(a) Section 329 of the Public Health Services Act;

(b) Section 330 of the Public Health Services Act;

(c) Community development block grant funds;

(d) Title V Urban Indian Health Service funds; or

(e) Other public or private funds providing the clinic demonstrates:

(i) Fifty-one percent of total clinic population are low income;

(ii) Fifty-one percent or greater of funds come from sources other than programs under WAC 182-20-160;

(3) Operate as a community health clinic providing primary health care for at least eighteen months prior to applying for funding;

(4) Provide primary health care services with:

(a) Twenty-four-hour coverage of the clinic including provision or arrangement for medical and/or dental services after clinic hours;

(b) Direct clinical services provided by one or more of the following:

(i) Physician licensed under chapters 18.57 and 18.71 RCW;

(ii) Physician's assistant licensed under chapters 18.71A and 18.57A RCW;

(iii) Advanced registered nurse practitioner under chapter 18.79 RCW;

(iv) Dentist under chapter 18.32 RCW;

(v) Dental hygienist under chapter 18.29 RCW;

(c) Provision or arrangement for services as follows:

(i) Preventive health services on-site or elsewhere including:

(A) Eye and ear examinations for children;

(B) Perinatal services;

(C) Well-child services; and

(D) Family planning services;

(ii) Diagnostic and treatment services of physicians and where feasible a physician's assistant and/or advanced registered nurse practitioner, on-site;

(iii) Services of a dental professional licensed under Title 18 RCW on-site or elsewhere;

(iv) Diagnostic laboratory and radiological services on-site or elsewhere;

(v) Emergency medical services on-site or elsewhere;

(vi) Arrangements for transportation services;

(vii) Preventive dental services on-site or elsewhere; and

(viii) Pharmaceutical services, as appropriate, on-site or elsewhere;

(5) Demonstrate eligibility to receive and receipt of reimbursement from:

(a) Public insurance programs; and

(b) Public assistant programs, where feasible and possible;

(6) Have established for at least eighteen months an operating sliding scale fee schedule for adjustment of charges, based upon the individual's ability to pay for low-income individuals;

(7) Provide health care regardless of the individual's ability to pay; and

(8) Establish policies and procedures reflecting sensitivity to cultural and linguistic differences of individuals served and provide sufficient staff with the ability to communicate with the individuals.

[Statutory Authority: RCW 41.05.160, 01-04-080 (Order 00-06), § 182-20-160, filed 2/7/01, effective 3/10/01. Statutory Authority: RCW 43.70.040, 95-12-010, § 182-20-160, filed 5/26/95, effective 6/26/95.]

WAC 182-20-200 Allocation of state funds. The authority shall allocate available funds to medical, dental and migrant contractors providing primary health care based on the following criteria:

(1) Medical.

(a) The authority may withhold appropriated funds as follows:

(i) As specified under law or up to ten percent to provide funding for new contractors, special projects, and emergency needs:

(A) With distribution of any remaining portion of this ten percent among contractors by the end of each funding year;

(B) Prorated according to the percentage of total medical contract funds distributed to each contractor;

(ii) Up to ten percent for administration.

(b) The remainder of the appropriated funds is referred to as the "medical base." The medical base means the total amount of money appropriated by the legislature for the medical program minus the amounts specified in (a)(i) and (ii) of this subsection. The medical base is distributed to medical contractors based upon the following formulas:

(i) Starting July 1, 1996, the medical base is distributed to medical contractors based upon the following formula:

(A) Forty percent of the medical base is distributed equally among all medical contractors;

(B) Thirty percent of the medical base is distributed by the ratio of the contractor's primary health care (PHC) medical sliding fee users divided by the total medical sliding fee users of all contractors as reported in the prior calendar year annual reports.

individual contractor's medical sliding fee users
_____ X 30% medical base

total of all contractors' medical sliding fee users

(C) Thirty percent of the medical base is distributed by the ratio of the contractor's primary health care (PHC) medical sliding fee encounters by the total number of medical sliding fee encounters reported by all contractors as reported in the prior calendar year annual reports.

individual contractor's medical sliding fee encounters
_____ X 30% medical base

total of all contractors' medical sliding fee encounters

(2) Dental.

(a) The authority may withhold appropriated funds as follows:

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(i) As specified under law or up to ten percent of appropriated funds to provide funding for new contractors, special projects, and emergency needs:

(A) With distribution of any remaining portion of this ten percent among contractors by the end of each funding year;

(B) Prorated according to the percentage of total dental contract funds distributed to each contractor.

(ii) Up to ten percent for administration.

(b) The remainder of the funds is referred to as the dental base. The dental base means the total amounts appropriated by the legislature for dental programs minus the amounts specified in (a)(i) and (ii) of this subsection and as follows:

(i) Starting July 1, 1996, the dental base is distributed to dental contractors based upon the following formula:

(A) Forty percent of the dental base is distributed equally among all dental contractors;

(B) Thirty percent of the dental base is distributed by the ratio of the contractor's primary health care (PHC) dental sliding fee users divided by the total dental sliding fee users of all contractors as reported in the prior calendar year annual reports.

individual contractor's dental sliding fee users
_____ X 30% dental base

total of all contractors' dental sliding fee users

(C) Thirty percent of the dental base is distributed by the ratio of the contractor's primary health care (PHC) dental sliding fee relative value units (RVU) divided by the total number of dental sliding fee relative value units (RVU) reported by all contractors as reported in the prior calendar year annual reports.

individual contractor's dental sliding fee RVUs
_____ X 30% dental base

total of all contractors' dental sliding fee RVUs

(3) Migrant.

(a) The authority may withhold appropriated funds as follows:

(i) As specified under law or up to ten percent to provide funding for new contractors, special projects, and emergency needs:

(A) With distribution of any remaining portion of this ten percent among contractors by the end of each funding year;

(B) Prorated according to the percentage of total migrant contract funds distributed to each contractor.

(ii) Up to ten percent for administration.

(b) The remainder of the appropriated funds is referred to as the "migrant base." The migrant base means the total amount of money appropriated by the legislature for the migrant program minus the amounts specified in (a)(i) and (ii) of this subsection. The migrant base is distributed to migrant contractors based upon the following formula:

The migrant base is distributed to migrant contractors based upon the following formula starting July 1, 1995: One hundred percent of the migrant base is distributed by the ratio of the contractor's primary health care (PHC) migrant users divided by the total migrant users of all contractors as reported in the prior calendar year annual reports.

individual contractor's migrant users
 _____ X 100% migrant base

total of all contractors' migrant users

[Statutory Authority: RCW 41.05.160, 01-04-080 (Order 00-06), § 182-20-200, filed 2/7/01, effective 3/10/01. Statutory Authority: RCW 43.70.040, 95-12-010, § 182-20-200, filed 5/26/95, effective 6/26/95.]

WAC 182-20-300 Dispute resolution procedures. The authority shall define dispute resolution procedures in the contract which shall be the exclusive remedy and shall be binding and final to all parties.

[Statutory Authority: RCW 43.70.040, 95-12-010, § 182-20-300, filed 5/26/95, effective 6/26/95.]

WAC 182-20-320 Audit review. Contractors shall:

(1) Maintain books, records, documents, and other materials relevant to the provision of goods or services adequate to document the scope and nature of the goods or services provided;

(2) Make the materials in subsection (1) of this section available at all reasonable times with prior notice for inspection by the authority;

(3) Retain these materials for at least three years after the initial contract with the authority;

(4) Provide access to the facilities at all reasonable times with prior notice for on-site inspection by the authority; and

(5) Submit annual reports consistent with the instructions of the authority.

[Statutory Authority: RCW 43.70.040, 95-12-010, § 182-20-320, filed 5/26/95, effective 6/26/95.]

WAC 182-20-400 Limitations on awards. Specific to the medical, dental, and migrant base as referenced in WAC 182-20-200 (1)(b), (2)(b), and (3)(b):

Starting July 1, 1997:

(1) Any approved contractor shall initially receive funding based on no more than a ratio of one hundred twenty-five percent of that contractor's previous year's initial allotment.

(2) Any approved contractor shall initially receive funding based on no less than a ratio of seventy-five percent of that contractor's previous year's initial allotment. In the event that funding is inadequate to provide seventy-five percent, criteria shall be established to equitably allocate the available funds.

(3) Funds in excess of the initial allocation shall be distributed in a supplemental allotment pursuant to WAC 182-20-200.

Starting July 1, 2004:

(4) Funds distributed pursuant to WAC 182-20-200 (1)(b)(i)(A) and (2)(b)(i)(A), the forty percent base, shall be limited to no more than \$30,000.

Funds distributed in excess of the \$30,000 limitation shall be added to the appropriate medical formulae in WAC 182-20-200 (1)(b)(i)(B) and (C), or dental formulae in WAC 182-20-200 (2)(b)(i)(B) and (C), productivity portions of the funding formulae.

[Statutory Authority: RCW 41.05.220, 04-03-006 (Order 03-03), § 182-20-400, filed 1/8/04, effective 2/8/04. Statutory Authority: RCW 41.05.160, 01-04-080 (Order 00-06), § 182-20-400, filed 2/7/01, effective 3/10/01. Statu-

tory Authority: RCW 43.70.040, 95-12-010, § 182-20-400, filed 5/26/95, effective 6/26/95.]

WAC 182-20-500 Dental residency pilot project. (1)

The provisions of this section apply to organizations that wish to apply for funding to operate a dental residency program pursuant to the provisions of RCW 18.32.040.

(2) The authority will, upon request, supply to interested parties the application forms and information needed to apply for funding for a dental residency program.

(3) The forms shall require applicants to provide the following information:

(a) The applicant's name, address, and telephone number;

(b) A full description of the dental residency program to be funded;

(c) A brief statement of intent to apply for funding.

(4) Clinics that wish to apply for funding must meet the following criteria:

(a) Have American Dental Association (ADA) accreditation;

(b) Comply with the department of health's dental residency licensure requirements; and

(c) Operate a one-year advanced education in general dentistry residency (AEGD) program.

(5) The authority will allocate funds pursuant to written procedures which may be updated annually. The authority will, upon request, supply a copy of the allocation procedures to interested parties.

[Statutory Authority: RCW 41.05.220, 06-07-101 (Order 05-07), § 182-20-500, filed 3/15/06, effective 7/1/06.]

WAC 182-20-600 Community health care collaborative program. The community health care collaborative grant program was established July 1, 2006, to develop innovative health care delivery models. The funding covers a two-year cycle; half of the award to be distributed throughout the first year and the final half distributed throughout the second year upon evidence of successful program progress and achieving grant objectives, based upon available funding.

[Statutory Authority: RCW 41.05.160, 41.05.220, 41.05.230, and 2006 c 67, 07-02-055 (Order 06-07), § 182-20-600, filed 12/28/06, effective 1/28/07.]

WAC 182-20-610 Administration. The authority is responsible for:

(1) Preaward development.

