Chapter 182-16 WAC
PRACTICE AND PROCEDURE

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DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

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? [Statutory Authority: RCW 41.05.160, 09-23-102 (Order 09-02), § 182-16-034, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-16-034, filed 10/1/08, effective 1/1/09.] Repealed by 10-20-147 (Order 10-02), filed 10/6/10, effective 1/1/11. Statutory Authority: RCW 41.05.160.

182-16-037  How can an enrollee appeal a decision by the agency's self-insured dental plan? [Statutory Authority: RCW 41.05.160, 09-23-102 (Order 09-02), § 182-16-037, filed 11/17/09, effective 1/1/10; 08-20-128 (Order 08-03), § 182-16-037, filed 10/1/08, effective 1/1/09.] Repealed by 10-20-147 (Order 10-02), filed 10/6/10, effective 1/1/11. Statutory Authority: RCW 41.05.160.

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 the authority in public employees benefits board (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, 12-20-022 (Order 2012-01), § 182-16-010, filed 9/25/12, effective 11/1/12; 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.]
"PEBB benefits" means one or more insurance coverage or other employee benefits administered by the PEBB program within the health care authority.

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

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

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

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

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

"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.

Note: Eligibility decisions address whether a subscriber or a subscriber’s dependent is entitled to insurance coverage, as described in public employees benefits board (PEBB) rules and policies. Enrollment decisions address the application for PEBB benefits as described in PEBB rules and policies including, but not limited to, the submission of proper documentation and meeting enrollment deadlines.

(1) Any employee of a state agency or his or her dependent aggrieved by a decision made by the employing state agency with regard to public employee benefits eligibility or enrollment may appeal that decision to the employing state agency by the process outlined in WAC 182-16-030.

(2) Any employee of an employer group or his or her dependent who is aggrieved by a decision made by an employer group with regard to PEBB eligibility or enrollment may appeal that decision to the employer group through the process established by the employer group.

Exception: Appeals by an employee of an employer group or his or her dependent based on eligibility or enrollment decisions regarding life insurance or LTD insurance must be made to the PEBB appeals committee by the process described in WAC 182-16-032.

(3) Any subscriber or dependent aggrieved by a decision made by the PEBB program with regard to public employee benefits eligibility, enrollment, or premium payments may appeal that decision to the PEBB appeals committee by the process described in WAC 182-16-032.

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

(5) Any PEBB enrollee aggrieved by a decision regarding the administration of PEBB long-term care insurance or property and casualty insurance may appeal that decision by following the appeal provisions of those plans.

(6) Any PEBB enrollee aggrieved by a decision regarding the medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP) offered under the state’s salary reduction plan may appeal that decision by the process described in WAC 182-16-036.

WAC 182-16-025 Where do members appeal decisions regarding eligibility, enrollment, premium payments, or the administration of benefits?

Note: Eligibility decisions address whether a subscriber or a subscriber’s dependent is entitled to insurance coverage, as described in public employees benefits board (PEBB) rules and policies. Enrollment decisions address the application for PEBB benefits as described in PEBB rules and policies including, but not limited to, the submission of proper documentation and meeting enrollment deadlines.

(1) Any employee of a state agency or his or her dependent aggrieved by a decision made by the employing state agency with regard to public employee benefits eligibility or enrollment may appeal that decision to the employing state agency by the process outlined in WAC 182-16-030.

(2) Any employee of an employer group or his or her dependent who is aggrieved by a decision made by an employer group with regard to PEBB eligibility or enrollment may appeal that decision to the employer group through the process established by the employer group.

Exception: Appeals by an employee of an employer group or his or her dependent based on eligibility or enrollment decisions regarding life insurance or LTD insurance must be made to the PEBB appeals committee by the process described in WAC 182-16-032.

(3) Any subscriber or dependent aggrieved by a decision made by the PEBB program with regard to public employee benefits eligibility, enrollment, or premium payments may appeal that decision to the PEBB appeals committee by the process described in WAC 182-16-032.

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

(5) Any PEBB enrollee aggrieved by a decision regarding the administration of PEBB long-term care insurance or property and casualty insurance may appeal that decision by following the appeal provisions of those plans.

(6) Any PEBB enrollee aggrieved by a decision regarding the medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP) offered under the state’s salary reduction plan may appeal that decision by the process described in WAC 182-16-036.

