

## Chapter 182-08 WAC PROCEDURES

Last Update: 7/28/20

### WAC

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### DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

182-08-020	Duties and responsibilities. [Statutory Authority: Chapter 41.05 RCW. WSR 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 Repealed by WSR 03-17-031 (Order 02-07), filed 8/14/03, effective 9/14/03.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 Repealed by WSR 96-08-042, filed 3/29/96, effective 4/29/96.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 Repealed by WSR 96-08-042, filed 3/29/96, effective 4/29/96.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. WSR 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 Repealed by WSR 96-08-042, filed 3/29/96, effective 4/29/96.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 Repealed by WSR 79-11-064 (Order 2-79), filed 10/18/79.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 Repealed by WSR 79-11-064 (Order 2-79), filed 10/18/79.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. WSR 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. WSR 01-24-048 (Order 01-05), § 182-08-095, filed 11/29/01, effective 12/30/01. Statutory Authority: RCW 41.05.160. WSR 99-19-029 (Order 99-03), § 182-08-095, filed 9/8/99, effective 10/9/99; WSR 97-21-126, § 182-08-095, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. WSR 96-08-042, § 182-08-095, filed 3/29/96, effective 4/29/96.] Repealed by WSR 04-18-039, filed 8/26/04, effective 1/1/05.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 Repealed by WSR 96-08-042, filed 3/29/96, effective 4/29/96.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. WSR 81-03-014 (Order 1-81), § 182-08-111, filed 1/9/81; WSR 79-11-064 (Order 2-79), § 182-08-111, filed 10/18/79.] Repealed by WSR 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. WSR 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. WSR 01-24-048 (Order 01-05), § 182-08-125, filed 11/29/01, effective 12/30/01.] Repealed by WSR 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 WSR 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 WSR 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. WSR 97-21-126, § 182-08-160, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. WSR 96-08-042, § 182-08-160, filed 3/29/96, effective 4/29/96; WSR 93-23-065, § 182-08-160, filed 11/16/93, effective 12/17/93; WSR 86-16-061 (Resolution No. 86-3), § 182-08-160, filed 8/5/86; WSR 83-22-042 (Resolution No. 6-83), § 182-08-160, filed 10/28/83; WSR 80-01-082 (Order 5-79), § 182-08-160, filed 12/27/79; WSR 78-03-021 (Order 3-78), § 182-08-160, filed 2/14/78; Order 7228, § 182-08-160, filed 12/8/76.] Repealed by WSR 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. WSR 96-08-042, § 182-08-165, filed 3/29/96, effective 4/29/96. Statutory Authority: RCW 41.05.065. WSR 89-05-013 (Resolution No. 89-1), § 182-08-165, filed 2/9/89.] Repealed by WSR 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. WSR 86-16-061 (Resolution No. 86-3), § 182-08-170, filed 8/5/86; WSR 78-02-015 (Order 2-78), § 182-08-170, filed 1/10/78; Order 7228, § 182-08-170, filed 12/8/76.] Repealed by WSR 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. WSR 03-17-031 (Order 02-07), § 182-08-175, filed 8/14/03, effective 9/14/03. Statutory Authority: RCW 41.05.160. WSR 97-21-126, § 182-08-175, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. WSR 93-23-065, § 182-08-175, filed 11/16/93, effective 12/17/93.] Repealed by WSR 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. WSR 84-09-043 (Resolution No. 2-84), § 182-08-195, filed 4/16/84.] Repealed by WSR 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. WSR 03-17-031 (Order 02-07), § 182-08-210, filed 8/14/03, effective 9/14/03. Statutory Authority: Chapter 41.05 RCW. WSR 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 WSR 04-18-039, filed 8/26/04, effective 1/1/05. Statutory Authority: RCW 41.05.160 and 41.05.165.
- 182-08-230 Participation in PEBB benefits by employer groups, including K-12 school districts and educational service districts. [Statutory Authority: RCW 41.05.160. WSR 09-23-102 (Order 09-02), § 182-08-230, filed 11/17/09, effective 1/1/10; WSR 08-20-128 (Order 08-03), § 182-08-230, filed 10/1/08, effective 1/1/09; WSR 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. WSR 04-18-039, § 182-08-230, filed 8/26/04, effective 1/1/05.] Repealed by WSR 12-20-022 (Order 2012-01), filed 9/25/12, effective 11/1/12. Statutory Authority: RCW 41.05.160.
- 182-08-300 Criteria for selection of insurance company for automobile and homeowners insurance. [Statutory Authority: Chapter 41.05 RCW. WSR 81-03-014 (Order 1-81), § 182-08-300, filed 1/9/81.] Repealed by WSR 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. WSR 07-20-129 (Order 07-01), § 182-08-010, filed 10/3/07, effective 11/3/07. Statutory Authority: Chapter 41.05 RCW. WSR 96-08-042, § 182-08-010, filed 3/29/96, effective 4/29/96; Order 7228, § 182-08-010, filed 12/8/76.]

**(Effective until January 1, 2021)**

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

"Accidental death and dismemberment insurance" or "AD&D" means basic accidental death and dismemberment (AD&D) insurance paid for by the employing agency, as well as supplemental accidental death and dismemberment insurance offered to and paid for by employees for themselves and their dependents.

"Affordable Care Act" means the federal Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, P.L. 111-152, or federal regulations or guidance issued under the Affordable Care Act.

"Annual open enrollment" means an annual event set aside for a period of time by the HCA when subscribers may make changes to their health plan enrollment and salary reduction elections for the following plan year. During the annual open enrollment, subscribers may transfer from one health plan to another, enroll or remove dependents from coverage, enroll in coverage, or waive enrollment in PEBB medical. Employees eligible to participate in the salary reduction plan may enroll in or change their election under the dependent care assistance program (DCAP) or the medical flexible spending arrangement (FSA). They may also enroll in or opt out of the premium payment plan.

"Authority" or "HCA" means the Washington state health care authority.

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

"Calendar days" or "days" means all days including Saturdays, Sundays, and all legal state holidays as set forth in RCW 1.16.050.

"Consolidated Omnibus Budget Reconciliation Act" or "COBRA" means continuation coverage as administered under 42 U.S.C. Secs. 300bb-1 through 300bb-8.

"Continuation coverage" means the temporary continuation of health plan coverage available to enrollees under the Consolidated Omnibus Budget Reconciliation Act (COBRA), 42 U.S.C. Secs. 300bb-1 through 300bb-8, the Uniformed Services Employment and Reemployment Rights Act (USERRA), 38 U.S.C. Secs. 4301 through 4335, or the public employees benefits board's policies.

"Contracted vendor" means any person, persons, or entity under contract or agreement with the HCA to provide goods or services for the provision or administration of PEBB benefits. The term "contracted vendor" includes subcontractors of the HCA and subcontractors of any person, persons, or entity under contract or agreement with the HCA that provide goods or services for the provision or administration of PEBB benefits.

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

"Defer" means to postpone enrollment or interrupt enrollment in a PEBB health plan by a retiree or an eligible survivor.

"Dependent" means a person who meets eligibility requirements in WAC 182-12-260, except that "surviving spouses, state registered domestic partners, and dependent children" of emergency service personnel who are killed in the line of duty is defined in WAC 182-12-250.

"Dependent care assistance program" or "DCAP" means a benefit plan whereby employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan under chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 129 or other sections of the Internal Revenue Code.

"Director" means the director of the authority.

"Documents" means papers, letters, writings, electronic mail, electronic files, or other printed or written items.

"Employee" for the public employees benefits board program includes all employees of the state, whether or not covered by civil service; elected and appointed officials of the executive branch of government, including full-time members of boards, commissions, or

committees; justices of the supreme court and judges of the court of appeals and the superior courts; and members of the state legislature. Pursuant to contractual agreement with the authority, "employee" may also include: (a) Employees of a county, municipality, or other political subdivision of the state and members of the legislative authority of any county, city, or town who are elected to office after February 20, 1970, if the legislative authority of the county, municipality, or other political subdivision of the state submits application materials to the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.04.205 and 41.05.021 (1)(g); (b) employees of employee organizations representing state civil service employees, at the option of each such employee organization; (c) through December 31, 2019, employees of a school district or represented employees of an educational service district if the authority agrees to provide any of the school districts' or educational service districts' insurance programs by contract with the authority as provided in RCW 28A.400.350; (d) employees of a tribal government, if the governing body of the tribal government seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(f) and (g); (e) employees of the Washington health benefit exchange if the governing board of the exchange established in RCW 43.71.020 seeks and receives approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(g) and (n); (f) through December 31, 2019, employees of a charter school established under chapter 28A.710 RCW; and (g) through December 31, 2023, nonrepresented employees of an educational service district. "Employee" does not include: Adult family home providers; unpaid volunteers; patients of state hospitals; inmates; employees of the Washington state convention and trade center as provided in RCW 41.05.110; students of institutions of higher education as determined by their institution; and any others not expressly defined as employees under RCW 41.05.011 or by the authority under this chapter.

"Employer" for the public employees benefits board program means the state of Washington.

"Employer-based group health plan" means group medical and group dental related to a current employment relationship. It does not include medical or dental coverage available to retired employees, individual market medical or dental coverage, or government-sponsored programs such as medicare or medicaid.

"Employer-based group medical" means group medical related to a current employment relationship. It does not include medical coverage available to retired employees, individual market medical coverage, or government-sponsored programs such as medicare or medicaid.

"Employer contribution" means the funding amount paid to the HCA by a state agency or employer group for its eligible employees as described under WAC 182-12-114 and 182-12-131.

"Employer group" means those counties, municipalities, political subdivisions, the Washington health benefit exchange, tribal governments, employee organizations representing state civil service employees, and through December 31, 2019, school districts and charter schools, and through December 31, 2023, educational service districts obtaining employee benefits through a contractual agreement with the authority to participate in benefit plans developed by the public employees benefits board as described in WAC 182-08-245.

"Employer group rate surcharge" means the rate surcharge described in RCW 41.05.050(2).

"Employer-paid coverage" means PEBB insurance coverage for which an employer contribution is made by a state agency or an employer group for employees eligible under WAC 182-12-114 and 182-12-131. It also means SEBB insurance coverage for which an employer contribution is made by a SEBB organization, or basic benefits described in RCW 28A.400.270(1) for which an employer contribution is made by an educational service district.

"Employing agency" for the public employees benefits board program means a division, department, or separate agency of state government, including an institution of higher education; a county, municipality, or other political subdivision; and a tribal government covered by chapter 41.05 RCW.

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

"Exchange" means the Washington health benefit exchange established in RCW 43.71.020, and any other health benefit exchange established under the Affordable Care Act.

"Exchange coverage" means coverage offered by a qualified health plan through an exchange.

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

"Forms" or "form" means both paper forms and forms completed electronically.

"Health plan" means a plan offering medical or dental, or both, developed by the PEBB and provided by a contracted vendor or self-insured plans administered by the HCA.

"Insignificant shortfall" means a premium balance owed that is less than or equal to the lesser of \$50 or ten percent of the premium required by the health plan as described in Treasury Regulation 26 C.F.R. 54.4980B-8.

"Institutions of higher education" means the state public research universities, the public regional universities, The Evergreen State College, the community and technical colleges, and the state board for community and technical colleges.

"Large claim" means a claim for more than \$25,000 in allowed costs for services in a quarter.

"Layoff," for purposes of this chapter, means a change in employment status due to an employer's lack of funds or an employer's organizational change.

"Life insurance" means basic life insurance paid for by the employing agency, as well as supplemental life insurance offered to and paid for by employees for themselves and their dependents. Life insurance for eligible retirees includes retiree term life insurance offered to and paid for by retirees.

"Long-term disability insurance" or "LTD insurance" means basic long-term disability insurance paid for by the employing agency and supplemental long-term disability insurance offered to and paid for by the employee.

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby eligible state employees may reduce their salary before taxes to pay for medical expenses not reimbursed by insurance as provided in the salary reduction plan established under chapter

41.05 RCW pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"Ongoing large claim" means a claim where the patient is expected to need ongoing case management into the next quarter for which the expected allowed cost is greater than \$25,000 in the quarter.

"PEBB" means the public employees benefits board.

"PEBB benefits" means one or more insurance coverages or other employee benefits administered by the PEBB program within the health care authority.