(a) Develop criteria for the selection of community-based organizations to receive grant funding;

(b) Develop equitable standards governing the granting of awards;

(c) Determine nature and format of the application and process.

(2) Award determinations.

(a) Consult with representatives, appointed by the secretary of the department of health, the assistant secretary of health and recovery services administration within the department of social and health services, and the office of the insurance commissioner to make recommendations for final applicant selection and grant determination;

(b) The administrator will review recommendations and make final determination based upon recommendations,

funds available and utilization of resources to meet the goals of the program;

(c) Conduct on-site visits to ensure applicant's ability to achieve grant objectives and performance measures identified in the application;

(d) Contract with successful applicants; and

(e) Disburse grant funds according to program policy.

(3) Post-award actions.

(a) Review periodic progress reports from contractors;

(b) Conduct on-site visits of contractors to provide assistance and ensure compliance of grant objectives;

(c) Consult with representatives from department of health, the assistant secretary of health and recovery services administration within the department of social and health services, and office of the insurance commissioner, one year following initial disbursement, to make recommendations to administrator for disbursement of the second half of grant funds, based upon performance measures identified in the application and evidence of successful program progress and achieving grant objectives;

(d) The administrator will review and make final determination for grant disbursements; and

(e) Compile a report to the governor and legislature on July 1, 2008, which:

(i) Describes organizations and programs funded;

(ii) Describes and analyzes results achieved;

(iii) Makes recommendations for improvements to the program; and

(iv) Highlights best practices that can be replicated statewide.

[Statutory Authority: RCW 41.05.160, 41.05.220, 41.05.230, and 2006 c 67. 07-02-055 (Order 06-07), § 182-20-610, filed 12/28/06, effective 1/28/07.]

WAC 182-20-620 Application process. (1) Eligibility.

(a) Applicants must provide the following in the application format prescribed by the authority:

(i) Evidence of private, nonprofit, tax exempt status incorporated in Washington state or public agency status under the jurisdiction of a local, county, or tribal government;

(ii) Evidence of the specific geographic region served and a formal collaborative governing structure by documentation that may include, but is not limited to:

(A) Bylaws;

(B) Agreements;

(C) Contracts;

(D) Memorandum of understanding;

(E) Minutes;

(F) Letters; or

(G) Other communications;

(iii) Amount of funds requested and how the dollars will be spent;

(iv) Data to evaluate program progress and grant objectives.

(b) Applicants will be evaluated competitively on their ability to:

(i) Address documented health care needs in the specific region served;

(ii) Engage key community members;

(iii) Show evidence of matching funds of at least two dollars for each grant dollar requested. All matching fund contributions, including cash and in-kind, shall meet the cri-

(2009 Ed.)

teria determined by the administrator and included in the application guidelines;

(iv) Ability to meet the documented health care needs and address sustainability of programs;

(v) Show innovation in program approaches that could be replicated throughout the state;

(vi) Make efficient and cost-effective use of funds by simplifying administration affecting the health care delivery system;

(vii) Clearly describe size of organization, program objectives, and populations served; and

(viii) Meet the reporting requirements of the authority.

(c) Application access.

(i) The call for grant applications will be made by posting the announcement to the authority's official web site and by notification sent to interested parties.

(ii) To be placed on the interested parties distribution list, send contact information, including mailing and e-mail addresses to community health care collaboration at Washington State Health Care Authority, P.O. Box 42721, Olympia, Washington 98504-2721.

(2) The guidelines and application forms will be available on the authority's official web site and included with the published guidelines distributed by e-mail to those who request an application. The application will be available in hard copy and sent by United States mail upon request. Applications must be completed and submitted in the format and filed by the deadlines prescribed by the authority and published in the guidelines.

[Statutory Authority: RCW 41.05.160, 41.05.220, 41.05.230, and 2006 c 67. 07-02-055 (Order 06-07), § 182-20-620, filed 12/28/06, effective 1/28/07.]

Chapter 182-25 WAC

WASHINGTON BASIC HEALTH PLAN

WAC

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182-25-010	Definitions.
182-25-020	BHP benefits.
182-25-030	Eligibility.
182-25-040	Enrollment in the plan.
182-25-050	Employer groups.
182-25-060	Home care agencies.
182-25-070	Financial sponsors.
182-25-080	Premiums and copayments.
182-25-085	Enrollees' failure to report correct income.
182-25-090	Disenrollment from BHP.
182-25-100	Where to find instructions for filing an appeal.
182-25-105	How to appeal health care authority (HCA) decisions.
182-25-110	How to appeal a managed health care system (MHCS) decision.
182-25-120	Basic health plan coverage for health coverage tax credit eligible enrollees.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

182-25-031	Transition coverage. [Statutory Authority: RCW 70.47.050, 70.47.060 and 70.47.100. 99-24-005 (Order 99-06), § 182-25-031, filed 11/18/99, effective 12/19/99.] Repealed by 03-24-041 (Order 03-04), filed 11/26/03, effective 12/27/03. Statutory Authority: RCW 70.47.050.
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WAC 182-25-001 Authority. The administrator's authority to promulgate and adopt rules is contained in RCW 70.47.050.

[Statutory Authority: RCW 70.47.050, 96-15-024, § 182-25-001, filed 7/9/96, effective 8/9/96.]

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) "Copayment" 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 copayments, 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 sharecropper, 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 additional 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 assis-

tance, 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 copayments, 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 182-25-020 BHP benefits. (1) The administrator shall design and from time to time may revise BHP benefits, according to the requirements of chapter 70.47 RCW, as amended. These benefits will include physician services, prescription drugs and medications, and inpatient and outpatient hospital services, limited mental health care services, limited chemical dependency services, limited organ transplant services, and all services necessary for prenatal, postnatal and well-child care, and will emphasize proven preventive and primary care services. The medicaid scope of benefits may be provided by BHP as the BHP plus program through coordination with DSHS for children under the age of nineteen, who are found to be medicaid eligible. BHP benefits may include copayments, waiting periods, limitations and exclusions which the administrator determines are appropriate and consistent with the goals and objectives of the plan. BHP benefits will be subject to a nine-month waiting period for preexisting

conditions. Exceptions (for example, maternity, prescription drugs, services for a newborn or newly adopted child) are outlined in the schedule of benefits. Credit toward the waiting period will be given for any continuous period of time for which an enrollee was covered under similar health coverage if that coverage was in effect at any time during the three-month period immediately preceding the date of reservation or application for coverage under BHP. Similar coverage includes BHP; all DSHS programs administered by the medical assistance administration which have the medicaid scope of benefits; the DSHS program for the medically indigent; Indian health services; most coverages offered by health carriers; and most self-insured health plans. A list of BHP benefits, including copayments, waiting periods, limitations and exclusions, will be provided to the subscriber.

(2) In designing and revising BHP benefits, the administrator will consider the effects of particular benefits, copayments, limitations and exclusions on access to necessary health care services, as well as the cost to the enrollees and to the state, and will also consider generally accepted practices of the health insurance and managed health care industries.

(3) Prior to enrolling in BHP, each applicant will be given a written description of covered benefits, including all copayments, waiting periods, limitations and exclusions, and be advised how to access information on the services, providers, facilities, hours of operation, and other information descriptive of the managed health care system(s) available to enrollees in a given service area.

(4) BHP will mail to all subscribers written notice of any changes in the scope of benefits provided under BHP, or program changes that will affect premiums and copayments at least thirty days prior to the due date of the premium payment for the month in which such revisions are to take effect. This subsection does not apply to premium changes that are the result of changes in income or family size. The administrator may make available a separate schedule of benefits for children, eighteen years of age and younger, for those dependent children in the plan.

[Statutory Authority: RCW 70.47.050 and 70.47.090, 02-19-053 (Order 01-08), § 182-25-020, filed 9/12/02, effective 10/13/02. Statutory Authority: RCW 70.47.050 and 70.47.060, 00-23-037, § 182-25-020, filed 11/9/00, effective 1/1/01. Statutory Authority: RCW 70.47.050, 98-07-002, § 182-25-020, filed 3/5/98, effective 4/5/98; 97-15-003, § 182-25-020, filed 7/3/97, effective 8/3/97; 96-15-024, § 182-25-020, 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, copayments, 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 182-25-050 Employer groups. (1) BHP will accept applications for group enrollment in BHP from business owners, their spouses and eligible dependents, and on behalf of their eligible full-time and/or part-time employees, their spouses and eligible dependents.

(2) With the exception of home care agencies (see WAC 182-25-060(2)), the employer must enroll at least seventy-five percent of all eligible employees within a classification of employees in the basic health plan, and the employer must not offer other health care coverage to the same classification of employees. For purposes of this section, a "classification of employees" will be defined as a subgroup of employees (for example, part-time employees, full-time employees or bargaining units). Employees who demonstrate in the application process that they have health care coverage from other sources, such as their spouse or a federal program, shall be excluded from the minimum participation calculation.

(3) BHP may require a minimum financial contribution from the employer for each enrolled employee.

(4) The employer will provide the employees the complete choice of BHP managed health care systems available within the employee's county of residence.

(5) The employer will pay all or a designated portion of the premium, as determined by the administrator, on behalf of the enrollee. It is the employer's responsibility to collect the employee's portion of the premium and remit the entire payment to BHP and to notify BHP of any changes in the employee's account.

(6) In the event that an employer group will be disenrolled, all affected employee(s) will be notified prior to the disenrollment, and will be informed of the opportunity to convert their BHP group membership to individual account(s).

(7) Employees enrolling in BHP must meet all BHP eligibility requirements as outlined in WAC 182-25-030.

[Statutory Authority: RCW 70.47.050. 96-15-024, § 182-25-050, filed 7/9/96, effective 8/9/96.]

WAC 182-25-060 Home care agencies. BHP will accept applications from home care agencies under contract with the department of social and health services (DSHS) for group enrollment in BHP, with premiums paid by the home care agency or DSHS or a designee, under the provisions for employer groups, WAC 182-25-050, with the following exceptions or additions:

(1) To qualify for premium reimbursement through DSHS, home care agencies who enroll under the provisions of this section must be under current contract with DSHS as a home care agency, as defined by DSHS.

(2) Home care agencies need not enroll at least seventy-five percent of all eligible employees in the basic health plan, and home care agencies may offer other coverage to the same classification of employees.

(3) Home care agencies need not make a minimum financial contribution for each enrolled employee.

(4) Home care agencies are not subject to WAC 182-25-050(5).

(5) Individual home care providers may enroll in BHP as individuals.

[Statutory Authority: RCW 70.47.050, 96-15-024, § 182-25-060, filed 7/9/96, effective 8/9/96.]

WAC 182-25-070 Financial sponsors. (1) A third party may, with the approval of the administrator, become a financial sponsor to BHP enrollees. Financial sponsors may not be a state agency or a managed health care system.