[Statutory Authority: RCW 41.05.160. 12-20-022 (Order 2012-01), § 182-16-025, filed 9/25/12, effective 11/1/12. Statutory Authority: RCW 41.05.160 and 2011 c 8. 11-22-036 (Order 11-02), § 182-16-025, filed 10/26/11, effective 11/1/12. Statutory Authority: RCW 41.05.160. 10-20-147 (Order 10-02), § 182-16-025, filed 10/6/10, effective 1/1/11]
(2) Any employee or employee's dependent who disagrees with the employing state agency's decision in response to a request for review, as described in subsection (1) of this section, may appeal that decision by submitting a notice of appeal to the PEBB appeals committee. The PEBB appeals manager must receive the notice of appeal within thirty days of the date of the employing state agency's written decision on the request for review.

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

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

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

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

(3) Any enrollee 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.

(4) The notice of appeal from an employee or employee's dependent must be received by the PEBB appeals manager within thirty days of the date of the denial notice by the PEBB program. The contents of the notice of appeal are to be provided in accordance with WAC 182-16-040.

(5) The notice of appeal from a retiree, self-pay enrollee, or dependent of a retiree or self-pay enrollee must be received by the PEBB appeals manager within sixty days of the date of the denial notice.

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

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

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

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 that decision to the third-party administrator that administers the medical FSA and DCAP under the state’s salary reduction plan. The contents of the notice of appeal are to be provided in accordance with WAC 182-16-040.

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

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

(c) Any appellant who disagrees with the decision of the PEBB appeals committee may request an administrative hearing, as described in WAC 182-16-050.
WAC 182-16-038 How can an entity or organization appeal a decision of the health care authority to deny an employer group application? An entity or organization whose employer group application is denied by the authority may appeal the decision to the public employees benefits board (PEBB) appeals committee. For rules regarding eligible entities, see WAC 182-12-111. The PEBB appeals manager must receive the notice of appeal within 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 to the appellant on the notice of appeal within thirty days of receiving the notice of appeal. The committee may extend the thirty-day time requirement for rendering a decision upon issuing a written finding of good cause explaining the cause for the delay.
3. Any appealing party aggrieved with the decision of the PEBB appeals committee may request an administrative hearing, as described in WAC 182-16-050.

[Statutory Authority: RCW 41.05.160. 91-14-025, § 182-16-040, filed 6/25/91, effective 7/26/91.]

WAC 182-16-050 How can an enrollee or entity request a hearing if aggrieved by a decision made by the public employees benefits board (PEBB) appeals committee? (1) Any party aggrieved by a decision of the public employees benefits board (PEBB) appeals committee, may request an administrative hearing.
(2) The request must be made in writing to the PEBB appeals manager. The PEBB appeals manager must receive the request for an administrative hearing within thirty days of the date of the written decision by the PEBB appeals committee.
(3) The authority shall set the time and place of the hearing and give not less than twenty days notice to all parties.
(4) The director, or his or her designee, shall preside at all hearings resulting from the filings of appeals under this chapter.
(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 director or his or her designee shall render a decision which shall be the final decision of the authority. A copy of that decision shall be mailed to all parties.

[Statutory Authority: RCW 41.05.160. 12-20-022 (Order 2012-01), § 182-16-050, filed 10/26/11, effective 1/1/12. Statutory Authority: RCW 41.05.160 and 2011 c 8. 11-22-036 (Order 11-02), § 182-16-050, filed 10/26/11, effective 1/1/12. Statutory Authority: RCW 41.05.160. 10-20-147 (Order 10-02), § 182-16-050, filed 10/6/10, effective 1/1/11. Statutory Authority: RCW 41.05.160. 91-14-025, § 182-16-040, filed 6/25/91, effective 7/26/91.]

WAC 182-16-060 Index of significant decisions. (1) A final decision may be relied upon, used, or cited as precedent by a party if the final order has been indexed in the authority's index of significant decisions in accordance with RCW 34.05.473 (1)(b).
(2) The index of significant decisions is available to the public at the health care authority (HCA) internet page. As decisions are indexed they will be linked on this page. For additional information on how to obtain a copy of the index, contact the HCA hearing representative.
(3) A final decision published in the index of significant decisions may be removed from the index when:
(a) A precedential published decision entered by the court of appeals or the supreme court reverses an indexed final decision; or
(b) HCA determines that the indexed final decision is no longer precedential due to changes in statute, rule or policy.

[Statutory Authority: RCW 41.05.160. 12-20-022 (Order 2012-01), § 182-16-060, filed 9/25/12, effective 11/1/12.]

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