"PEBB insurance coverage" means any health plan, life insurance, accidental death and dismemberment insurance, long-term disability (LTD) insurance, long-term care insurance, or property and casualty insurance administered as a PEBB benefit.

"PEBB program" means the program within the HCA that administers insurance and other benefits for eligible employees (as described in WAC 182-12-114), eligible retired employees (as described in WAC 182-12-171 and 182-12-180), eligible survivors (as described in WAC 182-12-180, 182-12-250, and 182-12-265), eligible dependents (as described in WAC 182-12-250 and 182-12-260) and others as defined in RCW 41.05.011.

"Plan year" means the time period established by the authority.

"Premium payment plan" means a benefit plan whereby public employees may pay their share of group health plan premiums with pretax dollars as provided in the salary reduction plan under chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"Premium surcharge" means a payment required from a subscriber, in addition to the subscriber's medical premium contribution, due to an enrollee's tobacco use or an enrolled subscriber's spouse or state registered domestic partner choosing not to enroll in their employer-based group medical when:

- The spouse's or state registered domestic partner's share of the medical premium is less than ninety-five percent of the additional cost an employee would be required to pay to enroll a spouse or state registered domestic partner in the public employees benefits board (PEBB) Uniform Medical Plan (UMP) Classic; and
- The benefits have an actuarial value of at least ninety-five percent of the actuarial value of PEBB UMP Classic benefits.

"Public employee" has the same meaning as employee.

"Qualified health plan" means a medical plan that is certified to be offered through an exchange.

"Salary reduction plan" means a benefit plan whereby public employees may agree to a reduction of salary on a pretax basis to participate in the dependent care assistance program, medical flexible spending arrangement, or premium payment plan offered pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"Special open enrollment" means a period of time when subscribers may make changes to their health plan enrollment and salary reduction elections outside of the annual open enrollment period when specific life events occur. During the special open enrollment subscribers may change health plans and enroll or remove dependents from coverage. Additionally, employees may enroll in or waive enrollment in PEBB medical. Employees eligible to participate in the salary reduction plan may enroll in or revoke their election under the DCAP, medical FSA, or the premium payment plan and make a new election. For special open enrollment events related to specific PEBB benefits, see WAC 182-08-198, 182-08-199, 182-12-128, and 182-12-262.

"State agency" means an office, department, board, commission, institution, or other separate unit or division, however designated, of the state government. 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.

"State registered domestic partner" has the same meaning as defined in RCW 26.60.020(1) and substantially equivalent legal unions from other jurisdictions as defined in RCW 26.60.090.

"Subscriber" means the employee, retiree, continuation coverage enrollee, or survivor who has been determined eligible by the PEBB program, employer group, or state agency, is enrolled in PEBB benefits, and is the individual to whom the PEBB program and contracted vendors will issue all notices, information, requests, and premium bills on behalf of an enrollee.

"Supplemental coverage" means any life insurance, accidental death and dismemberment (AD&D) insurance coverage, or long-term disability coverage purchased by the employee in addition to the coverage provided by the employing agency.

"Tobacco products" means any product made with or derived from tobacco that is intended for human consumption, including any component, part, or accessory of a tobacco product. This includes, but is not limited to, cigars, cigarettes, pipe tobacco, chewing tobacco, snuff, and other tobacco products. It does not include e-cigarettes or United States Food and Drug Administration (FDA) approved quit aids.

"Tobacco use" means any use of tobacco products within the past two months. Tobacco use, however, does not include the religious or ceremonial use of tobacco.

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

"Waive" means an eligible employee affirmatively declining enrollment in a PEBB health plan because the employee is enrolled in other employer-based group medical, TRICARE plans, or medicare as allowed under WAC 182-12-128, or is on approved educational leave and obtains another employer-based group health plan as allowed under WAC 182-12-136.

[Statutory Authority: RCW 41.05.021, 41.05.160, and PEBB policy resolutions. WSR 19-17-073 (Admin #2019-01), § 182-08-015, filed 8/20/19, effective 1/1/20; WSR 18-20-117 (Admin #2018-02), § 182-08-015, filed 10/3/18, effective 1/1/19; WSR 17-19-077 (Order 2017-01), § 182-08-015, filed 9/15/17, effective 1/1/18. Statutory Authority: RCW 41.05.021, 41.05.160, 2016 c 67, and PEBB policy resolutions. WSR 16-20-080, § 182-08-015, filed 10/4/16, effective 1/1/17. Statutory Authority: RCW 41.05.160, 2015 c 116, and PEBB policy resolutions. WSR 15-22-099 (PEBB Admin # 2015-01 Rev 1), § 182-08-015, filed 11/4/15, effective 1/1/16. Statutory Authority: RCW 41.05.160 and 2013 2nd sp.s. c 4. WSR 14-20-058 (PEBB Admin 2014-02), § 182-08-015, filed 9/25/14, effective 1/1/15. Statutory Authority: RCW 41.05.160, 2013 2nd sp.s. c 4 and PEBB policy resolutions. WSR 14-08-040, § 182-08-015, filed 3/26/14, effective 4/26/14. Statutory Authority: RCW 41.05.160 and 2012 2nd sp.s. c 3. WSR 13-22-019 (Admin. 2013-01), § 182-08-015, filed 10/28/13, effective 1/1/14. Statutory Authority: RCW 41.05.160. WSR 12-20-022 (Order 2012-01), § 182-08-015, filed 9/25/12,

effective 11/1/12. Statutory Authority: RCW 41.05.160 and 2011 c 8. WSR 11-22-036 (Order 11-02), § 182-08-015, filed 10/26/11, effective 1/1/12. Statutory Authority: RCW 41.05.160. WSR 10-20-147 (Order 10-02), § 182-08-015, filed 10/6/10, effective 1/1/11; WSR 09-23-102 (Order 09-02), § 182-08-015, filed 11/17/09, effective 1/1/10; WSR 08-20-128 (Order 08-03), § 182-08-015, filed 10/1/08, effective 1/1/09; WSR 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. WSR 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. WSR 04-18-039, § 182-08-015, filed 8/26/04, effective 1/1/05; WSR 03-17-031 (Order 02-07), § 182-08-015, filed 8/14/03, effective 9/14/03. Statutory Authority: Chapter 41.05 RCW. WSR 96-08-042, § 182-08-015, filed 3/29/96, effective 4/29/96.]

***(Effective January 1, 2021)***

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

"Accidental death and dismemberment insurance" or "AD&D" means basic accidental death and dismemberment (AD&D) insurance paid for by the employing agency, as well as supplemental accidental death and dismemberment insurance offered to and paid for by employees for themselves and their dependents.

"Affordable Care Act" means the federal Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, P.L. 111-152, or federal regulations or guidance issued under the Affordable Care Act.

"Annual open enrollment" means an annual event set aside for a period of time by the HCA when subscribers may make changes to their health plan enrollment and salary reduction elections for the following plan year. During the annual open enrollment, subscribers may transfer from one health plan to another, enroll or remove dependents from coverage, enroll in coverage, or waive enrollment in PEBB medical. Employees eligible to participate in the salary reduction plan may enroll in or change their election under the dependent care assistance program (DCAP) or the medical flexible spending arrangement (FSA). They may also enroll in or opt out of the premium payment plan.

"Authority" or "HCA" means the Washington state health care authority.

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

"Calendar days" or "days" means all days including Saturdays, Sundays, and all state legal holidays as set forth in RCW 1.16.050.

"Consolidated Omnibus Budget Reconciliation Act" or "COBRA" means continuation coverage as administered under 42 U.S.C. Secs. 300bb-1 through 300bb-8.

"Continuation coverage" means the temporary continuation of PEBB benefits available to enrollees under the Consolidated Omnibus Budget Reconciliation Act (COBRA), 42 U.S.C. Secs. 300bb-1 through 300bb-8, the Uniformed Services Employment and Reemployment Rights Act (USERRA), 38 U.S.C. Secs. 4301 through 4335, or the public employees benefits board's policies.

"Contracted vendor" means any person, persons, or entity under contract or agreement with the HCA to provide goods or services for



the provision or administration of PEBB benefits. The term "contracted vendor" includes subcontractors of the HCA and subcontractors of any person, persons, or entity under contract or agreement with the HCA that provide goods or services for the provision or administration of PEBB benefits.

"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 insurance coverage by a retiree or an eligible survivor.

"Dependent" means a person who meets eligibility requirements in WAC 182-12-260, except that "surviving spouses, state registered domestic partners, and dependent children" of emergency service personnel who are killed in the line of duty is defined in WAC 182-12-250.

"Dependent care assistance program" or "DCAP" means a benefit plan whereby employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan under chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 129 or other sections of the Internal Revenue Code.

"Director" means the director of the authority.

"Documents" means papers, letters, writings, electronic mail, electronic files, or other printed or written items.

"Employee" for the public employees benefits board program includes all employees of the state, whether or not covered by civil service; elected and appointed officials of the executive branch of government, including full-time members of boards, commissions, or committees; justices of the supreme court and judges of the court of appeals and the superior courts; and members of the state legislature. Pursuant to contractual agreement with the authority, "employee" may also include: (a) Employees of a county, municipality, or other political subdivision of the state and members of the legislative authority of any county, city, or town who are elected to office after February 20, 1970, if the legislative authority of the county, municipality, or other political subdivision of the state submits application materials to the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.04.205 and 41.05.021 (1)(g); (b) employees of employee organizations representing state civil service employees, at the option of each such employee organization; (c) through December 31, 2019, employees of a school district or represented employees of an educational service district if the authority agrees to provide any of the school districts' or educational service districts' insurance programs by contract with the authority as provided in RCW 28A.400.350; (d) employees of a tribal government, if the governing body of the tribal government seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(f) and (g); (e) employees of the Washington health benefit exchange if the governing board of the exchange established in RCW 43.71.020 seeks and receives approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(g) and (n); (f) through December 31, 2019, employees of a charter school established under chapter 28A.710 RCW; and (g) through December 31, 2023, nonrepresented employees of an educational service district. "Employee" does not include: Adult family home providers; unpaid volunteers; patients of state hospitals; inmates; employees of the Washington state convention and trade center as provided in RCW 41.05.110; students of institutions of higher education as determined by their

institution; and any others not expressly defined as employees under RCW 41.05.011 or by the authority under this chapter.

"Employer" for the public employees benefits board program means the state of Washington.

"Employer-based group health plan" means group medical and group dental related to a current employment relationship. It does not include medical or dental coverage available to retired employees, individual market medical or dental coverage, or government-sponsored programs such as medicare or medicaid.

"Employer-based group medical" means group medical related to a current employment relationship. It does not include medical coverage available to retired employees, individual market medical coverage, or government-sponsored programs such as medicare or medicaid.

"Employer contribution" means the funding amount paid to the HCA by a state agency or employer group for its eligible employees as described under WAC 182-12-114 and 182-12-131.

"Employer group" means those counties, municipalities, political subdivisions, the Washington health benefit exchange, tribal governments, employee organizations representing state civil service employees, and through December 31, 2019, school districts and charter schools, and through December 31, 2023, educational service districts obtaining employee benefits through a contractual agreement with the authority to participate in benefit plans developed by the public employees benefits board as described in WAC 182-08-245.

"Employer group rate surcharge" means the rate surcharge described in RCW 41.05.050(2).

"Employer-paid coverage" means PEBB insurance coverage for which an employer contribution is made by a state agency or an employer group for employees eligible under WAC 182-12-114 and 182-12-131. It also means SEBB insurance coverage for which an employer contribution is made by a SEBB organization, or basic benefits described in RCW 28A.400.270(1) for which an employer contribution is made by an educational service district.

"Employing agency" for the public employees benefits board program means a division, department, or separate agency of state government, including an institution of higher education; a county, municipality, or other political subdivision; and a tribal government covered by chapter 41.05 RCW.

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

"Exchange" means the Washington health benefit exchange established in RCW 43.71.020, and any other health benefit exchange established under the Affordable Care Act.

"Exchange coverage" means coverage offered by a qualified health plan through an exchange.

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

"Forms" or "form" means both paper forms and forms completed electronically.

"Health plan" means a plan offering medical or dental, or both, developed by the board and provided by a contracted vendor or self-insured plans administered by the HCA.