(2) BHP may require a minimum financial contribution from financial sponsors who are paid to deliver BHP services. Sponsors who meet the following criteria will be exempt from the minimum contribution:

(a) Organizations that are not paid to perform any function related to the delivery of BHP services, and do not receive contributions from other organizations paid to deliver BHP services;

(b) Charitable, fraternal or government organizations (other than state agencies) that are not paid to perform any function related to the delivery of BHP services, who receive contributions from other individuals or organizations who may be paid to deliver BHP services, if the organization can demonstrate all of the following:

(i) Organizational autonomy (the organization's governance is separate and distinct from any organization that is paid to deliver BHP services);

(ii) Financial autonomy and control over the funds contributed (contributors relinquish control of the donated funds);

(iii) Sponsored enrollees are selected by the sponsoring organization from all persons within the geographic boundaries established by the sponsor organization who meet the selection criteria agreed upon by the sponsor organization and the HCA; and

(iv) There is no direct financial gain to the sponsoring entity.

(c) Charitable, fraternal, or government organizations (other than state agencies) that are paid to perform a health care function related to the delivery of BHP services, if the organization can demonstrate all of the following:

(i) The organization's primary purpose is not the provision of health care or health care insurance, including activities as a third-party administrator or holding company;

(ii) There is organizational and financial autonomy (the organization's governance and funding of sponsored enrollees is separate and distinct from the function that is paid to deliver BHP services);

(iii) The selection of sponsored enrollees is made by the organization separate and distinct from the function that is paid to deliver BHP services, and sponsored enrollees are selected from all eligible persons who meet the selection criteria agreed upon by the sponsor organization and the HCA, who live within the geographic boundaries established by the sponsor organization; and

(iv) There is no direct financial gain to the sponsoring entity.

(3) The financial sponsor will establish eligibility for participation in that particular financial sponsor group; how-

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ever, sponsored enrollees must meet all BHP eligibility requirements as outlined in WAC 182-25-030.

(4) The financial sponsor will pay all or a designated portion of the premium on behalf of the sponsored enrollee. It is the financial sponsor's responsibility to collect the enrollee's portion of the premium, if any, and remit the entire payment to BHP and to notify BHP of any changes in the sponsored enrollee's account.

(5) A financial sponsor must inform sponsored enrollees and BHP of the minimum time period for which they will act as sponsor. At least sixty days before the end of that time period, it is the responsibility of the financial sponsor to notify sponsored enrollees and BHP if the sponsorship will or will not be extended.

(6) A financial sponsor must not discriminate for or against potential group members based on health status, race, color, creed, political beliefs, national origin, religion, age, sex or disability.

(7) A financial sponsor must disclose to the sponsored enrollee all the managed health care systems within the enrollee's county of residence, the estimated premiums for each of them, and the BHP toll-free information number.

(8) BHP may periodically conduct a review of the financial sponsor group members to verify the eligibility of all enrollees.

[Statutory Authority: RCW 70.47.050, 98-07-002, § 182-25-070, filed 3/5/98, effective 4/5/98; 96-15-024, § 182-25-070, filed 7/9/96, effective 8/9/96.]

WAC 182-25-080 Premiums and copayments. (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 copayment, coinsurance, or deductible directly to the provider of a covered service or directly to the MHCS. Repeated failure to pay copayments, 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.]

WAC 182-25-085 Enrollees' failure to report correct income. (1) If BHP determines that the enrollee has received a subsidy overpayment due to failure to report income correctly, BHP may:

(a) Bill the enrollee for the amount of subsidy overpaid by the state; or

(b) If the overpayment was due to fraud, intentional misrepresentation of information, or withholding information that the enrollee knew or should have known was material or necessary to accurately determine the premium, impose civil penalties of up to two hundred percent of the subsidy overpayment.

(2) Any BHP determination under subsection (1) of this section is subject to the enrollee appeal provisions in WAC 182-25-105.

(3) When a decision under subsection (1)(a) of this section is final, BHP may establish a payment schedule and, for enrollees who remain enrolled in BHP, will collect the amount owed through future premium statements. Enrollees who disenroll prior to paying the full amount of the subsidy overpayment may continue the payment plan previously approved by BHP or may be billed for the entire amount due. BHP may charge interest for the amount past due, at the rate specified under RCW 43.17.240 and rules promulgated thereunder. The payment schedule will be for a period of no more than six months, unless BHP approves an alternative payment schedule requested by the enrollee. When a payment schedule is established, BHP will send the enrollee advance written

notice of the schedule and the total amount due. The total amount due each month will include the regular monthly premium plus charges for subsidy overpayment. If an enrollee does not pay the amount due, including charges for subsidy overpayment, the enrollee and all family members enrolled on the account will be disenrolled for nonpayment under WAC 182-25-090 (2)(b).

(4) When a final decision is made under subsection (1)(b) of this section, BHP will send the enrollee notice that payment of the civil penalty is due in full within thirty days after the decision becomes final, unless BHP approves a different due date at the enrollee's request. If the enrollee does not pay the civil penalty by the due date, the enrollee and all family members on the account will be disenrolled for nonpayment under WAC 182-25-090 (2)(c).

(5) Individuals who are disenrolled from BHP may not reenroll until charges for subsidy overpayments or civil penalties imposed under subsection (1) of this section have been paid or BHP has approved a payment schedule and all other requirements for enrollment have been met.

(6) BHP will take all necessary and appropriate administrative and legal actions to collect the unpaid amount of any subsidy overpayment or civil penalty, including recovery from the enrollee's estate.

(7) Enrollees under employer group or financial sponsor group coverage who do not follow the income reporting procedures established by BHP and their employer or financial sponsor may be billed directly by BHP for subsidy overpayments or civil penalties assessed under subsection (1) of this section. Enrollees who do not pay the amount due will be disenrolled under WAC 182-25-090 (2)(b) or (c). Enrollees who are disenrolled for nonpayment of a subsidy overpayment or civil penalties will be excluded from the minimum participation calculation for employer groups under WAC 182-25-050(2).

[Statutory Authority: RCW 70.47.050, 70.47.060(9), and 2002 c 371 § 212(5), 02-19-054 (Order 01-07), § 182-25-085, filed 9/12/02, effective 10/13/02. Statutory Authority: RCW 70.47.050, 70.47.060 and 70.47.090, 99-12-033 (Order 99-01), § 182-25-085, filed 5/26/99, effective 6/26/99.]

WAC 182-25-090 Disenrollment from BHP. (1) An enrollee or employer group may disenroll effective the first day of any month by giving BHP at least ten days prior notice of the intention to disenroll.

(2) BHP may disenroll any enrollee or group from BHP for good cause, which includes:

(a) Failure to meet the eligibility requirements set forth in WAC 182-25-030, 182-25-050, 182-25-060, and 182-25-070;

(b) Nonpayment of premium under the provisions of subsection (6) of this section;

(c) Changes in MHCS or program availability when the enrollee's MHCS will no longer be available to him or her and no other MHCS in the area where the enrollee lives is accepting new enrollment in the enrollee's program;

(d) Repeated failure to pay copayments, coinsurance, or other cost-sharing in full on a timely basis;

(e) Fraud, intentional misrepresentation of information or withholding information that the enrollee knew or should have known was material or necessary to accurately determine their eligibility or premium responsibility, failure to

provide requested verification of eligibility or income, or knowingly providing false information;

(f) Abuse or intentional misconduct;

(g) Danger or threat to the safety or property of the MHCS or the health care authority or their staff, providers, patients or visitors; and

(h) Refusal to accept or follow procedures or treatment determined by a MHCS to be essential to the health of the enrollee, when the MHCS has advised the enrollee and demonstrated to the satisfaction of BHP that no professionally acceptable alternative form of treatment is available from the MHCS.

(3) In addition to being disenrolled, any enrollee who knowingly provides false information to BHP or to a participating managed health care system may be held financially responsible for any covered services fraudulently obtained through BHP.

(4) At least ten days prior to the effective date of disenrollment under subsection (2)(a) and (c) through (h) of this section, BHP will send enrollees written notice of disenrollment.

(a) The notice of disenrollment will:

(i) State the reason for the disenrollment;

(ii) State the effective date of the disenrollment;

(iii) Describe the procedures for disenrollment; and

(iv) Inform the enrollee of his or her right to appeal the disenrollment decision as set forth in WAC 182-25-100 and 182-25-105.

(b) The notice of disenrollment will be sent to both the employer or sponsor and to all members of an employer group, home care agency group or financial sponsor group that is disenrolled under these provisions. Enrollees affected by the disenrollment of a group account will be offered coverage under individual accounts. Coverage under individual accounts will not begin unless the premium for individual coverage is paid by the due date for the coverage month. A one-month break in coverage may occur for enrollees who choose to transfer to individual accounts.

(5) Enrollees covered under BHP Plus or receiving maternity benefits through medical assistance will not be disenrolled from those programs when other family members lose BHP coverage, as long as they remain eligible for those programs.

(6) Under the provisions of this subsection, BHP will suspend or disenroll enrollees and groups who do not pay their premiums when due, including amounts owed for subsidy overpayment, if any. Partial payment or payment by check which cannot be processed or is returned due to non-sufficient funds will be regarded as nonpayment.

(a) At least ten days before coverage will lapse, BHP will send a delinquency notice to each subscriber whose premium payment has not been received by the due date. The delinquency notice will include a final due date and a notice that BHP coverage will lapse unless payment is received by the final due date.

(b) Except as provided in (c) of this subsection, coverage will be suspended for one month if an enrollee's premium payment is not received by the final due date, as shown on the delinquency notice. BHP will send written notice of suspension to the subscriber, which will include:

(i) The effective date of the suspension;

(ii) The due date by which payment must be received to restore coverage after the one-month suspension;

(iii) Notification that the subscriber and any enrolled dependents will be disenrolled if payment is not received by the final due date; and

(iv) Instructions for filing an appeal under WAC 182-25-105.

(c) Enrollees whose premium payment has not been received by the delinquency due date, and who have been suspended twice within the previous twelve months will be disenrolled for nonpayment as of the effective date of the third suspension.

(d) Enrollees who are suspended and do not pay the premium for the next coverage month by the due date on the notice of suspension will be immediately disenrolled and issued a notice of disenrollment, which will include:

(i) The effective date of the disenrollment; and

(ii) Instructions for filing an appeal under WAC 182-25-105.

(7)(a) Unless otherwise specified in this chapter, enrollees who voluntarily disenroll or are disenrolled from BHP may not reenroll for a period of twelve months from the date their coverage ended and until all other requirements for enrollment have been satisfied. An exception to this provision will be made for:

(i) Enrollees who left BHP for other health insurance, who are able to provide proof of continuous coverage from the date of disenrollment, and who apply to reenroll in BHP within thirty days of losing the other coverage;

(ii) Enrollees who left BHP because they lost eligibility and who subsequently become eligible to reenroll; and

(iii) Persons enrolling in subsidized BHP, who had enrolled and subsequently disenrolled from nonsubsidized BHP under subsection (1) or (2)(b) of this section while waiting on a reservation list for subsidized coverage.