"Insignificant shortfall" means a premium balance owed that is less than or equal to the lesser of \$50 or ten percent of the premium required by the health plan as described in Treasury Regulation 26 C.F.R. 54.4980B-8.

"Institutions of higher education" means the state public research universities, the public regional universities, The Evergreen State College, the community and technical colleges, and the state board for community and technical colleges.

"Large claim" means a claim for more than \$25,000 in allowed costs for services in a quarter.

"Layoff," for purposes of this chapter, means a change in employment status due to an employer's lack of funds or an employer's organizational change.

"Life insurance" means basic life insurance paid for by the employing agency, as well as supplemental life insurance offered to and paid for by employees for themselves and their dependents. Life insurance for eligible retirees includes retiree term life insurance offered to and paid for by retirees.

"Long-term disability insurance" or "LTD insurance" means basic long-term disability insurance paid for by the employing agency and supplemental long-term disability insurance offered to and paid for by the employee.

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby eligible state employees may reduce their salary before taxes to pay for medical expenses not reimbursed by insurance as provided in the salary reduction plan established under chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"Ongoing large claim" means a claim where the patient is expected to need ongoing case management into the next quarter for which the expected allowed cost is greater than \$25,000 in the quarter.

"PEBB" means the public employees benefits board.

"PEBB benefits" means one or more insurance coverages or other employee benefits administered by the PEBB program within the health care authority.

"PEBB insurance coverage" means any health plan, life insurance, accidental death and dismemberment insurance, long-term disability (LTD) insurance, long-term care insurance, or property and casualty insurance administered as a PEBB benefit.

"PEBB program" means the program within the HCA that administers insurance and other benefits for eligible employees (as described in WAC 182-12-114), eligible retired employees (as described in WAC 182-12-171, 182-12-180, and 182-12-211), eligible survivors (as described in WAC 182-12-180, 182-12-250, and 182-12-265), eligible dependents (as described in WAC 182-12-250 and 182-12-260) and others as defined in RCW 41.05.011.

"Plan year" means the time period established by the authority.

"Premium payment plan" means a benefit plan whereby public employees may pay their share of group health plan premiums with pretax dollars as provided in the salary reduction plan under chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"Premium surcharge" means a payment required from a subscriber, in addition to the subscriber's medical premium contribution, due to an enrollee's tobacco use or an enrolled subscriber's spouse or state registered domestic partner choosing not to enroll in their employer-based group medical when:

- The spouse's or state registered domestic partner's share of the medical premium is less than ninety-five percent of the additional cost an employee would be required to pay to enroll a spouse or state registered domestic partner in the public employees benefits board (PEBB) Uniform Medical Plan (UMP) Classic; and

- The benefits have an actuarial value of at least ninety-five percent of the actuarial value of PEBB UMP Classic benefits.

"Public employee" has the same meaning as employee.

"Qualified health plan" means a medical plan that is certified to be offered through an exchange.

"Salary reduction plan" means a benefit plan whereby public employees may agree to a reduction of salary on a pretax basis to participate in the dependent care assistance program, medical flexible spending arrangement, or premium payment plan offered pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"Special open enrollment" means a period of time when subscribers may make changes to their health plan enrollment and salary reduction elections outside of the annual open enrollment period when specific life events occur. During the special open enrollment subscribers may change health plans and enroll or remove dependents from coverage. Additionally, employees may enroll in or waive enrollment in PEBB medical. Employees eligible to participate in the salary reduction plan may enroll in or revoke their election under the DCAP, medical FSA, or the premium payment plan and make a new election. For special open enrollment events related to specific PEBB benefits, see WAC 182-08-198, 182-08-199, 182-12-128, and 182-12-262.

"State agency" means an office, department, board, commission, institution, or other separate unit or division, however designated, of the state government. 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.

"State registered domestic partner" has the same meaning as defined in RCW 26.60.020(1) and substantially equivalent legal unions from other jurisdictions as defined in RCW 26.60.090.

"Subscriber" means the employee, retiree, continuation coverage enrollee, or survivor who has been determined eligible by the PEBB program, employer group, or state agency, is enrolled in PEBB benefits, and is the individual to whom the PEBB program and contracted vendors will issue all notices, information, requests, and premium bills on behalf of an enrollee.

"Supplemental coverage" means any life insurance, accidental death and dismemberment (AD&D) insurance coverage, or long-term disability coverage purchased by the employee in addition to the coverage provided by the employing agency.

"Tobacco products" means any product made with or derived from tobacco that is intended for human consumption, including any component, part, or accessory of a tobacco product. This includes, but is not limited to, cigars, cigarettes, pipe tobacco, chewing tobacco, snuff, and other tobacco products. It does not include e-cigarettes or United States Food and Drug Administration (FDA) approved quit aids.

"Tobacco use" means any use of tobacco products within the past two months. Tobacco use, however, does not include the religious or ceremonial use of tobacco.

"Tribal government" means an Indian tribal government as defined in Section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, or an agency or instrumentality of the trib-

al government, that has government offices principally located in this state.

"Waive" means an eligible employee affirmatively declining enrollment in PEBB medical plan because the employee is enrolled in other employer-based group medical, a TRICARE plan, or medicare as allowed under WAC 182-12-128, or is on approved educational leave and obtains another employer-based group health plan as allowed under WAC 182-12-136.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 20-16-062 (Admin #2020-03), § 182-08-015, filed 7/28/20, effective 1/1/21. Statutory Authority: RCW 41.05.021, 41.05.160, and PEBB policy resolutions. WSR 19-17-073 (Admin #2019-01), § 182-08-015, filed 8/20/19, effective 1/1/20; WSR 18-20-117 (Admin #2018-02), § 182-08-015, filed 10/3/18, effective 1/1/19; WSR 17-19-077 (Order 2017-01), § 182-08-015, filed 9/15/17, effective 1/1/18. Statutory Authority: RCW 41.05.021, 41.05.160, 2016 c 67, and PEBB policy resolutions. WSR 16-20-080, § 182-08-015, filed 10/4/16, effective 1/1/17. Statutory Authority: RCW 41.05.160, 2015 c 116, and PEBB policy resolutions. WSR 15-22-099 (PEBB Admin # 2015-01 Rev 1), § 182-08-015, filed 11/4/15, effective 1/1/16. Statutory Authority: RCW 41.05.160 and 2013 2nd sp.s. c 4. WSR 14-20-058 (PEBB Admin 2014-02), § 182-08-015, filed 9/25/14, effective 1/1/15. Statutory Authority: RCW 41.05.160, 2013 2nd sp.s. c 4 and PEBB policy resolutions. WSR 14-08-040, § 182-08-015, filed 3/26/14, effective 4/26/14. Statutory Authority: RCW 41.05.160 and 2012 2nd sp.s. c 3. WSR 13-22-019 (Admin. 2013-01), § 182-08-015, filed 10/28/13, effective 1/1/14. Statutory Authority: RCW 41.05.160. WSR 12-20-022 (Order 2012-01), § 182-08-015, filed 9/25/12, effective 11/1/12. Statutory Authority: RCW 41.05.160 and 2011 c 8. WSR 11-22-036 (Order 11-02), § 182-08-015, filed 10/26/11, effective 1/1/12. Statutory Authority: RCW 41.05.160. WSR 10-20-147 (Order 10-02), § 182-08-015, filed 10/6/10, effective 1/1/11; WSR 09-23-102 (Order 09-02), § 182-08-015, filed 11/17/09, effective 1/1/10; WSR 08-20-128 (Order 08-03), § 182-08-015, filed 10/1/08, effective 1/1/09; WSR 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. WSR 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. WSR 04-18-039, § 182-08-015, filed 8/26/04, effective 1/1/05; WSR 03-17-031 (Order 02-07), § 182-08-015, filed 8/14/03, effective 9/14/03. Statutory Authority: Chapter 41.05 RCW. WSR 96-08-042, § 182-08-015, filed 3/29/96, effective 4/29/96.]

**WAC 182-08-120 Employer contribution for the public employees benefits board (PEBB) benefits.** The employer contribution must be used to provide public employees benefits board (PEBB) insurance coverage for the basic life insurance benefit, basic accidental death and dismemberment insurance benefit (AD&D), the basic long-term disability (LTD) insurance benefit, medical insurance, dental insurance, and to establish a reserve for any remaining balance. There is no employer contribution available for any other insurance coverage for employees employed by state agencies.

[Statutory Authority: RCW 41.05.021, 41.05.160, and PEBB policy resolutions. WSR 19-17-073 (Admin #2019-01), § 182-08-120, filed 8/20/19, effective 1/1/20. Statutory Authority: RCW 41.05.021, 41.05.160, 2016

c 67, and PEBB policy resolutions. WSR 16-20-080, § 182-08-120, filed 10/4/16, effective 1/1/17. Statutory Authority: RCW 41.05.160 and 2012 2nd sp.s. c 3. WSR 13-22-019 (Admin. 2013-01), § 182-08-120, filed 10/28/13, effective 1/1/14. Statutory Authority: RCW 41.05.160. WSR 12-20-022 (Order 2012-01), § 182-08-120, filed 9/25/12, effective 11/1/12; WSR 09-23-102 (Order 09-02), § 182-08-120, filed 11/17/09, effective 1/1/10; WSR 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. WSR 03-17-031 (Order 02-07), § 182-08-120, filed 8/14/03, effective 9/14/03. Statutory Authority: Chapter 41.05 RCW. WSR 96-08-042, § 182-08-120, filed 3/29/96, effective 4/29/96; WSR 86-16-061 (Resolution No. 86-3), § 182-08-120, filed 8/5/86; WSR 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.]

***(Effective until January 1, 2021)***

**WAC 182-08-180 Premium payments and premium refunds.** Public employees benefits board (PEBB) insurance coverage premiums and applicable premium surcharges for all subscribers are due as described in this section, except when an employing agency is correcting its enrollment error as described in WAC 182-08-187 (4) or (5).

(1) **Premium payments.** PEBB insurance coverage premiums and applicable premium surcharges for all subscribers become due the first of the month in which PEBB insurance coverage is effective.

Premiums and applicable premium surcharges are due from the subscriber for the entire month of PEBB insurance coverage and will not be prorated during any month.

(a) For subscribers not eligible for the employer contribution that are electing to enroll in PEBB retiree insurance coverage as described in WAC 182-12-171 (1)(a), 182-12-180 (3)(a), 182-12-200 (3)(a) or (b), 182-12-205 (6)(a) through (f), 182-12-211, and 182-12-265; or electing to enroll in continuation coverage as described in WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, and 182-12-270, the first premium payment and applicable premium surcharges are due to the health care authority (HCA) no later than forty-five days after the election period ends as described within the Washington Administrative Code applicable to the subscriber. Premiums and applicable premium surcharges associated with continuing PEBB medical must be made to the HCA as well as premiums associated with continuing PEBB dental or long-term disability insurance coverage. Premiums associated with life insurance and accidental death and dismemberment insurance coverage must be made to the contracted vendor. Following the first premium payment, premiums and applicable premium surcharges must be paid as premiums become due.

(b) For employees who are eligible for the employer contribution, premiums and applicable premium surcharges are due to the employing agency. If an employee elects supplemental coverage as described in WAC 182-08-197 (1)(a) or (3)(a), the employee is responsible for payment of premiums from the month that the supplemental coverage begins.

(c) Unpaid or underpaid premiums or applicable premium surcharges for all subscribers must be paid, and are due from the employing agency, subscriber, or a subscriber's legal representative to the HCA. For subscribers not eligible for the employer contribution or employees eligible for the employer contribution as described in WAC 182-12-138,

monthly premiums or applicable premium surcharges that remain unpaid for thirty days will be considered delinquent. A subscriber is allowed a grace period of thirty days from the date the monthly premiums or applicable premium surcharges become delinquent to pay the unpaid premium balance or applicable premium surcharges. If a subscriber's monthly premiums or applicable premium surcharges remain unpaid for sixty days from the original due date, the subscriber's PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premiums and any applicable premium surcharges were paid. If it is determined by the HCA that payment of the unpaid balance in a lump sum would be considered a hardship, the HCA may develop a reasonable payment plan of up to twelve months in duration with the subscriber or the subscriber's legal representative upon request.

(d) Monthly premiums or applicable premium surcharges due from a subscriber who is not eligible for the employer contribution will be considered unpaid if one of the following occurs:

(i) No payment of premiums or applicable premium surcharges are received by the HCA and the monthly premiums or applicable premium surcharges remain unpaid for thirty days; or

(ii) Premium payments or applicable premium surcharges received by the HCA are underpaid by an amount greater than an insignificant shortfall and the monthly premiums or applicable premium surcharges remain underpaid for thirty days past the date the monthly premiums or applicable premium surcharges were due.

(2) **Premium refunds.** PEBB insurance coverage premiums and applicable premium surcharges will be refunded using the following methods:

(a) When a subscriber submits an enrollment change affecting subscriber or dependent eligibility, HCA may allow up to three months of accounting adjustments. HCA will refund to the individual or the employing agency any excess premiums and applicable premium surcharges paid during the three month adjustment period, except as indicated in WAC 182-12-148(5).

(b) If a PEBB subscriber, dependent, or beneficiary submits a written appeal as described in WAC 182-16-2010, and provides clear and convincing evidence of extraordinary circumstances, such that the subscriber could not timely submit the necessary information to accomplish an allowable enrollment change within sixty days after the event that created a change of premiums, the PEBB director, the PEBB director's designee, or the PEBB appeals unit may:

(i) Approve a refund of premiums and applicable premium surcharges which does not exceed twelve months of premiums; and

(ii) Approve the enrollment change that was originally requested and which forms the basis for the refund.

(c) If a federal government entity determines that an enrollee is retroactively enrolled in coverage (for example, medicare) the subscriber or beneficiary may be eligible for a refund of premiums and applicable premium surcharges paid during the time they were enrolled under the federal program if approved by the PEBB director or the director's designee.

(d) HCA errors will be corrected by returning all excess premiums and applicable premium surcharges paid by the employing agency, subscriber, or beneficiary.

(e) Employing agency errors will be corrected by returning all excess premiums and applicable premium surcharges paid by the employee or beneficiary as described in WAC 182-08-187 (4) and (5).

[Statutory Authority: RCW 41.05.021, 41.05.160, and PEBB policy resolutions. WSR 19-17-073 (Admin #2019-01), § 182-08-180, filed 8/20/19, effective 1/1/20; WSR 18-20-117 (Admin #2018-02), § 182-08-180, filed 10/3/18, effective 1/1/19; WSR 17-19-077 (Order 2017-01), § 182-08-180, filed 9/15/17, effective 1/1/18. Statutory Authority: RCW 41.05.021, 41.05.160, 2016 c 67, and PEBB policy resolutions. WSR 16-20-080, § 182-08-180, filed 10/4/16, effective 1/1/17. Statutory Authority: RCW 41.05.160 and 2013 2nd sp.s. c 4. WSR 14-20-058 (PEBB Admin 2014-02), § 182-08-180, filed 9/25/14, effective 1/1/15. Statutory Authority: RCW 41.05.160 and 2012 2nd sp.s. c 3. WSR 13-22-019 (Admin. 2013-01), § 182-08-180, filed 10/28/13, effective 1/1/14. Statutory Authority: RCW 41.05.160. WSR 12-20-022 (Order 2012-01), § 182-08-180, filed 9/25/12, effective 11/1/12. Statutory Authority: RCW 41.05.160 and 2011 c 8. WSR 11-22-036 (Order 11-02), § 182-08-180, filed 10/26/11, effective 1/1/12. Statutory Authority: RCW 41.05.160. WSR 10-20-147 (Order 10-02), § 182-08-180, filed 10/6/10, effective 1/1/11; WSR 09-23-102 (Order 09-02), § 182-08-180, filed 11/17/09, effective 1/1/10; WSR 08-20-128 (Order 08-03), § 182-08-180, filed 10/1/08, effective 1/1/09; WSR 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. WSR 04-18-039, § 182-08-180, filed 8/26/04, effective 1/1/05; WSR 03-17-031 (Order 02-07), § 182-08-180, filed 8/14/03, effective 9/14/03. Statutory Authority: Chapter 41.05 RCW. WSR 96-08-042, § 182-08-180, filed 3/29/96, effective 4/29/96; Order 01-77, § 182-08-180, filed 8/26/77.]

***(Effective January 1, 2021)***

**WAC 182-08-180 Premium payments and premium refunds.** Public employees benefits board (PEBB) insurance coverage premiums and applicable premium surcharges for all subscribers are due as described in this section, except when an employing agency is correcting its enrollment error as described in WAC 182-08-187 (4) or (5).

(1) **Premium payments.** PEBB insurance coverage premiums and applicable premium surcharges for all subscribers become due the first of the month in which PEBB insurance coverage is effective.

Premiums and applicable premium surcharges are due from the subscriber for the entire month of PEBB insurance coverage and will not be prorated during any month.

(a) For subscribers not eligible for the employer contribution that are electing to enroll in PEBB retiree insurance coverage as described in WAC 182-12-171 (1)(a), 182-12-180 (3)(a), 182-12-200 (3)(a) or (b), 182-12-205 (6)(a) through (f), 182-12-211, and 182-12-265; or electing to enroll in continuation coverage as described in WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, and 182-12-270, the first premium payment and applicable premium surcharges are due to the health care authority (HCA) or the contracted vendor no later than forty-five days after the election period ends as described within the Washington Administrative Code applicable to the subscriber. Premiums and applicable premium surcharges associated with continuing PEBB medical must be made to the HCA as well as premiums associated with continuing PEBB dental or long-term disability insurance coverage. Premiums associated with life insurance and accidental death and dismemberment (AD&D) insurance coverage must be made to the



contracted vendor. Following the first premium payment, premiums and applicable premium surcharges must be paid as premiums become due.

(b) For employees who are eligible for the employer contribution, premiums and applicable premium surcharges are due to the employing agency. If an employee elects supplemental coverage as described in WAC 182-08-197 (1)(a) or (3)(a), the employee is responsible for payment of premiums from the month that the supplemental coverage begins.

(c) Unpaid or underpaid premiums or applicable premium surcharges for all subscribers must be paid, and are due from the employing agency, subscriber, or a subscriber's legal representative to the HCA or contracted vendor. For subscribers not eligible for the employer contribution, monthly premiums or applicable premium surcharges that remain unpaid for thirty days will be considered delinquent. A subscriber is allowed a grace period of thirty days from the date the monthly premiums or applicable premium surcharges become delinquent to pay the unpaid premium balance or applicable premium surcharges. If a subscriber's monthly premiums or applicable premium surcharges remain unpaid for sixty days from the original due date, the subscriber's PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premiums and any applicable premium surcharges were paid. If it is determined by the HCA that payment of the unpaid balance in a lump sum would be considered a hardship, the HCA may develop a reasonable payment plan of up to twelve months in duration with the subscriber or the subscriber's legal representative upon request.

**Exception:** For a subscriber enrolled in a medicare advantage or a medicare advantage-prescription drug plan a notice will be sent to them notifying them that they are delinquent on their monthly premiums and that the enrollment will be terminated prospectively to the end of the month after the notice is sent.

(d) Monthly premiums or applicable premium surcharges due from a subscriber who is not eligible for the employer contribution will be considered unpaid if one of the following occurs:

(i) No payment of premiums or applicable premium surcharges are received by the HCA or contracted vendor and the monthly premiums or applicable premium surcharges remain unpaid for thirty days; or

(ii) Premium payments or applicable premium surcharges received by the HCA or contracted vendor are underpaid by an amount greater than an insignificant shortfall and the monthly premiums or applicable premium surcharges remain underpaid for thirty days past the date the monthly premiums or applicable premium surcharges were due.

(2) **Premium refunds.** PEBB insurance coverage premiums and applicable premium surcharges will be refunded using the following methods:

(a) When a subscriber submits an enrollment change affecting subscriber or dependent eligibility, HCA may allow up to three months of accounting adjustments. HCA will refund to the individual or the employing agency any excess premiums and applicable premium surcharges paid during the three month adjustment period, except as indicated in WAC 182-12-148(5).

(b) If a PEBB subscriber, dependent, or beneficiary submits a written appeal as described in WAC 182-16-2010, and provides clear and convincing evidence of extraordinary circumstances, such that the subscriber could not timely submit the necessary information to accomplish an allowable enrollment change within sixty days after the event that created a change of premiums, the PEBB director, the PEBB director's designee, or the PEBB appeals unit may:

(i) Approve a refund of premiums and applicable premium surcharges which does not exceed twelve months of premiums; and

(ii) Approve the enrollment change that was originally requested and which forms the basis for the refund.

(c) If a federal government entity determines that an enrollee is retroactively enrolled in coverage (for example, medicare) the subscriber or beneficiary may be eligible for a refund of premiums and applicable premium surcharges paid during the time they were enrolled under the federal program if approved by the PEBB director or the PEBB director's designee.

(d) HCA errors will be corrected by returning all excess premiums and applicable premium surcharges paid by the employing agency, subscriber, or beneficiary.

(e) Employing agency errors will be corrected by returning all excess premiums and applicable premium surcharges paid by the employee or beneficiary as described in WAC 182-08-187 (4) and (5).

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 20-16-062 (Admin #2020-03), § 182-08-180, filed 7/28/20, effective 1/1/21. Statutory Authority: RCW 41.05.021, 41.05.160, and PEBB policy resolutions. WSR 19-17-073 (Admin #2019-01), § 182-08-180, filed 8/20/19, effective 1/1/20; WSR 18-20-117 (Admin #2018-02), § 182-08-180, filed 10/3/18, effective 1/1/19; WSR 17-19-077 (Order 2017-01), § 182-08-180, filed 9/15/17, effective 1/1/18. Statutory Authority: RCW 41.05.021, 41.05.160, 2016 c 67, and PEBB policy resolutions. WSR 16-20-080, § 182-08-180, filed 10/4/16, effective 1/1/17. Statutory Authority: RCW 41.05.160 and 2013 2nd sp.s. c 4. WSR 14-20-058 (PEBB Admin 2014-02), § 182-08-180, filed 9/25/14, effective 1/1/15. Statutory Authority: RCW 41.05.160 and 2012 2nd sp.s. c 3. WSR 13-22-019 (Admin. 2013-01), § 182-08-180, filed 10/28/13, effective 1/1/14. Statutory Authority: RCW 41.05.160. WSR 12-20-022 (Order 2012-01), § 182-08-180, filed 9/25/12, effective 11/1/12. Statutory Authority: RCW 41.05.160 and 2011 c 8. WSR 11-22-036 (Order 11-02), § 182-08-180, filed 10/26/11, effective 1/1/12. Statutory Authority: RCW 41.05.160. WSR 10-20-147 (Order 10-02), § 182-08-180, filed 10/6/10, effective 1/1/11; WSR 09-23-102 (Order 09-02), § 182-08-180, filed 11/17/09, effective 1/1/10; WSR 08-20-128 (Order 08-03), § 182-08-180, filed 10/1/08, effective 1/1/09; WSR 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. WSR 04-18-039, § 182-08-180, filed 8/26/04, effective 1/1/05; WSR 03-17-031 (Order 02-07), § 182-08-180, filed 8/14/03, effective 9/14/03. Statutory Authority: Chapter 41.05 RCW. WSR 96-08-042, § 182-08-180, filed 3/29/96, effective 4/29/96; Order 01-77, § 182-08-180, filed 8/26/77.]

***(Effective until January 1, 2021)***

**WAC 182-08-185 What are the requirements regarding premium surcharges?** (1) A subscriber's account will incur a premium surcharge in addition to the subscriber's monthly medical premium, when any enrollee, thirteen years and older, engages in tobacco use.

(a) A subscriber must attest to whether any enrollee, thirteen years and older, enrolled in their public employees benefits board (PEBB) medical engages in tobacco use. The subscriber must attest as described in (a)(i) through (vii) of this subsection:

(i) An employee who is newly eligible or regains eligibility for the employer contribution toward PEBB benefits must complete the required form to enroll in PEBB medical as described in WAC 182-08-197

(1) or (3). The employee must include their attestation on that form. The employee must submit the form to their employing agency. If the employee's attestation results in a premium surcharge, it will take effect the same date as PEBB medical begins.