(iv) Enrollees who were disenrolled by BHP because no MHCS was contracted to serve the program in which they were enrolled in the geographic area where they live; these enrollees may reenroll, provided all enrollment requirements are met, if a MHCS begins accepting enrollment for their program in their area or if they become eligible and apply for another BHP program.

(v) Enrollees who were disenrolled for failing to provide requested documentation of income or eligibility, who had attempted to comply with the request but were unable to meet the due date, and who provide all required documentation within six months of disenrollment and are eligible to reenroll.

(b) An enrollee who is required to wait twelve months for reenrollment under (a) of this subsection may not reenroll prior to the end of the required twelve-month wait. If an enrollee satisfies the required twelve-month wait after applying for subsidized coverage and while waiting to be offered coverage, enrollment will not be completed until funding is available to enroll him or her.

[Statutory Authority: RCW 70.47.050 and 2004 c 192. 04-23-012 (Order 04-03), § 182-25-090, filed 11/5/04, effective 1/1/05. Statutory Authority: RCW 70.47.050. 03-24-040 (Order 03-05), § 182-25-090, filed 11/26/03, effective 12/27/03. Statutory Authority: RCW 70.47.050, 70.47.060(9), and 2002 c 371 § 212(5). 02-19-054 (Order 01-07), § 182-25-090, 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), § 182-25-090, filed 11/18/99, effective

12/19/99. Statutory Authority: RCW 70.47.050, 70.47.060 and 70.47.090. 99-12-033 (Order 99-01), § 182-25-090, filed 5/26/99, effective 6/26/99. Statutory Authority: RCW 70.47.050. 98-07-002, § 182-25-090, filed 3/5/98, effective 4/5/98; 97-15-003, § 182-25-090, filed 7/3/97, effective 8/3/97; 96-15-024, § 182-25-090, filed 7/9/96, effective 8/9/96.]

WAC 182-25-100 Where to find instructions for filing an appeal. (1) WAC 182-25-105 and 182-25-110 cover appeals submitted by or on behalf of **basic health plan** enrollees or applicants. To appeal a decision regarding a child enrolled in **BHP plus** or a woman receiving **maternity benefits through medical assistance**, subscribers must contact the Washington state department of social and health services (DSHS) to request a fair hearing under chapters 388-08 and 388-526 WAC.

(2) WAC 182-25-105 covers appeals of decisions made by the health care authority, such as decisions regarding basic health plan eligibility, premium, premium adjustments or penalties, enrollment, suspension, disenrollment, or a member's selection of managed health care system (MHCS). Decisions which affect an entire group (for example, the disenrollment of an employer group) should be appealed for the entire group by the employer, home care agency, or financial sponsor, using these same rules.

(3) WAC 182-25-110 covers appeals of decisions made by the enrollee's managed health care system (MHCS), such as decisions regarding coverage disputes or benefits interpretation. The term MHCS, which is defined in WAC 182-25-010(22), refers to the health plan or carrier that provides BHP coverage.

[Statutory Authority: RCW 70.47.050. 99-07-078, § 182-25-100, filed 3/18/99, effective 4/18/99; 98-07-002, § 182-25-100, filed 3/5/98, effective 4/5/98; 96-15-024, § 182-25-100, filed 7/9/96, effective 8/9/96.]

WAC 182-25-105 How to appeal health care authority (HCA) decisions. (1) Health care authority decisions regarding the following may be appealed under this section:

- (a) Eligibility;
 - (b) Premiums;
 - (c) Premium adjustments or penalties;
 - (d) Enrollment;
 - (e) Suspension;
 - (f) Disenrollment; or
 - (g) Selection of managed health care system (MHCS).
- (2) To appeal a health care authority decision, enrollees or applicants must send a letter of appeal to the HCA. The letter of appeal must be signed by the appealing party and received by the HCA within thirty calendar days of the date of the decision. The letter of appeal must include:

- (a) The name, mailing address, and BHP account number of the subscriber or applicant;
- (b) The name and address of the enrollee or applicant affected by the decision, if that person is not the subscriber on the account;
- (c) A copy of the HCA notice of the decision that is being appealed or, if the notice is not available, a statement of the decision being appealed;
- (d) A statement explaining why the appealing party believes the decision was incorrect, outlining the facts surrounding the decision and including supporting documentation; and

(e) If the appealing party is not an enrollee or the subscriber on the account, a signed agreement from the enrollee, authorizing the appealing party to act on his/her behalf.

(3) When an appeal is received, the HCA will send a notice to the appealing party, confirming that the appeal has been received and indicating when a decision can be expected. If the appealing party is not an enrollee on the affected BHP account, the notice will also be sent to the subscriber.

(4) **Initial HCA decisions:** The HCA will conduct appeals according to RCW 34.05.485. The HCA appeals committee or a single presiding officer designated by the HCA will review and decide the appeal. The appealing party may request an opportunity to be present in person or by telephone to explain his or her view. If the appealing party does not request an opportunity to be present to explain, the HCA appeals committee or presiding officer will review and decide the appeal based on the information and documentation submitted.

(5) The HCA will give priority handling to appeals regarding a loss of coverage for an enrollee with an urgent medical need that could seriously jeopardize the enrollee's life, health, or ability to regain maximum function, provided:

- (a) The appeal is received within ten business days of the effective date of the loss of coverage; and
- (b) The enrollee has clearly stated in the letter of appeal or has otherwise notified the HCA that he or she has an urgent medical need.

(6) For all other appeals, the HCA will send the appealing party written notice of the initial HCA decision within sixty days of receiving the letter of appeal. If the appealing party is not an enrollee on the affected BHP account, the notice will also be sent to the subscriber. The notice will include the reasons for the initial decision and instructions on further appeal rights.

(7) **Review of initial HCA decision:** The initial HCA decision becomes the final agency decision unless the HCA receives a valid request for a review from the appealing party.

(a) To be a valid request for review, the appealing party's request may be either verbal or in writing, but must:

- (i) Be received within thirty days of the date of the initial HCA decision.
- (ii) Include a summary of the initial HCA decision being appealed and state why the appealing party believes the decision was incorrect; and
- (iii) Provide any additional information or documentation that the appealing party would like considered in the review.

(b) Requests for review of an initial HCA decision regarding a disenrollment for nonpayment will be reviewed by the office of administrative hearings through a hearing conducted under chapter 34.12 RCW and RCW 34.05.488 through 34.05.494.

(c) All other requests for review of an initial HCA decision will be reviewed by a presiding officer designated by the HCA according to the requirements of RCW 34.05.488 through 34.05.494, with the following exception: These review decisions will be based on the record and documentation submitted, unless the presiding officer decides that an in-person or telephone hearing is needed. If an in-person or telephone hearing is needed, the presiding officer will decide

whether to conduct the hearing as an informal hearing or formal adjudicative proceeding.

(d) The presiding officer will issue a written notice of the review decision, giving reasons for the decision, within twenty-one days of receiving the request for review, unless the presiding officer finds that additional time is needed for the decision.

(8) Enrollees who appeal a disenrollment decision that was based on eligibility issues and not related to premium payments may remain enrolled during the appeal process, provided:

(a) The appeal was submitted according to the requirements of this section; and

(b) The enrollee:

(i) Remains otherwise eligible;

(ii) Continues to make all premium payments when due; and

(iii) Has not demonstrated a danger or threat to the safety or property of the MHCS or health care authority or their staff, providers, patients or visitors.

(9) Enrollees who appeal a disenrollment decision related to nonpayment of premium or any issue other than eligibility will remain disenrolled during the appeal process.

(10) If the appealing party disagrees with a review decision under subsection (6) of this section, the appealing party may request judicial review of the decision, as provided for in RCW 34.05.542. Request for judicial review must be filed with the court within thirty days of service of the final agency decision.

[Statutory Authority: RCW 70.47.050, 01-23-095 (Order 00-01), § 182-25-105, filed 11/21/01, effective 1/1/02; 99-07-078, § 182-25-105, filed 3/18/99, effective 4/18/99; 98-07-002, § 182-25-105, filed 3/5/98, effective 4/5/98; 96-15-024, § 182-25-105, filed 7/9/96, effective 8/9/96.]

WAC 182-25-110 How to appeal a managed health care system (MHCS) decision. (1) Enrollees who are appealing a MHCS decision, including decisions related to coverage disputes; denial of claims; benefits interpretation; or resolution of complaints must follow their MHCS's complaint/appeals process.

(2) Each MHCS must maintain a complaint/appeals process for enrollees and must provide enrollees with instructions for filing a complaint and/or appeal. This complaint/appeals process must comply with the requirements of chapter 48.43 RCW and chapter 284-43 WAC.

(3) On the request of the enrollee, the HCA may assist an enrollee by:

(a) Attempting to informally resolve complaints against the enrollee's MHCS;

(b) Investigating and resolving MHCS contractual issues; and

(c) Providing information and assistance to facilitate review of the decision by an independent review organization.

[Statutory Authority: RCW 70.47.050, 01-23-095 (Order 00-01), § 182-25-110, filed 11/21/01, effective 1/1/02; 99-07-078, § 182-25-110, filed 3/18/99, effective 4/18/99; 96-15-024, § 182-25-110, filed 7/9/96, effective 8/9/96.]

WAC 182-25-120 Basic health plan coverage for health coverage tax credit eligible enrollees. (1) "Health

(2009 Ed.)

coverage tax credit eligible enrollee" or "HCTC enrollee" means an individual or qualified dependent determined by the federal Department of the Treasury to be eligible for a tax credit, as defined under RCW 70.47.020 (3) and (4). In the event that the federal health coverage tax credit program is no longer available, HCTC enrollment in BHP will end.

(2) Eligibility for HCTC enrollment, as subscriber or dependent, is determined by the federal Health Coverage Tax Credit program. HCTC enrollees must provide proof of eligibility for HCTC enrollment, but are not required to also meet the eligibility criteria in WAC 182-25-030.

(3) Unless the enrollee has applied for, is eligible, and has enrolled as a subsidized enrollee, the monthly premium due from or on behalf of an HCTC enrollee will be the full cost charged by the MHCS for coverage, plus the administrative cost of providing BHP coverage and the premium tax under RCW 48.14.0201.

(4) HCTC enrollees may pay the full premium for coverage to BHP or, if they are claiming the HCTC advance tax credit, may pay their portion of the premium to the federal HCTC program of the Internal Revenue Service (IRS) by the date required by the IRS.

(5) With the exception of subsections (3) and (7) of this section, subsidized enrollees who are HCTC eligible will be subject to the rules for subsidized enrollees.

(6) Notice of disenrollment will be sent to the HCTC enrollees for whom the premium has not been paid. This notice will be sent prior to the month of coverage, but will not be subject to the notification requirements in WAC 182-25-090(6). If payment is received no later than the first day of the month of coverage, the enrollee's coverage for that month will be reinstated.

(7) The nine-month waiting period for treatment of pre-existing conditions will be waived for HCTC enrollees who have had three months or more of creditable coverage, as defined under Public Law 104-191, without a break in coverage of more than sixty-two consecutive days at the time of application. Subsidized enrollees who are HCTC eligible, who provide proof of that eligibility to their MHCS, will be treated as HCTC enrollees for purposes of determining whether the preexisting condition waiting period can be waived.

(8) HCTC enrollees who disenroll may return to HCTC enrollment without being subject to the provisions of WAC 182-25-090(7).

(9) Because eligibility for the HCTC program is determined by the federal HCTC program at the Internal Revenue Service, BHP will not review appeals of eligibility for the HCTC program. Instructions on appealing an HCTC eligibility determination are available through the HCTC customer contact center.

[Statutory Authority: RCW 70.47.050 and 2004 c 192, 04-23-012 (Order 04-03), § 182-25-120, filed 11/5/04, effective 1/1/05.]

Chapter 182-26 WAC

WASHINGTON HEALTH INSURANCE PARTNERSHIP (HIP) PROGRAM

WAC

182-26-010

182-26-020

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[Statutory Authority: RCW 70.47A.060, 08-22-041 (Order 08-02), § 182-26-010, filed 10/31/08, effective 12/1/08.]

WAC 182-26-020 Definitions—Generally. Unless the context clearly indicates otherwise, the definitions in Part 1 of this chapter apply throughout this chapter.

[Statutory Authority: RCW 70.47A.060, 08-22-041 (Order 08-02), § 182-26-020, filed 10/31/08, effective 12/1/08.]

PART 1
DEFINITIONS

WAC 182-26-100 Definitions. "Administrator" means the administrator of the Washington state health care authority established under chapter 41.05 RCW.

"Appeal" means a formal written request to the HIP or its designee for resolution of problems or concerns that cannot be resolved informally. For the purposes of this chapter, "appeal" applies only to HIP decisions regarding subsidy determinations and employer eligibility for the HIP.

"Applicant" means:

- An individual who applies for a premium subsidy through the HIP on behalf of the individual and his or her dependents; or
- A partnership participant who applies or reapplies for premium subsidy through the HIP on behalf of the partnership participant and his or her dependents during the annual subsidy application and renewal period as described in WAC 182-26-320.

"Application" means a form developed by the administrator that an applicant must sign, complete, and submit to the administrator to apply for a premium subsidy through the

HIP. To be considered complete, the application must be accompanied by all supporting documents as required and determined by the administrator.

"Benchmark health benefit plan" or "benchmark plan" means a health benefit plan selected by the board and upon which the subsidy scale shall be determined and from which the administrator will calculate a partnership participant's premium subsidy.

"Board" or "HIP board" means the health insurance partnership board established under RCW 70.47A.100.

"Carrier" or "insurance carrier" means the same as defined in RCW 48.43.005.

"The department of social and health services" or "DSHS" means the department of social and health services as defined in RCW 43.20A.020.

"Dependent," for the purpose of determining subsidy eligibility, "dependent" means:

(1) A partnership participant's lawful spouse, not legally separated, who shares a home with the partnership participant; or

(2) The unmarried child of the partnership participant or participant's dependent spouse, whether by birth, adoption, legal guardianship, or placement pending adoption, and not given up for adoption, who is:

(a) Younger than age twenty-five; or

(b) Is of any age, is not able to take care of himself or herself due to disability, and is under legal guardianship of the partnership participant or the participant's dependent spouse.

(3) A dependent may be placed on only one HIP account at any given time.

"Designated health benefit plan" means a health benefit plan selected by the board as eligible for offer through the HIP.

"Disenroll" or "disenrollment" means the termination of a partnership participants' enrollment in the HIP program. Decisions regarding eligibility or enrollment status for insurance coverage will be made by the carrier.

"Eligible partnership participant" means a partnership participant who:

- Is a resident of the state of Washington;
- Has a family income that does not exceed two hundred percent of the federal poverty level, as determined annually by the federal Department of Health and Human Services; and
- Is a health plan eligible employee as defined in this section that is enrolled or is applying to enroll in the participating small employer's offered coverage.

"Employee" has the same meaning as defined in RCW 48.43.005.

"Employer agreement" means a form developed by the administrator that a small employer must complete, sign, and submit to the administrator to request enrollment in the HIP.

"Health insurance partnership" or "HIP" means the health insurance partnership established in RCW 70.47A.-030.

"Health plan eligible employee" means an individual who meets the participating small employer's enrollment criteria.

"HIP account" means an account maintained by the administrator for each partnership participant that includes but is not limited to:

- Demographic information for participants and dependents, if any;
- Subsidy status;
- Carrier and plan enrollment status; and
- Other information as required by the administrator.

"Income" or "family gross income" means total cash receipts, as defined in WAC 182-26-345, before taxes, for participants and all dependents.

"Individual health benefit plan selection." Reserved.

The "office of the insurance commissioner" or "OIC" means the insurance commissioner as defined in RCW 48.02.010.

"Open enrollment" means a designated time period during which partnership participants may enroll additional dependents or make other changes to their employer-sponsored health benefit plan coverage.

"Participating small employer" means a small employer who:

- Enters into a written agreement with the HIP to purchase a designated health benefit plan through the HIP;
- Attests at the date of the agreement that the employer does not currently offer coverage, including insurance purchased through the small group and association health plan markets, self-funded plans, and multiple employer welfare arrangements; and
- Attests at the date of the agreement that at least fifty percent of its employees are low-wage workers, as defined by the board.

"Partnership participant" means:

- A participating small employer as defined in this section;
- An employee of a participating small employer;
- A former employee of a participating small employer who chooses to continue coverage through the HIP following separation from employment, to the extent the employee is eligible for continuation of coverage under 29 U.S.C. Sec. 1161 et seq.; and
- A former employee of a participating small employer who chooses to continue coverage through HIP following separation from employment, to the extent determined by the board.

"Philanthropy" means a person, organization or other entity, approved by the administrator that is responsible for payment of all or part of the monthly premium obligation on behalf of a partnership participant.

"Premium" has the same meaning as described in RCW 48.43.005.

"Premium subsidy" or "subsidy" means payment to or reimbursement by the HIP on behalf of an eligible partnership participant toward the purchase of a designated health benefit plan.

"Qualifying change in family status" is defined in WAC 182-26-325.

"Section 125 plan" means a cafeteria plan compliant with section 125 of the federal Internal Revenue Code that enables employees to use pretax dollars to pay their share of their health benefit plan premium.

(2009 Ed.)

"Small employer" or "employer" as used in this chapter means an employer who meets the definition of "small employer" in RCW 48.43.005.

"Subsidy application and renewal period" means an annual period that lasts at least sixty days, during which:

- All partnership participants may apply for premium subsidies for themselves and their dependents; and
- All partnership participants receiving a subsidy are required to provide proof of their continuing eligibility for a premium subsidy.

The subsidy application and renewal period will begin ninety days before the employer-sponsored health benefit plan open enrollment period begins.

"Surcharge" means an amount, determined by the administrator, that may be added to a partnership participant's premium as provided for in WAC 182-26-500. The surcharge is not part of the premium and applies only to coverage purchased through the HIP.

"Washington state resident" means:

(a) A person who physically resides in and maintains a residence in the state of Washington.

(b) To be considered a Washington resident, individuals who are temporarily out of Washington state for any reason may be required to demonstrate their intent to return to Washington state.

(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 stays; or
- (iii) Another person's home.

[Statutory Authority: RCW 70.47A.060. 08-22-041 (Order 08-02), § 182-26-100, filed 10/31/08, effective 12/1/08.]

PART 2 EMPLOYER ENROLLMENT

WAC 182-26-200 Employer eligibility for the HIP.

To enroll in the HIP, a small employer must:

- Meet the minimum contribution requirement under WAC 182-26-210;
- Meet the minimum participation requirement under WAC 182-26-220; and
- Agree to establish a section 125 plan under RCW 70.47A.030 (2)(a).

[Statutory Authority: RCW 70.47A.060. 08-22-041 (Order 08-02), § 182-26-200, filed 10/31/08, effective 12/1/08.]

WAC 182-26-210 Minimum employer contribution.

- A small employer must contribute at least forty percent of each health plan eligible employee's total premium obligation.
- The minimum contribution requirement does not apply to a health plan eligible employee's dependent's premium.

[Statutory Authority: RCW 70.47A.060. 08-22-041 (Order 08-02), § 182-26-210, filed 10/31/08, effective 12/1/08.]

WAC 182-26-220 Minimum participation.

- A participating small employer will determine the criteria for eligibility and enrollment in his or her designated health benefit plan.

- To participate in the HIP, the small employer must enroll at least seventy-five percent of the health plan eligible employees in the designated health benefit plan.

- When calculating the minimum participation percentage, employees who have similar existing coverage from another source and the health plan eligible employees' dependents will not be included.

[Statutory Authority: RCW 70.47A.060. 08-22-041 (Order 08-02), § 182-26-220, filed 10/31/08, effective 12/1/08.]

PART 3 PREMIUM SUBSIDIES

WAC 182-26-300 Who can receive a premium subsidy? An eligible partnership participant may receive a premium subsidy if there is sufficient funding available, as determined by the administrator.

[Statutory Authority: RCW 70.47A.060. 08-22-041 (Order 08-02), § 182-26-300, filed 10/31/08, effective 12/1/08.]

WAC 182-26-305 Applying for a HIP premium subsidy. (1) To receive a HIP subsidy, an applicant must submit a complete application and all supporting documents as described in WAC 182-26-310 to the HIP.

(2) On a subsidy application, an applicant must list all eligible dependents up to age nineteen. The applicant must also provide other information and documents as required by the HIP.

(3) An applicant is not required to list dependents aged nineteen or over and under twenty-five on the application, but if they are listed on the application, the HIP will include the dependents' income for purposes of subsidy eligibility and calculation.

(4) An applicant is not required to apply for a subsidy for all of his or her dependents. However, any dependent that does not apply for a subsidy at the same time that the other family members apply must wait to apply as a dependent until the next subsidy application and renewal period.

[Statutory Authority: RCW 70.47A.060. 08-22-041 (Order 08-02), § 182-26-305, filed 10/31/08, effective 12/1/08.]

WAC 182-26-310 Application—Supporting documents. (1) An application for a HIP subsidy must be accompanied by all of the following supporting documents:

- Proof of the family gross income as described in WAC 182-26-345.

- Proof of the applicant's Washington state residence, displaying the applicant's name and current address, such as a utility bill or rent receipt. The HIP may accept other documents if the applicant does not have a physical residence, for example, a signed statement from a person or other entity that is providing temporary shelter. The HIP will not accept a post office box or other mailing address as proof of residence.