(ii) If there is a change in the tobacco use status of any enrollee, thirteen years and older on the subscriber's PEBB medical, the subscriber must update their attestation on the required form. An employee must submit the form to their employing agency. Any other subscriber must submit their form to the PEBB program. The attestation change will apply as follows:

- A change that results in a premium surcharge will begin the first day of the month following the status change. If that day is the first of the month, the change to the surcharge begins on that day.

- A change that results in removing the premium surcharge will begin the first day of the month following receipt of the attestation. If that day is the first of the month, the change to the surcharge begins on that day.

(iii) If a subscriber submits the required form to enroll a dependent, thirteen years and older, in PEBB medical as described in WAC 182-12-262, the subscriber must attest for their dependent on the required form. An employee must submit the form to their employing agency. Any other subscriber must submit their form to the PEBB program. A change that results in a premium surcharge will take effect the same date as PEBB medical begins.

(iv) An enrollee, thirteen years and older, who elects to continue medical coverage as described in WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, or 182-12-270, must provide an attestation on the required form if they have not previously attested as described in (a) of this subsection. The enrollee must submit their form to the PEBB program. An attestation that results in a premium surcharge will take effect the same date as PEBB medical begins.

(v) An employee or retiree who enrolls in PEBB medical as described in WAC 182-12-171 (1)(a), 182-12-180 (3)(a), 182-12-200 (3)(a) or (b), 182-12-205 (6)(a) through (f), or 182-12-211, must provide an attestation on the required form if they have not previously attested as described in (a) of this subsection. The employee or retiree must submit their form to the PEBB program. An attestation that results in a premium surcharge will take effect the same date as PEBB medical begins.

(vi) A surviving spouse, state registered domestic partner, or dependent child, thirteen years and older, who enrolls in PEBB medical as described in WAC 182-12-180 (3)(a), 182-12-250(5) or 182-12-265, must provide an attestation on the required form to the PEBB program if they have not previously attested as described in (a) of this subsection. An attestation that results in a premium surcharge will take effect the same date as PEBB medical begins.

(vii) An employee who previously waived PEBB medical must complete the required form to enroll in PEBB medical as described in WAC 182-12-128(3). The employee must include their attestation on that form. An employee must submit the form to their employing agency. An attestation that results in a premium surcharge will take effect the same date as PEBB medical begins.

**Exceptions:**

(1) A subscriber enrolled in both Medicare Parts A and B and in the Medicare risk pool as described in RCW 41.05.080(3) is not required to provide an attestation and no premium surcharge will be imposed on the subscriber's account.

(2) An employee who waives PEBB medical as described in WAC 182-12-128 is not required to provide an attestation and no premium surcharge will be applied to their account as long as the employee remains in waived status.

(b) A subscriber's account will incur a premium surcharge when a subscriber fails to attest to the tobacco use status of all enrollees as described in subsection (1)(a) of this section.

(c) The PEBB program will provide a reasonable alternative for enrollees who use tobacco products. A subscriber can avoid the tobacco use premium surcharge if the subscriber attests on the required form that all enrollees who use tobacco products enrolled in or accessed one of the applicable reasonable alternatives offered below:

(i) An enrollee who is eighteen years and older and uses tobacco products is currently enrolled in the free tobacco cessation program through their PEBB medical.

(ii) An enrollee who is thirteen through seventeen years old and uses tobacco products accessed the information and resources aimed at teens on the Washington state department of health's web site at <https://teen.smokefree.gov>.

(iii) A subscriber may contact the PEBB program to accommodate a physician's recommendation that addresses an enrollee's use of tobacco products or for information on how to avoid the tobacco use premium surcharge.

(2) A subscriber will incur a premium surcharge in addition to the subscriber's monthly medical premium, if an enrolled spouse or state registered domestic partner has chosen not to enroll in another employer-based group medical where the spouse's or state registered domestic partner's share of the medical premium is less than ninety-five percent of the additional cost an employee would be required to pay to enroll a spouse or state registered domestic partner in the PEBB Uniform Medical Plan (UMP) Classic and the benefits have an actuarial value of at least ninety-five percent of the actuarial value of the PEBB UMP Classic's benefits.

(a) A subscriber who enrolled a spouse or state registered domestic partner under their PEBB medical may only attest during the following times:

(i) When a subscriber becomes eligible to enroll a spouse or state registered domestic partner in PEBB medical as described in WAC 182-12-262. The subscriber must complete the required form to enroll their spouse or state registered domestic partner, and include their attestation on that form. The employee must submit the form to their employing agency. Any other subscriber must submit the form to the PEBB program. If the subscriber's attestation results in a premium surcharge it will take effect the same date as PEBB medical begins;

(ii) During the annual open enrollment. A subscriber must attest if during the month prior to the annual open enrollment the subscriber was:

- Incurring the surcharge;
- Not incurring the surcharge because the spouse's or state registered domestic partner's share of the medical premium through their employer-based group medical was more than ninety-five percent of the additional cost an employee would be required to pay to enroll a spouse or state registered domestic partner in the PEBB UMP Classic; or
- Not incurring the surcharge because the actuarial value of benefits provided through the spouse's or state registered domestic partner's employer-based group medical was less than ninety-five percent of the actuarial value of the PEBB UMP Classic's benefits.

A subscriber must update their attestation on the required form. An employee must submit the form to their employing agency. Any other subscriber must submit the form to the PEBB program. The subscriber's

attestation or any correction to a subscriber's attestation must be received no later than December 31st of the year in which the annual open enrollment occurs. If the subscriber's attestation results in a premium surcharge, being added or removed, the change to the surcharge will take effect January 1st of the following year; and

(iii) When there is a change in the spouse's or state registered domestic partner's employer-based group medical. A subscriber must update their attestation on the required form. An employee must submit the form to their employing agency no later than sixty days after the spouse's or state registered domestic partner's employer-based group medical status changes. Any other subscriber must submit the form to the PEBB program no later than sixty days after the spouse's or state registered domestic partner's employer-based group medical status changes.

- A change that results in a premium surcharge will begin the first day of the month following the status change. If that day is the first day of the month, the change to the premium surcharge begins on that day.

- A change that results in removing the premium surcharge will begin the first day of the month following receipt of the attestation. If that day is the first day of the month, the change to the premium surcharge begins on that day.

**Exceptions:**

- (1) A subscriber enrolled in both Medicare Parts A and B and in the Medicare risk pool as described in RCW 41.05.080(3) is not required to provide an attestation and no premium surcharge will be imposed on the subscriber's account.
- (2) An employee who waives PEBB medical as described in WAC 182-12-128 is not required to provide an attestation and no premium surcharge will be applied to their account as long as the employee remains in waived status.
- (3) An employee who covers their spouse or state registered domestic partner who has waived their own PEBB medical must attest as described in this subsection, but will not incur a premium surcharge if the employee provides an attestation that their spouse or state registered domestic partner is eligible for PEBB coverage.
- (4) A subscriber who covers their spouse or state registered domestic partner who elected not to enroll in a TRICARE plan must attest as described in this subsection, but will not incur a premium surcharge if the subscriber provides an attestation that their spouse or state registered domestic partner is eligible for a TRICARE plan.

(b) A premium surcharge will be applied to a subscriber who does not attest as described in (a) of this subsection.

[Statutory Authority: RCW 41.05.021, 41.05.160, and PEBB policy resolutions. WSR 19-17-073 (Admin #2019-01), § 182-08-185, filed 8/20/19, effective 1/1/20; WSR 18-20-117 (Admin #2018-02), § 182-08-185, filed 10/3/18, effective 1/1/19. Statutory Authority: RCW 41.05.021, 41.05.160, 2016 c 67, and PEBB policy resolutions. WSR 16-20-080, § 182-08-185, filed 10/4/16, effective 1/1/17. Statutory Authority: RCW 41.05.160, 2015 c 116, and PEBB policy resolutions. WSR 15-22-099 (PEBB Admin # 2015-01 Rev 1), § 182-08-185, filed 11/4/15, effective 1/1/16. Statutory Authority: RCW 41.05.160 and 2013 2nd sp.s. c 4. WSR 14-20-058 (PEBB Admin 2014-02), § 182-08-185, filed 9/25/14, effective 1/1/15. Statutory Authority: RCW 41.05.160, 2013 2nd sp.s. c 4 and PEBB policy resolutions. WSR 14-08-040, § 182-08-185, filed 3/26/14, effective 4/26/14.]

***(Effective January 1, 2021)***

**WAC 182-08-185 What are the requirements regarding premium surcharges?** (1) A subscriber's account will incur a premium surcharge in addition to the subscriber's monthly medical premium, when any enrollee, thirteen years and older, engages in tobacco use.

(a) A subscriber must attest to whether any enrollee, thirteen years and older, enrolled in their public employees benefits board

(PEBB) medical engages in tobacco use. The subscriber must attest as described in (a) (i) through (vii) of this subsection:

(i) An employee who is newly eligible or regains eligibility for the employer contribution toward PEBB benefits must complete the required form to enroll in PEBB medical as described in WAC 182-08-197 (1) or (3). The employee must include their attestation on that form. The employee must submit the form to their employing agency. If the employee's attestation results in a premium surcharge, it will take effect the same date as PEBB medical begins.

(ii) If there is a change in the tobacco use status of any enrollee, thirteen years and older on the subscriber's PEBB medical, the subscriber must update their attestation on the required form. An employee must submit the form to their employing agency. Any other subscriber must submit their form to the PEBB program. The attestation change will apply as follows:

- A change that results in a premium surcharge will begin the first day of the month following the status change. If that day is the first of the month, the change to the surcharge begins on that day.

- A change that results in removing the premium surcharge will begin the first day of the month following receipt of the attestation. If that day is the first of the month, the change to the surcharge begins on that day.

(iii) If a subscriber submits the required form to enroll a dependent, thirteen years and older, in PEBB medical as described in WAC 182-12-262, the subscriber must attest for their dependent on the required form. An employee must submit the form to their employing agency. Any other subscriber must submit their form to the PEBB program. A change that results in a premium surcharge will take effect the same date as PEBB medical begins.

(iv) An enrollee, thirteen years and older, who elects to continue medical coverage as described in WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, or 182-12-270, must provide an attestation on the required form if they have not previously attested as described in (a) of this subsection. The enrollee must submit their form to the PEBB program. An attestation that results in a premium surcharge will take effect the same date as PEBB medical begins.

(v) An employee or retiree who enrolls in PEBB medical as described in WAC 182-12-171 (1)(a), 182-12-180 (3)(a), 182-12-200 (3)(a) or (b), 182-12-205 (6)(a) through (f), or 182-12-211, must provide an attestation on the required form if they have not previously attested as described in (a) of this subsection. The employee or retiree must submit their form to the PEBB program. An attestation that results in a premium surcharge will take effect the same date as PEBB medical begins.

(vi) A surviving spouse, state registered domestic partner, or dependent child, thirteen years and older, who enrolls in PEBB medical as described in WAC 182-12-180 (3)(a), 182-12-250(5) or 182-12-265, must provide an attestation on the required form to the PEBB program if they have not previously attested as described in (a) of this subsection. An attestation that results in a premium surcharge will take effect the same date as PEBB medical begins.

(vii) An employee who previously waived PEBB medical must complete the required form to enroll in PEBB medical as described in WAC 182-12-128(3). The employee must include their attestation on that form. An employee must submit the form to their employing agency. An attestation that results in a premium surcharge will take effect the same date as PEBB medical begins.

**Exceptions:**

(1) A subscriber enrolled in both medicare Parts A and B and in the medicare risk pool as described in RCW 41.05.080(3) is not required to provide an attestation and no premium surcharge will be imposed on the subscriber's account.

(2) An employee who waives PEBB medical as described in WAC 182-12-128 is not required to provide an attestation and no premium surcharge will be applied to their account as long as the employee remains in waived status.

(b) A subscriber's account will incur a premium surcharge when a subscriber fails to attest to the tobacco use status of all enrollees as described in (a) of this subsection.

(c) The PEBB program will provide a reasonable alternative for enrollees who use tobacco products. A subscriber can avoid the tobacco use premium surcharge if the subscriber attests on the required form that all enrollees who use tobacco products enrolled in or accessed one of the applicable reasonable alternatives offered below:

(i) An enrollee who is eighteen years and older and uses tobacco products is currently enrolled in the free tobacco cessation program through their PEBB medical.