- Other documents or information as requested by the HIP to establish or verify eligibility.

(2) The HIP may verify income of applicants for a HIP subsidy through comparison with other state and federal agency records or other third-party sources.

(3) Incomplete or inaccurate information may delay or prevent an applicant from receiving a premium subsidy. Intentionally submitting false information will, at a mini-

num, result in the loss of subsidy eligibility for an applicant or partnership participant and all of his or her subsidized dependents.

[Statutory Authority: RCW 70.47A.060. 08-22-041 (Order 08-02), § 182-26-310, filed 10/31/08, effective 12/1/08.]

WAC 182-26-315 HIP application review. (1) Except as provided in WAC 182-26-300, the HIP will review subsidy applications within thirty days of receipt. The HIP will send notification of an applicant's subsidy status upon completion of the review.

(2) Eligible applicants will be subsidized in the HIP in the order in which their completed applications have been received by the HIP, provided the administrator has determined there is subsidy funding available and the participating small employer also remits full payment of the first full month's premium to the HIP by the due date specified by the HIP.

[Statutory Authority: RCW 70.47A.060. 08-22-041 (Order 08-02), § 182-26-315, filed 10/31/08, effective 12/1/08.]

WAC 182-26-320 Annual subsidy application and renewal. (1) The HIP will verify the continuing eligibility of eligible partnership participants at least annually, or upon renewal or a change of the employer-sponsored health benefit plan.

(2) Upon request of the HIP, subsidized eligible partnership participants must submit evidence satisfactory to the HIP that proves their continued eligibility for a premium subsidy and for the amount of subsidy they receive.

(3) The HIP may verify income of subsidized eligible partnership participants through comparison with other state and federal agency records or other third-party sources.

(4) If the eligible partnership participant's income on record with other agencies or third-party sources differs from the income the participant has reported to the HIP, or if questions arise concerning the documents submitted, the HIP may require updated documents from the participant to prove continued eligibility for the subsidy they receive. At that time, the HIP may also require updated proof of residence.

(5) Eligible partnership participants who have documented that they did not file a federal income tax return for previous years may not be required to provide additional verification of nonfiling, unless their circumstances appear to have changed or other information received by the HIP indicates they may have filed a federal income tax return.

(6) In addition to verification of income, eligible partnership participants must annually submit proof of Washington state residence to the HIP.

(7) Partnership participants who fail to comply with an annual subsidy renewal request will be disenrolled from the HIP subsidy program and will no longer receive a premium subsidy from the HIP.

(8) If, as the result of an annual subsidy renewal review, the HIP determines that a partnership participant has not reported income accurately, the partnership participant will be subject to the provisions of WAC 182-26-335.

[Statutory Authority: RCW 70.47A.060. 08-22-041 (Order 08-02), § 182-26-320, filed 10/31/08, effective 12/1/08.]

WAC 182-26-325 Making changes to a HIP account.

(1) A partnership participant may add an eligible dependent to a HIP account:

(a) Annually, during the subsidy application and renewal period; or

(b) When there is a qualifying change in family status. In these cases, the partnership participant must notify the administrator on the required form within thirty calendar days of the change in family status. A "qualifying change in family status" means:

- The loss of other health care coverage for a dependent who has previously waived coverage in the partnership participant's employer-sponsored health benefit plan;
- The birth, adoption, or placement for adoption of a dependent child in the partnership participant's home;
- The partnership participant marries;
- The partnership participant or his or her spouse assumes custody or dependency of a child or adult dependent; or
- A dependent that was previously ineligible for the partnership participant's employer-sponsored health benefit plan coverage has become eligible.

(2) A partnership participant may remove dependents from a HIP account upon divorce, annulment, or legal separation, or upon the death of a dependent. In these cases, the partnership participant must notify the HIP within thirty calendar days of the change in family status.

(3) A partnership participant must notify the HIP of a change in his or her physical address within thirty calendar days of the change of address.

[Statutory Authority: RCW 70.47A.060. 08-22-041 (Order 08-02), § 182-26-325, filed 10/31/08, effective 12/1/08.]

WAC 182-26-330 Loss of subsidy eligibility. A partnership participant may lose subsidy eligibility for himself or herself and his or her dependents when:

- The partnership participant's or dependent's coverage under his or her designated health benefit plan has been suspended or terminated;
- The partnership participant is no longer a Washington state resident;
- The partnership participant has not accurately reported his or her family gross income at the time of subsidy application or renewal; or
- The partnership participant's employer is disenrolled from the HIP program.

If the partnership participant loses subsidy eligibility, he or she will no longer receive a premium subsidy, beginning with the next coverage month following the determination of the change.

[Statutory Authority: RCW 70.47A.060. 08-22-041 (Order 08-02), § 182-26-330, filed 10/31/08, effective 12/1/08.]

WAC 182-26-335 Recoupment. The HIP may recoup overpaid subsidy amounts from current and former partnership participants when the HIP determines that a subsidy overpayment occurred because the current or former partnership participant misrepresented or withheld information necessary to accurately determine their subsidy eligibility or subsidy amount.

(2009 Ed.)

[Statutory Authority: RCW 70.47A.060. 08-22-041 (Order 08-02), § 182-26-335, filed 10/31/08, effective 12/1/08.]

WAC 182-26-340 How does the HIP determine the premium subsidy amount? (1) The HIP will apply a sliding scale subsidy schedule based on the partnership participant's family gross income and family size to determine the percentage of the employee's premium obligation the state will pay.

(2) The percentage in subsection (1) of this section will be applied to the health benefit plan employee premium share, including the amount due for dependents' coverage, remaining after deducting the employer contribution from the total premium amount for that participant.

(3) If a participating small employer chooses a health benefit plan with a higher premium than the benchmark plan, the subsidy will not exceed the amount applicable to the benchmark plan.

(4) In no case will the subsidy percentage exceed ninety percent of the benchmark plan employee premium share.

(5) Once enrolled in the HIP, the subsidy percentage will not change until the next subsidy application and renewal period, even if the total premium share changes because of a qualifying change in family status.

[Statutory Authority: RCW 70.47A.060. 08-22-041 (Order 08-02), § 182-26-340, filed 10/31/08, effective 12/1/08.]

WAC 182-26-345 How does the HIP calculate income? (1) The HIP will average applicants' or dependents' family gross income over a twelve-month period using the total income reported on the most recent tax year's federal income tax return.

(2) If the applicant or dependent cannot provide a copy or IRS transcript of the most recent tax year's federal income tax return, the applicant or dependent must submit a signed declaration of nonfiling and the HIP will calculate the income based on documents deemed acceptable to the administrator.

(3) If an applicant or his or her spouse is self-employed or receives rental income, the applicant or spouse may be required to submit a twelve-month history of receipts and expenses for proof of self-employment or rental income unless the applicant or spouse has not owned the business or rental for at least twelve months. In these cases, the applicant or spouse must send proof of all receipts and expenses for all months he or she has owned the business or rental.

(4) The HIP will deduct expenses an applicant or spouse pays for child or dependent care when calculating family income. The HIP will establish a maximum amount that can be deducted, consistent with IRS requirements. To qualify for this deduction:

(a) The care must be for a dependent on the account, as described under "dependent" as defined in WAC 182-26-100;

(b) The applicant and spouse, if any, listed on the account, must be employed, attend school, or be receiving Social Security disability benefits during the months the care was provided; and

(c) The person who was paid for the dependent's care cannot be the dependent's parent or stepparent or another of the applicant's or spouse's dependents.

(5) The HIP will deduct payments made for alimony when calculating family income.

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[Statutory Authority: RCW 70.47A.060. 08-22-041 (Order 08-02), § 182-26-345, filed 10/31/08, effective 12/1/08.]

WAC 182-26-350 What does the HIP count as income? Income includes all of the following, before any deductions (gross income):

Source	Received by the participant, spouse, child dependent aged nineteen or over and under twenty-five, or adult dependent	Received by a dependent child under age nine-teen
Wages, tips, and salaries	Yes	No
Taxable interest	Yes	Yes
Ordinary dividends	Yes	Yes
Taxable refunds, credits, or offsets of state and local income taxes	Yes	Yes
Alimony received	Yes	N/A
Business income or loss	Yes	Yes
Capital gain or loss	Yes	Yes
Other gains or losses	Yes	Yes
IRA distributions	Yes	Yes
Pensions and annuities	Yes	N/A
Rental real estate, royalties, partnerships, S corporations	Yes	Yes
Farm income	Yes	Yes
Unemployment compensation	Yes	No
Social Security benefits	Yes	Yes
Other income	Yes	Yes

[Statutory Authority: RCW 70.47A.060. 08-22-041 (Order 08-02), § 182-26-350, filed 10/31/08, effective 12/1/08.]

**PART 4
ADMINISTRATIVE PROCEDURES**

WAC 182-26-400 Appeals—Grounds. (1) An employer may appeal a HIP decision regarding the employer group's eligibility or enrollment status in the HIP.

(2) A partnership participant or applicant may appeal a HIP decision regarding:

- Eligibility for a premium subsidy;
- Premium subsidy amounts;
- Premium subsidy adjustments or penalties.

[Statutory Authority: RCW 70.47A.060. 08-22-041 (Order 08-02), § 182-26-400, filed 10/31/08, effective 12/1/08.]

WAC 182-26-405 Appeals—Who may appeal a HIP decision? The HIP will accept appeals from an appealing

party. For the purposes of this chapter, "appealing party" means:

(1) A participating small employer or small employer who has been denied enrollment in the HIP;

(2) An eligible partnership participant or applicant; or

(3) A third party on the behalf of the person listed in subsection (1) or (2) of this section, as long as the HIP has authorization from the person appealing. The authorization must:

- Be in writing; and
- Verify that the third party represents the person appealing, and that the HIP can share the person's HIP account information with the third party.

[Statutory Authority: RCW 70.47A.060. 08-22-041 (Order 08-02), § 182-26-405, filed 10/31/08, effective 12/1/08.]

WAC 182-26-410 How to appeal a HIP decision. (1)

To appeal a HIP decision, submit a signed letter of appeal to the HIP. The HIP must receive the letter of appeal within thirty calendar days of the date of the decision. The letter of appeal should include:

(a) The appealing party's name, mailing address, and HIP account number if assigned;

(b) A copy of the notice of the decision being appealed or an explanation of the decision being appealed; and

(c) A statement explaining why the appealing party believes the decision was incorrect, outlining the facts surrounding the decision and including supporting documents.

(2) If an appealing party would like an opportunity to explain in person or by phone, the appealing party should include that in the letter of appeal.

(3) Within fifteen calendar days of the date the HIP receives the letter of appeal, the HIP will send the appealing party written confirmation of receipt of the appeal. If requested by the appealing party, the HIP will schedule an opportunity for the appealing party to explain in person or by phone.

(4) Within sixty calendar days of the date the HIP receives the letter of appeal, the HIP will send the appealing party written notice of the HIP appeal decision. If the appeal is from a third party, the HIP will send a copy of the notice to the appealing party. The notice will include the reasons for the appeal decision and instructions for requesting a review of the appeal decision.

(5) The appeal decision becomes the final agency decision unless the HIP receives a valid request for an additional review from the appealing party. To be valid the request must:

• Be received by the HIP within thirty calendar days of the date of the appeal decision;

• Include a summary of the decision to be reviewed and explain why the appealing party believes the decision was incorrect; and

• Provide additional information or documents the appealing party would like the HIP to consider in the review.

(6) When a valid request for an additional review is received, HIP appeal decisions will be reviewed by a presiding officer according to the requirements of RCW 34.05.488 through 34.05.494. These review decisions will be based on the record and documents submitted, unless the presiding officer decides that an in-person or telephone hearing is needed. If an in-person or telephone hearing is needed, the

presiding officer will decide whether to conduct the hearing as an informal hearing or formal adjudicative proceeding.

(7) The presiding officer will send a written notice of the review decision, including the reasons for the decision, within twenty-one calendar days of receiving the request for review, unless the presiding officer finds that additional time is needed for the decision.

(8) If the appealing party disagrees with a review decision under subsection (5) of this section, he or she may request judicial review of the decision, as provided for in RCW 34.05.542.

[Statutory Authority: RCW 70.47A.060. 08-22-041 (Order 08-02), § 182-26-410, filed 10/31/08, effective 12/1/08.]

**PART 5
AGENCY OPERATIONS**

WAC 182-26-500 Surcharge applicability. (1) The HIP may apply the surcharge uniformly to each health benefit plan purchased through the HIP to reflect the HIP's administrative and operational expenses remaining after any legislative appropriation for this purpose during the year the surcharge is assessed.

(2) The surcharge may be added to the premium, but will not be considered a part of the small group community rate and applies only to coverage purchased through the HIP.

(3) The surcharge may not be used to pay any premium assistance payments.

[Statutory Authority: RCW 70.47A.060. 08-22-041 (Order 08-02), § 182-26-500, filed 10/31/08, effective 12/1/08.]

**Chapter 182-50 WAC
PRESCRIPTION DRUG PROGRAMS**

WAC

182-50-001	Authority and purpose.
182-50-005	Definitions.
182-50-010	Purpose of the pharmacy and therapeutics committee.
182-50-015	Open Public Meetings Act and Administrative Procedure Act; exception as technical review committee.
182-50-025	Membership and qualifications of pharmacy and therapeutics committee.
182-50-030	Period of appointment.
182-50-035	Duties.
182-50-200	Endorsing practitioner therapeutic interchange program; effect of practitioner's endorsing status; dispense as written instructions.

WAC 182-50-001 Authority and purpose. RCW 41.05.021 (1)(a)(iii) and 70.14.050 authorize the administrator to establish an independent Washington state pharmacy and therapeutics committee within the health care authority to evaluate available evidence of the relative safety, efficacy and the effectiveness of prescription drugs within a class of prescription drugs, in the development of an evidence-based prescription drug program for participating state purchased health care programs. This section requires the administrator to adopt rules governing practitioner endorsement and use of any preferred drug list developed as part of the prescription drug program.

[Statutory Authority: RCW 41.05.160; 2004 1st sp.s. c 29 § 10. 04-06-021 (Order 03-02), § 182-50-001, filed 2/23/04, effective 3/25/04.]

(2009 Ed.)

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 a 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 182-50-010 Purpose of the pharmacy and therapeutics committee. The purpose of the committee is to evaluate the available evidence of the relative safety, efficacy, and effectiveness of prescription drugs within a class of prescription drugs and make recommendations to the

appointing authority for its deliberation in the development of the preferred drug list established in RCW 70.14.050.

[Statutory Authority: RCW 41.05.160; 2004 1st sp.s. c 29 § 10. 04-06-021 (Order 03-02), § 182-50-010, filed 2/23/04, effective 3/25/04.]

WAC 182-50-015 Open Public Meetings Act and Administrative Procedure Act; exception as technical review committee. (1) Meetings of the pharmacy and therapeutics committee shall in all respects comply with the provisions of the Open Public Meetings Act, chapter 42.30 RCW, and shall be subject to the provisions of the Administrative Procedure Act, chapter 34.05 RCW, as applicable.

(2) The pharmacy and therapeutics committee shall constitute a technical review committee created to facilitate the development, acquisition, or implementation of a preferred drug list, for the purposes of state purchased health care under RCW 41.05.026, and as such may hold an executive session in accordance with chapter 42.30 RCW during any regular or special meeting to discuss information submitted in accordance with RCW 41.05.026 (1) through (5).

[Statutory Authority: RCW 41.05.160; 2004 1st sp.s. c 29 § 10. 04-06-021 (Order 03-02), § 182-50-015, filed 2/23/04, effective 3/25/04.]

WAC 182-50-025 Membership and qualifications of pharmacy and therapeutics committee. (1) The committee shall consist of no fewer than ten members appointed by the appointing authority.

(2) The appointing authority has the sole right to appoint committee members and may terminate appointment of any member at any time during the term.

(3) The appointing authority will make appointments to the committee from a pool of interested applicants. Interested persons will be provided an opportunity to submit applications to the appointing authority.

(4) Members shall enter into an agreement with the health care authority at the time of their appointment to the committee and shall act in accordance with all of its terms and conditions. Failure to do so may result in termination of the appointment.

(5) The membership composition at all times shall be consistent with applicable federal requirements under the federal Social Security Act, Title 19 § 1927 and the requirements of the department of social and health services medical assistance administration for its drug utilization review board. Therefore, pharmacists and physicians each shall represent at least thirty-one percent, but no more than fifty-one percent of committee membership respectively.

(6) Members must be actively practicing in their clinical area of expertise throughout the entire term of their appointments.

(7) Members must have knowledge and expertise in one or more of the following:

- (a) Clinically appropriate prescribing of covered outpatient drugs;
- (b) Clinically appropriate dispensing and monitoring of covered outpatient drugs;
- (c) Drug use review;
- (d) Medical quality assurance;
- (e) Disease state management; or
- (f) Evidence-based medicine.

(8) Members of the committee shall not be employed by a pharmaceutical manufacturer, a pharmacy benefits management company, or by any state agency administering state purchased health care programs during their term shall not have been so employed and for eighteen months prior to their appointment.

(9) A member shall not have a substantial financial conflict of interest including any interest in any pharmaceutical company, including the holding of stock options or the receipt of honoraria or consultant moneys. The appointing authority in its sole discretion may disqualify any potential member if it determines that a substantial conflict of interest exists.

(10) As part of the application process, prospective committee members shall complete a conflict of interest disclosure form, provided by the appointing authority, and after appointment, annually by July 1st of each year. Members must keep their disclosure statements current and provide updated information whenever circumstances change.

(11) Committee members must agree to keep all proprietary information confidential.

[Statutory Authority: RCW 41.05.160; 2004 1st sp.s. c 29 § 10. 04-06-021 (Order 03-02), § 182-50-025, filed 2/23/04, effective 3/25/04.]

WAC 182-50-030 Period of appointment. (1) Members shall be appointed to a term of three years and shall serve until a successor is duly appointed. A member may be reappointed to one additional three-year term for a total of six years. One year after the end of a six-year term, a person is eligible for appointment to one additional three-year term.

(2) Committee members serve staggered three-year terms. Of the initial appointees, in order to provide for staggered terms, some members may be appointed initially for less than three years. If the initial appointment is for less than twenty-four months, that period of time shall not be counted toward the limitation of years of appointment described in subsection (1) of this section.

(3) Vacancies on the committee will be filled for the balance of the unexpired term from nominee lists for the appropriate committee category as provided under WAC 182-50-025.

(4) Members of the committee will be compensated for participation in the work of the committee in accordance with a personal services contract executed after appointment and prior to commencement of activities related to the work of the committee.

[Statutory Authority: RCW 41.05.160; 2004 1st sp.s. c 29 § 10. 04-06-021 (Order 03-02), § 182-50-030, filed 2/23/04, effective 3/25/04.]

WAC 182-50-035 Duties. Committee members shall:

(1) Select a chair and a vice-chair from among the committee membership.

(2) Meet at least quarterly and may meet at other times at the discretion of the chair.

(3) Adopt a plan of operation that sets forth the policies and procedures established by the committee to develop an evidence-based prescription drug program as authorized by state law for approval by the appointing authority.

(4) Operate according to the plan of operation as approved by the appointing authority.

[Statutory Authority: RCW 41.05.160; 2004 1st sp.s. c 29 § 10. 04-06-021 (Order 03-02), § 182-50-035, 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 a 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: RCW 41.05.160; 2004 1st sp.s. c 29 § 10. 04-06-021 (Order 03-02), § 182-50-200, filed 2/23/04, effective 3/25/04.]

Chapter 182-55 WAC

HEALTH TECHNOLOGY ASSESSMENT PROGRAM

WAC

182-55-005	Authority and purpose.
182-55-010	Definitions.
182-55-015	Committee purpose.
182-55-020	Committee selection.
182-55-025	Committee member requirements and terms.
182-55-030	Committee coverage determination process.
182-55-035	Committee coverage determination.
182-55-040	Publication of committee determinations.
182-55-045	Advisory group.
182-55-050	Health technology selection.
182-55-055	Health technology assessment.

WAC 182-55-005 Authority and purpose. Under RCW 70.14.080 through 70.14.140, the administrator of the Washington state health care authority is required to establish and support, and is authorized to adopt rules to govern, a health technology assessment program that uses evidence to make coverage determinations for participating state agencies that purchased health care. The health technology assessment program:

- (1) Selects health technologies for assessment;
- (2) Contracts with an evidence-based technology assessment center to produce health technology assessments;
- (3) Establishes an independent health technology committee; and
- (4) Maintains a centralized, internet based communication tool.

(2009 Ed.)

[Statutory Authority: RCW 41.05.013, 41.05.160, and 70.14.090. 06-23-083 (Order 06-10), § 182-55-005, filed 11/13/06, effective 12/14/06.]

WAC 182-55-010 Definitions. When used in this chapter:

(1) "Administrator" means the administrator of the Washington state health care authority under chapter 41.05 RCW, as set forth in RCW 70.14.080, as amended.

(2) "Advisory group" means a group established under RCW 70.14.110 (2)(c).

(3) "Committee" means the health technology clinical committee established under RCW 70.14.090.

(4) "Coverage determination" means a determination of the circumstances, if any, under which a health technology will be included as a covered benefit in a state purchased health care program, as set forth in RCW 70.14.080, as amended.

(5) "Health technology" means medical and surgical devices and procedures, medical equipment, and diagnostic tests. Health technologies do not include prescription drugs governed by RCW 70.14.050.