(ii) An enrollee who is thirteen through seventeen years old and uses tobacco products accessed the information and resources aimed at teens on the Washington state department of health's website at <https://teen.smokefree.gov>.

(iii) A subscriber may contact the PEBB program to accommodate a physician's recommendation that addresses an enrollee's use of tobacco products or for information on how to avoid the tobacco use premium surcharge.

(2) A subscriber will incur a premium surcharge in addition to the subscriber's monthly medical premium, if an enrolled spouse or state registered domestic partner has chosen not to enroll in another employer-based group medical where the spouse's or state registered domestic partner's share of the medical premium is less than ninety-five percent of the additional cost an employee would be required to pay to enroll a spouse or state registered domestic partner in the PEBB Uniform Medical Plan (UMP) Classic and the benefits have an actuarial value of at least ninety-five percent of the actuarial value of the PEBB UMP Classic's benefits.

(a) A subscriber who enrolled a spouse or state registered domestic partner under their PEBB medical may only attest during the following times:

(i) When a subscriber becomes eligible to enroll a spouse or state registered domestic partner in PEBB medical as described in WAC 182-12-262. The subscriber must complete the required form to enroll their spouse or state registered domestic partner, and include their attestation on that form. The employee must submit the form to their employing agency. Any other subscriber must submit the form to the PEBB program. If the subscriber's attestation results in a premium surcharge it will take effect the same date as PEBB medical begins;

(ii) During the annual open enrollment. A subscriber must attest if during the month prior to the annual open enrollment the subscriber was:

- Incurring the surcharge;
- Not incurring the surcharge because the spouse's or state registered domestic partner's share of the medical premium through their employer-based group medical was more than ninety-five percent of the additional cost an employee would be required to pay to enroll a spouse or state registered domestic partner in the PEBB UMP Classic; or
- Not incurring the surcharge because the actuarial value of benefits provided through the spouse's or state registered domestic partner's employer-based group medical was less than ninety-five percent of the actuarial value of the PEBB UMP Classic's benefits.

A subscriber must update their attestation on the required form. An employee must submit the form to their employing agency. Any other subscriber must submit the form to the PEBB program. The subscriber's attestation or any correction to a subscriber's attestation must be received no later than December 31st of the year in which the annual open enrollment occurs. If the subscriber's attestation results in a premium surcharge, being added or removed, the change to the surcharge will take effect January 1st of the following year; and

(iii) When there is a change in the spouse's or state registered domestic partner's employer-based group medical. A subscriber must update their attestation on the required form. An employee must submit the form to their employing agency no later than sixty days after the spouse's or state registered domestic partner's employer-based group medical status changes. Any other subscriber must submit the form to the PEBB program no later than sixty days after the spouse's or state registered domestic partner's employer-based group medical status changes.

- A change that results in a premium surcharge will begin the first day of the month following the status change. If that day is the first day of the month, the change to the premium surcharge begins on that day.

- A change that results in removing the premium surcharge will begin the first day of the month following receipt of the attestation. If that day is the first day of the month, the change to the premium surcharge begins on that day.

**Exceptions:**

- (1) A subscriber enrolled in both Medicare Parts A and B and in the Medicare risk pool as described in RCW 41.05.080(3) is not required to provide an attestation and no premium surcharge will be imposed on the subscriber's account.
- (2) An employee who waives PEBB medical as described in WAC 182-12-128 is not required to provide an attestation and no premium surcharge will be applied to their account as long as the employee remains in waived status.
- (3) An employee who covers their spouse or state registered domestic partner who has waived their own PEBB medical must attest as described in this subsection, but will not incur a premium surcharge if the employee provides an attestation that their spouse or state registered domestic partner is eligible for PEBB medical.
- (4) A subscriber who covers their spouse or state registered domestic partner who elected not to enroll in a TRICARE plan must attest as described in this subsection, but will not incur a premium surcharge if the subscriber provides an attestation that their spouse or state registered domestic partner is eligible for a TRICARE plan.

(b) A premium surcharge will be applied to a subscriber who does not attest as described in (a) of this subsection.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 20-16-062 (Admin #2020-03), § 182-08-185, filed 7/28/20, effective 1/1/21. Statutory Authority: RCW 41.05.021, 41.05.160, and PEBB policy resolutions. WSR 19-17-073 (Admin #2019-01), § 182-08-185, filed 8/20/19, effective 1/1/20; WSR 18-20-117 (Admin #2018-02), § 182-08-185, filed 10/3/18, effective 1/1/19. Statutory Authority: RCW 41.05.021, 41.05.160, 2016 c 67, and PEBB policy resolutions. WSR 16-20-080, § 182-08-185, filed 10/4/16, effective 1/1/17. Statutory Authority: RCW 41.05.160, 2015 c 116, and PEBB policy resolutions. WSR 15-22-099 (PEBB Admin # 2015-01 Rev 1), § 182-08-185, filed 11/4/15, effective 1/1/16. Statutory Authority: RCW 41.05.160 and 2013 2nd sp.s. c 4. WSR 14-20-058 (PEBB Admin 2014-02), § 182-08-185, filed 9/25/14, effective 1/1/15. Statutory Authority: RCW 41.05.160, 2013 2nd sp.s. c 4 and PEBB policy resolutions. WSR 14-08-040, § 182-08-185, filed 3/26/14, effective 4/26/14.]

***(Effective until January 1, 2021)***

**WAC 182-08-187 How do employing agencies and contracted vendors correct enrollment errors and is there a limit on retroactive enrollment?** (1) An employing agency or contracted vendor that makes one or



more of the following enrollment errors must correct the error as described in subsections (2) through (4) of this section.

(a) Failure to timely notify an employee of their eligibility for public employee benefits board (PEBB) benefits and the employer contribution as described in WAC 182-12-113(2);

(b) Failure to enroll the employee and their dependents in PEBB insurance coverage as elected by the employee, if the elections were timely;

(c) Failure to enroll an employee and their dependents in PEBB insurance coverage as described in WAC 182-08-197 (1)(b);

(d) Failure to accurately reflect an employee's premium surcharge attestation on the employee's account;

(e) Enrolling an employee or their dependent in PEBB insurance coverage when they are not eligible as described in WAC 182-12-114 or 182-12-260 and it is clear there was no fraud or intentional misrepresentation by the employee involved; or

(f) Providing incorrect information regarding PEBB benefits to the employee that they relied upon.

(2) The employing agency or the applicable contracted vendor must enroll the employee and the employee's dependents, as elected, or terminate enrollment in PEBB benefits as described in subsection (3) of this section, reconcile premium payments and applicable premium surcharges as described in subsection (4) of this section, and provide recourse as described in subsection (5) of this section.

**Note:** If the employing agency failed to provide the notice required in WAC 182-12-113 or the employer group contract before the end of the employee's thirty-one day enrollment period described in WAC 182-08-197 (1)(a), the employing agency must provide the employee a written notice of eligibility for PEBB benefits and offer a new enrollment period of thirty-one days. Employees who do not return the required enrollment forms by the due date required under the new enrollment period must be defaulted according to WAC 182-08-197 (1)(b). This notice requirement does not remove the ability to offer recourse.

**(3) Enrollment or termination.**

(a) PEBB medical and dental enrollment is effective at a minimum the first day of the month following the date the enrollment error is identified, unless the authority determines additional recourse is warranted, as described in subsection (5) of this section. If the enrollment error is identified on the first day of the month, the enrollment correction is effective that day;

(b) Basic life, basic accidental death and dismemberment (AD&D), and basic long-term disability (LTD) insurance enrollment is retroactive to the first day of the month following the day the employee became newly eligible, or the first day of the month the employee regained eligibility, as described in WAC 182-08-197. If the employee became newly eligible on the first working day of a month, basic life, basic AD&D, and basic LTD insurance begins on that date;

(c) Supplemental life, supplemental AD&D, and supplemental LTD insurance enrollment is retroactive to the first day of the month following the day the employee became newly eligible if the employee elects to enroll in this coverage (or if previously elected, the first of the month following the signature date of the employee's application for this coverage). If an employing agency enrollment error occurred when the employee regained eligibility for the employer contribution following a period of leave as described in WAC 182-08-197(3):

(i) Supplemental life, supplemental AD&D, and supplemental LTD insurance is enrolled the first day of the month the employee regained eligibility, at the same level of coverage the employee continued during the period of leave, without evidence of insurability.

(ii) If the employee was not eligible to continue supplemental LTD insurance during the period of leave, supplemental LTD insurance is reinstated the first day of the month the employee regained eligi-

bility, to the level of coverage the employee was enrolled in prior to the period of leave, without evidence of insurability.

(iii) If the employee was eligible to continue supplemental life insurance, supplemental AD&D insurance, and supplemental LTD insurance under the period of leave but did not, the employee must provide evidence of insurability and receive approval from the contracted vendor.

(d) If the employee is eligible and elects (or elected) to enroll in the medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP), enrollment is limited to three months prior to the date enrollment is processed, but not earlier than the current plan year. If an employee was not enrolled in a medical FSA or DCAP as elected, the employee may either participate at the amount originally elected with a corresponding increase in contributions for the balance of the plan year, or participate at a reduced amount for the plan year by maintaining the per-pay period contribution in effect;

(e) If the employee or their dependent was not eligible but still enrolled as described in subsection (1)(e) of this section, the employee's or their dependent's PEBB insurance coverage will be terminated prospectively effective as of the last day of the month.

**(4) Premium payments.**

(a) The employing agency must remit to the authority the employer contribution and the employee contribution for health plan premiums, applicable premium surcharges, basic life, basic AD&D, and basic LTD starting the date PEBB insurance coverage begins as described in subsections (3) and (5)(a)(i) of this section. If a state agency failed to notify a newly eligible employee of their eligibility for PEBB benefits, the state agency may only collect the employee contribution for health plan premiums and applicable premium surcharges for coverage for months following notification of a new enrollment period.

(b) When an employing agency fails to correctly enroll the amount of supplemental LTD insurance elected by the employee, premiums will be corrected as follows:

(i) When additional premiums are due to the authority, the employee is responsible for premiums for the most recent twenty-four months of coverage. The employing agency is responsible for additional months of premiums.

(ii) When premium refunds are due to the employee, the supplemental LTD insurance vendor is responsible for premium refunds for the most recent twenty-four months of coverage. The employing agency is responsible for additional months of premium refunds.

(c) When an employing agency mistakenly enrolls an employee or their dependent as described in subsection (1)(e) of this section, premiums and any applicable premium surcharges will be refunded by the employing agency to the employee without rescinding the insurance coverage.

**(5) Recourse.**

(a) Employee eligibility for PEBB benefits begins on the first day of the month following the date eligibility is established as described in WAC 182-12-114. Dependent eligibility is described in WAC 182-12-260, and dependent enrollment is described in WAC 182-12-262. When retroactive correction of an enrollment error is limited as described in subsection (3) of this section, the employing agency must work with the employee, and receive approval from the authority, to implement retroactive PEBB insurance coverage within the following parameters:

(i) Retroactive enrollment in a PEBB health plan;

(ii) Reimbursement of claims paid;

- (iii) Reimbursement of amounts paid by the employee or dependent for medical and dental premiums;
  - (iv) Other legal remedy received or offered; or
  - (v) Other recourse, upon approval by the authority.
- (b) Recourse must not contradict a specific provision of federal law or statute and does not apply to requests for noncovered services or in the case of an individual who is not eligible for PEBB benefits.

[Statutory Authority: RCW 41.05.021, 41.05.160, and PEBB policy resolutions. WSR 19-17-073 (Admin #2019-01), § 182-08-187, filed 8/20/19, effective 1/1/20; WSR 18-20-117 (Admin #2018-02), § 182-08-187, filed 10/3/18, effective 1/1/19; WSR 17-19-077 (Order 2017-01), § 182-08-187, filed 9/15/17, effective 1/1/18. Statutory Authority: RCW 41.05.021, 41.05.160, 2016 c 67, and PEBB policy resolutions. WSR 16-20-080, § 182-08-187, filed 10/4/16, effective 1/1/17. Statutory Authority: RCW 41.05.160, 2015 c 116, and PEBB policy resolutions. WSR 15-22-099 (PEBB Admin # 2015-01 Rev 1), § 182-08-187, filed 11/4/15, effective 1/1/16. Statutory Authority: RCW 41.05.160 and 2013 2nd sp.s. c 4. WSR 14-20-058 (PEBB Admin 2014-02), § 182-08-187, filed 9/25/14, effective 1/1/15. Statutory Authority: RCW 41.05.160 and 2012 2nd sp.s. c 3. WSR 13-22-019 (Admin. 2013-01), § 182-08-187, filed 10/28/13, effective 1/1/14.]