(6) "Participating agency" means the department of social and health services, the state health care authority, and the department of labor and industries, as set forth in RCW 70.14.080, as amended.

(7) "Reimbursement determination" means a determination to provide or deny reimbursement for a health technology included as a covered benefit in a specific circumstance for an individual patient who is eligible to receive health care services from the state purchased health care program making the determination, as set forth in RCW 70.14.080, as amended.

(8) "Health technology assessment" means a report produced by a contracted evidence-based technology assessment center as provided for in RCW 70.14.100(4) that is based on a systematic review of evidence of a technology's safety, efficacy, and cost-effectiveness.

[Statutory Authority: RCW 41.05.013, 41.05.160, and 70.14.090. 06-23-083 (Order 06-10), § 182-55-010, filed 11/13/06, effective 12/14/06.]

WAC 182-55-015 Committee purpose. The purpose of the committee is to make coverage determinations for the participating agencies based on: A health technology assessment that reviews the scientific evidence of the relative safety, efficacy, and cost; information from any special advisory groups; and their professional knowledge and expertise.

[Statutory Authority: RCW 41.05.013, 41.05.160, and 70.14.090. 06-23-083 (Order 06-10), § 182-55-015, filed 11/13/06, effective 12/14/06.]

WAC 182-55-020 Committee selection. (1) The administrator, in consultation with the participating state agencies, shall make appointments to vacant committee positions, including the appointment of a chair, from a pool of interested applicants. Interested persons will be provided an opportunity to submit applications to the administrator for consideration.

(2) When appointing committee members, the administrator will consider, in addition to the membership requirements imposed by RCW 70.14.090 and any other relevant information, the following factors: Practitioner specialty or type and use of health technologies, especially in relation to

current committee member specialty or types; practice location and community knowledge; length of practice experience; knowledge of and experience with evidence-based medicine, including formal additional training in fields relevant to evidence-based medicine; medical quality assurance experience; health technology assessment review experience.

[Statutory Authority: RCW 41.05.013, 41.05.160, and 70.14.090. 06-23-083 (Order 06-10), § 182-55-020, filed 11/13/06, effective 12/14/06.]

WAC 182-55-025 Committee member requirements and terms. (1) As a continuing condition of appointment, committee members:

(a) Shall not have a substantial financial conflict of interest, such as an interest in a health technology company, including the holding of stock options, or the receipt of honoraria, or consultant moneys;

(b) Must complete a conflict of interest disclosure form, update the form annually, and keep disclosure statements current;

(c) Must abide by confidentiality requirements and keep all personal medical information and proprietary information confidential; and

(d) Shall not utilize information gained as a result of committee membership outside of committee responsibilities, unless such information is publicly available. The administrator, in his/her sole discretion, may disqualify committee members if he/she determines that the committee member has violated a condition of appointment.

(2) Committee members shall be appointed to a term of three years and shall serve until a successor is appointed. A member may be reappointed for additional three-year terms for a total of nine years. One year after the end of a nine-year term, a person is eligible for appointment to one additional three-year term. Committee members serve staggered three-year terms. Of the initial members, in order to provide for staggered terms, some members may be appointed initially for less than three years. If an initial appointment is for less than twenty-four months, that period of time shall not be counted toward the limitation of years of appointment. Vacancies on the committee will be filled for the balance of the unexpired term.

(3) The appointed committee chair shall select a vice-chair from among the committee membership; ratify committee bylaws approved by the administrator; and operate the committee according to the bylaws and committee member agreements.

[Statutory Authority: RCW 41.05.013, 41.05.160, and 70.14.090. 06-23-083 (Order 06-10), § 182-55-025, filed 11/13/06, effective 12/14/06.]

WAC 182-55-030 Committee coverage determination process. (1) In making a coverage determination, committee members shall review and consider the health technology assessment. The committee may also consider other information it deems relevant, including other information provided by the administrator, reports and/or testimony from an advisory group, and submissions or comments from the public.

(2) The committee shall give the greatest weight to the evidence determined, based on objective factors, to be the most valid and reliable, considering the nature and source of the evidence, the empirical characteristic of the studies or tri-

als upon which the evidence is based, and the consistency of the outcome with comparable studies. The committee may also consider additional evidentiary valuation factors such as recency (date of information); relevance (the applicability of the information to the key questions presented or participating agency programs and clients); and bias (presence of conflict of interest or political considerations).

[Statutory Authority: RCW 41.05.013, 41.05.160, and 70.14.090. 06-23-083 (Order 06-10), § 182-55-030, filed 11/13/06, effective 12/14/06.]

WAC 182-55-035 Committee coverage determination. Based on the evidence regarding safety, efficacy, and cost-effectiveness of the health technology, the committee shall:

(1) Determine the conditions, if any, under which the health technology will be included as a covered benefit in health care programs of participating agencies by deciding that:

(a) Coverage is allowed without special conditions because the evidence is sufficient to conclude that the health technology is safe, efficacious, and cost-effective for all indicated conditions; or

(b) Coverage is allowed with special conditions because the evidence is sufficient to conclude that the health technology is safe, efficacious, and cost-effective in only certain situations; or

(c) Coverage is not allowed because either the evidence is insufficient to conclude that the health technology is safe, efficacious, and cost-effective or the evidence is sufficient to conclude that the health technology is unsafe, ineffectual, or not cost-effective.

(2) Identify whether the determination is consistent with the identified medicare decisions and expert guidelines.

(3) For decisions that are inconsistent with either the identified medicare decisions or expert guidelines, specify the reason(s) for the decision and the evidentiary basis.

(4) For covered health technologies, specify criteria for participating agencies to use when deciding whether the health technology is medically necessary or proper and necessary treatment.

[Statutory Authority: RCW 41.05.013, 41.05.160, and 70.14.090. 06-23-083 (Order 06-10), § 182-55-035, filed 11/13/06, effective 12/14/06.]

WAC 182-55-040 Publication of committee determinations. (1) The administrator shall publish final committee determinations by posting on a centralized, internet-based communication tool within ten days.

(2) Upon publication, participating agencies will implement the committee determination according to their statutory, regulatory, or contractual process unless:

(a) The determination conflicts with an applicable federal statute or regulation, or applicable state statute; or

(b) Reimbursement is provided under an agency policy regarding experimental or investigational treatment, services under a clinical investigation approved by an institutional review board, or health technologies that have a humanitarian device exemption from the federal food and drug administration.

[Statutory Authority: RCW 41.05.013, 41.05.160, and 70.14.090. 06-23-083 (Order 06-10), § 182-55-040, filed 11/13/06, effective 12/14/06.]

WAC 182-55-045 Advisory group. (1) The committee chair, upon an affirmative vote of the committee members, may establish ad hoc temporary advisory group(s) if specialized expertise or input from enrollees or clients is needed to review a particular health technology or group of health technologies. The purpose or scope of the advisory group and time period shall be stated. The advisory group shall provide a report and/or testimony to the committee on the key questions identified by the committee as requiring the input of the advisory group.

(2) **Advisory group membership:** An ad hoc temporary advisory group shall include at least three members. Membership should reflect the diverse perspectives and/or technical expertise that drive the need for the specialized advisory group. The advisory group will generally include at least one enrollee, client, or patient; and two or more experts or specialists within the field relevant to the health technology, preferably with demonstrated experience in the use, evaluation, or research of the health technology. If substantial controversy over the health technology is present, at least one expert that is a proponent or advocate of the health technology and at least one expert that is an opponent or critic of the health technology should be appointed. A majority of each advisory group shall have no substantial financial interest in the health technology under review.

(3) As a continuing condition of appointment, advisory group members:

(a) Must complete an advisory group member agreement, including a conflict of interest disclosure form, and keep disclosure statements current;

(b) Must abide by confidentiality requirements and keep all personal medical information and proprietary information confidential; and

(c) Shall not utilize information gained as a result of advisory group membership outside of advisory group responsibilities, unless such information is publicly available.

[Statutory Authority: RCW 41.05.013, 41.05.160, and 70.14.090. 06-23-083 (Order 06-10), § 182-55-045, filed 11/13/06, effective 12/14/06.]

WAC 182-55-050 Health technology selection. (1) Prior to selection of a health technology for review or rereview, the administrator shall consider nominations from participating agencies and recommendations from the committee. The administrator may also consider petitions from interested parties. The administrator shall make available, including publication to the centralized internet-based communication tool required at RCW 70.14.130, a petition for interested parties to request a health technology be selected for a review or rereview. Interested parties shall complete the petition and submit it to the administrator. The administrator, or designee, will provide copies of the petition to participating agencies and the committee for comment, and provide the completed petition, with any comments, to the administrator for consideration.

(2) Interested parties that have submitted a petition for the review or rereview of a health technology that was not selected by the administrator may submit the petition to the committee for review or rereview.

(3) The committee may consider petitions submitted by interested parties for review or rereview of a health technol-

ogy. The committee shall apply the priority criteria set forth in RCW 70.14.100.

(4) A health technology selected by the committee shall be referred to the administrator for the next available contract for health technology assessment review.

[Statutory Authority: RCW 41.05.013, 41.05.160, and 70.14.090. 06-23-083 (Order 06-10), § 182-55-050, filed 11/13/06, effective 12/14/06.]

WAC 182-55-055 Health technology assessment. (1) Upon notice of the selection of the health technology for review, the administrator shall post an invitation for interested parties to submit information relevant to the health technology for consideration by the evidence-based technology assessment center. Such information shall be required to be submitted to the administrator, or designee, no earlier than thirty days from the date of the notice.

(2) Upon notice of the selection of the health technology for review, the administrator shall request participating agencies to provide information relevant to the health technology, including data on safety, health outcome, and cost. Such information shall be required to be submitted to the administrator, or designee, no earlier than thirty days from the date of the notice.

(3) Upon notice of the selection of the health technology for review, the administrator shall require staff to identify and organize relevant federal medicare national coverage determinations and expert treatment guidelines, and any referenced information used as the basis for such determinations and/or guidelines.

(4) The administrator shall provide all information relevant to the selected health technology to the evidence-based technology assessment center; and shall post such information, along with the key questions for review, on a centralized, internet based communication tool.

(5) Upon completion of the health technology assessment by the evidence-based technology assessment center, the administrator shall provide the committee with:

(a) Final copy of the health technology assessment;

(b) Information as to whether the federal medicare program has made a national coverage determination;

(c) A copy of identified national coverage decisions and accompanying information describing the basis for the decision;

(d) Information as to whether expert treatment guidelines exist, including those from specialty physician organizations and patient advocacy organizations; and

(e) A copy of identified guidelines and accompanying information describing the basis for the guidelines.

[Statutory Authority: RCW 41.05.013, 41.05.160, and 70.14.090. 06-23-083 (Order 06-10), § 182-55-055, filed 11/13/06, effective 12/14/06.]