***(Effective January 1, 2021)***

**WAC 182-08-187 How do employing agencies and contracted vendors correct enrollment errors and is there a limit on retroactive enrollment?** (1) An employing agency or contracted vendor that makes one or more of the following enrollment errors must correct the error as described in subsections (2) through (5) of this section.

(a) Failure to timely notify an employee of their eligibility for public employee benefits board (PEBB) benefits and the employer contribution as described in WAC 182-12-113(2);

(b) Failure to enroll the employee and their dependents in PEBB benefits as elected by the employee, if the elections were timely;

(c) Failure to enroll an employee and their dependents in PEBB benefits as described in WAC 182-08-197 (1)(b);

(d) Failure to accurately reflect an employee's premium surcharge attestation on the employee's account;

(e) Enrolling an employee or their dependent in PEBB insurance coverage when they are not eligible as described in WAC 182-12-114 or 182-12-260 and it is clear there was no fraud or intentional misrepresentation by the employee involved; or

(f) Providing incorrect information regarding PEBB benefits to the employee that they relied upon.

(2) The employing agency or the applicable contracted vendor must enroll the employee and the employee's dependents, as elected, or terminate enrollment in PEBB benefits as described in subsection (3) of this section, reconcile premium payments and applicable premium surcharges as described in subsection (4) of this section, and provide recourse as described in subsection (5) of this section.

**(3) Enrollment or termination.**

(a) PEBB medical and dental enrollment is effective at a minimum the first day of the month following the date the enrollment error is identified, unless the authority determines additional recourse is warranted, as described in subsection (5) of this section. If the en-

rollment error is identified on the first day of the month, the enrollment correction is effective that day;

(b) Basic life, basic accidental death and dismemberment (AD&D), and basic long-term disability (LTD) insurance enrollment is retroactive to the first day of the month following the day the employee became newly eligible, or the first day of the month the employee regained eligibility, as described in WAC 182-08-197. If the employee became newly eligible on the first working day of a month, basic life, basic AD&D, and basic LTD insurance begins on that date;

(c) Supplemental life, supplemental AD&D, and supplemental LTD insurance enrollment is retroactive to the first day of the month following the day the employee became newly eligible if the employee elects to enroll in this coverage (or if previously elected, the first of the month following the signature date on the employee's application for this coverage). If an employing agency enrollment error occurred when the employee regained eligibility for the employer contribution following a period of leave as described in WAC 182-08-197(3):

(i) Supplemental life, supplemental AD&D, and supplemental LTD insurance is enrolled the first day of the month the employee regained eligibility, at the same level of coverage the employee continued during the period of leave, without evidence of insurability.

(ii) If the employee was not eligible to continue supplemental LTD insurance during the period of leave as described in WAC 182-12-133, supplemental LTD insurance is reinstated the first day of the month the employee regained eligibility, to the level of coverage the employee was enrolled in prior to the period of leave, without evidence of insurability.

(iii) If the employee was eligible to continue supplemental life insurance, supplemental AD&D insurance, and supplemental LTD insurance under the period of leave but did not, the employee must provide evidence of insurability and receive approval from the contracted vendor.

(d) If the employee is eligible and elects (or elected) to enroll in the medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP), enrollment is limited to three months prior to the date enrollment is processed, but not earlier than the current plan year. If an employee was not enrolled in a medical FSA or DCAP as elected, the employee may either participate at the amount originally elected with a corresponding increase in contributions for the balance of the plan year, or participate at a reduced amount for the plan year by maintaining the per-pay period contribution in effect;

(e) If the employee or their dependent was not eligible but still enrolled as described in subsection (1)(e) of this section, the employee's or their dependent's PEBB benefits will be terminated prospectively effective as of the last day of the month.

**(4) Premium payments.**

(a) The employing agency must remit to the authority the employer contribution and the employee contribution for health plan premiums, applicable premium surcharges, basic life, basic AD&D, and basic LTD starting the date PEBB benefits begins as described in subsections (3) and (5)(a)(i) of this section. If a state agency failed to notify a newly eligible employee of their eligibility for PEBB benefits, the state agency may only collect the employee contribution for health plan premiums and applicable premium surcharges for coverage for the months after the employee was notified.

(b) When an employing agency fails to correctly enroll the amount of supplemental LTD insurance elected by the employee, premiums will be corrected as follows:

(i) When additional premiums are due to the authority, the employee is responsible for premiums for the most recent twenty-four months of coverage. The employing agency is responsible for additional months of premiums.

(ii) When a premium refund is due to the employee, the supplemental LTD insurance contracted vendor is responsible for premium refunds for the most recent twenty-four months of coverage. The employing agency is responsible for additional months of premium refund.

(c) When an employing agency mistakenly enrolls an employee or their dependent as described in subsection (1)(e) of this section, premiums and any applicable premium surcharges will be refunded by the employing agency to the employee without rescinding the insurance coverage.

(5) **Recourse.**

(a) Employee eligibility for PEBB benefits begins on the first day of the month following the date eligibility is established as described in WAC 182-12-114. Dependent eligibility is described in WAC 182-12-260, and dependent enrollment is described in WAC 182-12-262. When retroactive correction of an enrollment error is limited as described in subsection (3)(b), (c) and (d) of this section, the employing agency must work with the employee, and receive approval from the authority, to implement retroactive PEBB benefits within the following parameters:

(i) Retroactive enrollment in a PEBB insurance coverage;

(ii) Reimbursement of claims paid;

(iii) Reimbursement of amounts paid by the employee or dependent for medical and dental premiums;

(iv) Reimbursement of amounts paid by the employee for the premium surcharges;

(v) Other legal remedy received or offered; or

(vi) Other recourse, upon approval by the authority.

(b) Recourse must not contradict a specific provision of federal law or statute and does not apply to requests for noncovered services or in the case of an individual who is not eligible for PEBB benefits.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 20-16-062 (Admin #2020-03), § 182-08-187, filed 7/28/20, effective 1/1/21. Statutory Authority: RCW 41.05.021, 41.05.160, and PEBB policy resolutions. WSR 19-17-073 (Admin #2019-01), § 182-08-187, filed 8/20/19, effective 1/1/20; WSR 18-20-117 (Admin #2018-02), § 182-08-187, filed 10/3/18, effective 1/1/19; WSR 17-19-077 (Order 2017-01), § 182-08-187, filed 9/15/17, effective 1/1/18. Statutory Authority: RCW 41.05.021, 41.05.160, 2016 c 67, and PEBB policy resolutions. WSR 16-20-080, § 182-08-187, filed 10/4/16, effective 1/1/17. Statutory Authority: RCW 41.05.160, 2015 c 116, and PEBB policy resolutions. WSR 15-22-099 (PEBB Admin # 2015-01 Rev 1), § 182-08-187, filed 11/4/15, effective 1/1/16. Statutory Authority: RCW 41.05.160 and 2013 2nd sp.s. c 4. WSR 14-20-058 (PEBB Admin 2014-02), § 182-08-187, filed 9/25/14, effective 1/1/15. Statutory Authority: RCW 41.05.160 and 2012 2nd sp.s. c 3. WSR 13-22-019 (Admin. 2013-01), § 182-08-187, filed 10/28/13, effective 1/1/14.]

***(Effective until January 1, 2021)***

**WAC 182-08-190 The employer contribution is set by the health care authority (HCA) and paid to the HCA for all eligible employees.**

State agencies and employer groups that participate in the public employees benefits board (PEBB) program under contract with the health care authority (HCA) must pay the employer contributions to the health care authority (HCA) for PEBB insurance coverage for all eligible employees and their dependents.

(1) Employer contributions for state agencies are set by the HCA, and are subject to the approval of the governor for availability of funds as specifically appropriated by the legislature for that purpose. Insurance and health care contributions for ferry employees shall be governed by RCW 47.64.270.

(2) Employer contributions must include an amount determined by the HCA to pay administrative costs to administer PEBB insurance coverage for employees of these groups.

(3) Each employee of a state agency eligible under WAC 182-12-131 or each eligible employee of a state agency on leave under the federal Family and Medical Leave Act (FMLA) or the paid family and medical leave program is eligible for the employer contribution as described in WAC 182-12-138. The entire employer contribution is due and payable to HCA even if PEBB medical is waived as described in WAC 182-12-128.

(4) Employees of employer groups eligible under criteria stipulated under contract with the HCA are eligible for the employer contribution.

(5) The entire employer contribution is due and payable to the HCA even if PEBB medical is waived as described in WAC 182-12-128.

(6) 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 medical 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 described in WAC 182-12-114 or 182-12-131.

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

[Statutory Authority: RCW 41.05.021, 41.05.160, and PEBB policy resolutions. WSR 19-17-073 (Admin #2019-01), § 182-08-190, filed 8/20/19, effective 1/1/20. Statutory Authority: RCW 41.05.021, 41.05.160, 2016 c 67, and PEBB policy resolutions. WSR 16-20-080, § 182-08-190, filed 10/4/16, effective 1/1/17. Statutory Authority: RCW 41.05.160, 2015 c 116, and PEBB policy resolutions. WSR 15-22-099 (PEBB Admin # 2015-01 Rev 1), § 182-08-190, filed 11/4/15, effective 1/1/16. Statutory Authority: RCW 41.05.160 and 2013 2nd sp.s. c 4. WSR 14-20-058 (PEBB Admin 2014-02), § 182-08-190, filed 9/25/14, effective 1/1/15. Statutory Authority: RCW 41.05.160 and 2012 2nd sp.s. c 3. WSR 13-22-019 (Admin. 2013-01), § 182-08-190, filed 10/28/13, effective 1/1/14. Statutory Authority: RCW 41.05.160. WSR 09-23-102 (Order 09-02), § 182-08-190, filed 11/17/09, effective 1/1/10; WSR 08-20-128 (Order 08-03), § 182-08-190, filed 10/1/08, effective 1/1/09; WSR 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. WSR 04-18-039, § 182-08-190, filed 8/26/04, effective 1/1/05; WSR 03-17-031 (Order 02-07), § 182-08-190, filed 8/14/03, effective 9/14/03. Statutory Authority: RCW 41.05.160. WSR 02-18-088 (Order 02-03), § 182-08-190, filed 9/3/02, effective 10/4/02. Statutory Authority: Chapter 41.05 RCW. WSR 96-08-042, § 182-08-190, filed 3/29/96, effective 4/29/96; WSR 93-23-065, § 182-08-190, filed 11/16/93, effective 12/17/93; WSR 78-02-015 (Order 2-78), § 182-08-190, filed 1/10/78; Order 3-77, § 182-08-190, filed 11/17/77.]

**(Effective January 1, 2021)**

**WAC 182-08-190 The employer contribution is set by the health care authority (HCA) and paid to the HCA for all eligible employees.** State agencies and employer groups that participate in the public employees benefits board (PEBB) program under contract with the health care authority (HCA) must pay the employer contributions to the HCA for PEBB for all eligible employees and their enrolled dependents.

(1) Employer contributions for state agencies are set by the HCA, and are subject to the approval of the governor for availability of funds as specifically appropriated by the legislature for that purpose. Insurance and health care contributions for ferry employees shall be governed by RCW 47.64.270.

(2) Employer contributions must include an amount determined by the HCA to pay administrative costs to administer PEBB benefits for employees of these groups.

(3) Each employee of a state agency eligible under WAC 182-12-131 or each eligible employee of a state agency on leave under the federal Family and Medical Leave Act (FMLA) or the paid family and medical leave program is eligible for the employer contribution as described in WAC 182-12-138.

(4) Employees of employer groups eligible under criteria stipulated under contract with the HCA are eligible for the employer contribution.

(5) The entire employer contribution is due and payable to the HCA even if PEBB medical is waived as described in WAC 182-12-128.

(6) 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 medical 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 described in WAC 182-12-114 or 182-12-131.

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

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 20-16-062 (Admin #2020-03), § 182-08-190, filed 7/28/20, effective 1/1/21. Statutory Authority: RCW 41.05.021, 41.05.160, and PEBB policy resolutions. WSR 19-17-073 (Admin #2019-01), § 182-08-190, filed 8/20/19, effective 1/1/20. Statutory Authority: RCW 41.05.021, 41.05.160, 2016 c 67, and PEBB policy resolutions. WSR 16-20-080, § 182-08-190, filed 10/4/16, effective 1/1/17. Statutory Authority: RCW 41.05.160, 2015 c 116, and PEBB policy resolutions. WSR 15-22-099 (PEBB Admin # 2015-01 Rev 1), § 182-08-190, filed 11/4/15, effective 1/1/16. Statutory Authority: RCW 41.05.160 and 2013 2nd sp.s. c 4. WSR 14-20-058 (PEBB Admin 2014-02), § 182-08-190, filed 9/25/14, effective 1/1/15. Statutory Authority: RCW 41.05.160 and 2012 2nd sp.s. c 3. WSR 13-22-019 (Admin. 2013-01), § 182-08-190, filed 10/28/13, effective 1/1/14. Statutory Authority: RCW 41.05.160. WSR 09-23-102 (Order 09-02), § 182-08-190, filed 11/17/09, effective 1/1/10; WSR 08-20-128 (Order 08-03), § 182-08-190, filed 10/1/08, effective 1/1/09; WSR 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. WSR 04-18-039, § 182-08-190, filed 8/26/04, effective 1/1/05; WSR 03-17-031 (Order 02-07), § 182-08-190, filed 8/14/03, effective 9/14/03. Statutory Authority: RCW 41.05.160. WSR 02-18-088 (Order 02-03), § 182-08-190, filed 9/3/02, effective 10/4/02. Statutory Authority: Chapter 41.05 RCW. WSR 96-08-042, §

182-08-190, filed 3/29/96, effective 4/29/96; WSR 93-23-065, § 182-08-190, filed 11/16/93, effective 12/17/93; WSR 78-02-015 (Order 2-78), § 182-08-190, filed 1/10/78; Order 3-77, § 182-08-190, filed 11/17/77.]

***(Effective until January 1, 2021)***

**WAC 182-08-191 Subscriber address requirements.** (1) All employees must provide their employing agency with their correct address and update their address if it changes. A subscriber on PEBB retiree insurance coverage or continuation coverage must provide the PEBB program with their correct address and updates to their address if it changes.

(2) Employees who are appealing a decision to the public employees benefits board (PEBB) program must update their address as required in WAC 182-16-055.

[Statutory Authority: RCW 41.05.021, 41.05.160, and PEBB policy resolutions. WSR 19-17-073 (Admin #2019-01), § 182-08-191, filed 8/20/19, effective 1/1/20.]

***(Effective January 1, 2021)***

**WAC 182-08-191 Subscriber address requirements.** (1) All employees must provide their employing agency with their correct address and update their address if it changes. A subscriber on public employees benefits board (PEBB) retiree insurance coverage, or continuation coverage must provide the PEBB program with their correct address and updates to their address if it changes.

(2) In the event of an appeal, appellants must update their address as required in WAC 182-16-055.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 20-16-062 (Admin #2020-03), § 182-08-191, filed 7/28/20, effective 1/1/21. Statutory Authority: RCW 41.05.021, 41.05.160, and PEBB policy resolutions. WSR 19-17-073 (Admin #2019-01), § 182-08-191, filed 8/20/19, effective 1/1/20.]

***(Effective until January 1, 2021)***

**WAC 182-08-196 What happens if my health plan becomes unavailable due to a change in contracted service area or eligibility for medicare?** (1) A subscriber must elect a new health plan when their previously selected health plan becomes unavailable due to a change in contracting service area as described below:

(a) When a health plan becomes unavailable during the plan year, a subscriber must elect a new health plan no later than sixty days after the date their previously selected health plan becomes unavailable.

(i) An employee must submit the required forms to their employing agency electing their new health plan.

(ii) Any other subscriber must submit the required forms to the PEBB program electing their new health plan.



(iii) The effective date of the change in health plan will be the first day of the month following the later of the date the health plan becomes unavailable or the date the form is received. If that day is the first of the month, the change in health plan begins on that day.

(b) When a health plan becomes unavailable at the beginning of the next plan year, a subscriber must elect a new health plan no later than the last day of the public employees benefits board (PEBB) annual open enrollment.

(i) An employee must submit the required forms to their employing agency electing their new health plan.

(ii) Any other subscriber must submit the required forms to the PEBB program electing their new health plan.

(iii) The effective date of the change in health plan will be January 1st of the following year.

(c) A subscriber who fails to elect a new health plan within the required time period as required in (a) or (b) of this subsection will be enrolled in a health plan designated by the director or designee.

(2) A subscriber must elect a new health plan when their previously selected health plan becomes unavailable due to the subscriber or subscriber's dependent ceasing to be eligible for their current health plan because of enrollment in medicare as described below:

(a) The required forms electing a new health plan must be received no later than sixty days after the date their previously selected health plan becomes unavailable.

(b) An employee must submit the required forms to their employing agency electing their new health plan.

(c) Any other subscriber must submit the required forms to the PEBB program electing their new health plan.

(d) The effective date of the change in health plan will be the first day of the month following the later of the date the health plan becomes unavailable or the date the form is received. If that day is the first of the month, the change in health plan begins on that day.

(e) A subscriber who is enrolled in a consumer directed health plan (CDHP) with a health savings account (HSA), who fails to elect a new health plan within the required time period as required in this subsection, will not be eligible to receive contributions to the HSA. A subscriber will be liable for any tax penalties resulting from contributions made when they are no longer eligible.

(3) A subscriber enrolled in a health plan as described in subsection (1)(c) or (2) of this section may not change health plans except as allowed in WAC 182-08-198.

[Statutory Authority: RCW 41.05.021, 41.05.160, and PEBB policy resolutions. WSR 19-17-073 (Admin #2019-01), § 182-08-196, filed 8/20/19, effective 1/1/20; WSR 18-20-117 (Admin #2018-02), § 182-08-196, filed 10/3/18, effective 1/1/19; WSR 17-19-077 (Order 2017-01), § 182-08-196, filed 9/15/17, effective 1/1/18. Statutory Authority: RCW 41.05.021, 41.05.160, 2016 c 67, and PEBB policy resolutions. WSR 16-20-080, § 182-08-196, filed 10/4/16, effective 1/1/17. Statutory Authority: RCW 41.05.160 and 2011 c 8. WSR 11-22-036 (Order 11-02), § 182-08-196, filed 10/26/11, effective 1/1/12. Statutory Authority: RCW 41.05.160. WSR 10-20-147 (Order 10-02), § 182-08-196, filed 10/6/10, effective 1/1/11; WSR 09-23-102 (Order 09-02), § 182-08-196, filed 11/17/09, effective 1/1/10; WSR 08-20-128 (Order 08-03), § 182-08-196, filed 10/1/08, effective 1/1/09; WSR 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. WSR 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. WSR 04-18-039, § 182-08-196, filed 8/26/04, effective 1/1/05; WSR 03-17-031 (Order 02-07), § 182-08-196, filed 8/14/03, effective 9/14/03.]

**(Effective January 1, 2021)**

**WAC 182-08-196 What happens if my health plan becomes unavailable due to a change in contracted service area or eligibility for medicare?** (1) A subscriber must elect a new health plan when their previously selected health plan becomes unavailable due to a change in contracting service area as described below:

(a) When a health plan becomes unavailable during the plan year, a subscriber must elect a new health plan no later than sixty days after the date their previously selected health plan becomes unavailable.

(i) An employee must submit the required forms to their employing agency electing their new health plan.

(ii) Any other subscriber must submit the required forms to the PEBB program electing their new health plan.

(iii) The effective date of the change in health plan will be the first day of the month following the later of the date the health plan becomes unavailable or the date the form is received. If that day is the first of the month, the change in health plan begins on that day.

(b) When a health plan becomes unavailable at the beginning of the next plan year, a subscriber must elect a new health plan no later than the last day of the public employees benefits board (PEBB) annual open enrollment.

(i) An employee must submit the required forms to their employing agency electing their new health plan.

(ii) Any other subscriber must submit the required forms to the PEBB program electing their new health plan.

(iii) The effective date of the change in health plan will be January 1st of the following year.

(c) A subscriber who fails to elect a new health plan within the required time period as required in (a) or (b) of this subsection will be enrolled in a health plan designated by the director or designee.

(2) A subscriber must elect a new health plan when their previously selected health plan becomes unavailable due to the subscriber or subscriber's dependent ceasing to be eligible for their current health plan because of enrollment in medicare as described below:

(a) The required forms electing a new health plan must be received no later than sixty days after the date their previously selected health plan becomes unavailable.

**Exception:** The required forms electing a new medicare advantage plan must be received no later than two months after the date their previously selected health plan becomes unavailable.

(b) An employee must submit the required forms to their employing agency electing their new health plan.

(c) Any other subscriber must submit the required forms to the PEBB program electing their new health plan.

(d) The effective date of the change in health plan will be the first day of the month following the later of the date the health plan becomes unavailable or the date the form is received. If that day is the first of the month, the change in health plan begins on that day.

(e) A subscriber who is enrolled in a high deductible health plan (HDHP) with a health savings account (HSA), and fails to elect a new health plan within the required time period as required in this subsection, will not be eligible to receive contributions to the HSA. A subscriber will be liable for any tax penalties resulting from contributions made when they are no longer eligible.

(3) A subscriber enrolled in a health plan as described in subsection (1)(c) or (2)(e) of this section may not change health plans except as allowed in WAC 182-08-198.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 20-16-062 (Admin #2020-03), § 182-08-196, filed 7/28/20, effective 1/1/21. Statutory Authority: RCW 41.05.021, 41.05.160, and PEBB policy resolutions. WSR 19-17-073 (Admin #2019-01), § 182-08-196, filed 8/20/19, effective 1/1/20; WSR 18-20-117 (Admin #2018-02), § 182-08-196, filed 10/3/18, effective 1/1/19; WSR 17-19-077 (Order 2017-01), § 182-08-196, filed 9/15/17, effective 1/1/18. Statutory Authority: RCW 41.05.021, 41.05.160, 2016 c 67, and PEBB policy resolutions. WSR 16-20-080, § 182-08-196, filed 10/4/16, effective 1/1/17. Statutory Authority: RCW 41.05.160 and 2011 c 8. WSR 11-22-036 (Order 11-02), § 182-08-196, filed 10/26/11, effective 1/1/12. Statutory Authority: RCW 41.05.160. WSR 10-20-147 (Order 10-02), § 182-08-196, filed 10/6/10, effective 1/1/11; WSR 09-23-102 (Order 09-02), § 182-08-196, filed 11/17/09, effective 1/1/10; WSR 08-20-128 (Order 08-03), § 182-08-196, filed 10/1/08, effective 1/1/09; WSR 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. WSR 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. WSR 04-18-039, § 182-08-196, filed 8/26/04, effective 1/1/05; WSR 03-17-031 (Order 02-07), § 182-08-196, filed 8/14/03, effective 9/14/03.]

***(Effective until January 1, 2021)***

**WAC 182-08-197 When must a newly eligible employee, or an employee who regains eligibility for the employer contribution, elect public employees benefits board (PEBB) benefits and complete required forms?** An employee who is newly eligible or who regains eligibility for the employer contribution toward public employees benefits board (PEBB) benefits enrolls as described in this section.

(1) When an employee is newly eligible for PEBB benefits:

(a) An employee must complete the required forms indicating their enrollment elections, including an election to waive PEBB medical provided the employee is eligible to waive PEBB medical and elects to waive as described in WAC 182-12-128. The required forms must be returned to the employee's employing agency. Their employing agency must receive the forms no later than thirty-one days after the employee becomes eligible for PEBB benefits under WAC 182-12-114.

(i) An employee may enroll in supplemental life, supplemental accidental death and dismemberment (AD&D), and supplemental long-term disability (LTD) insurance up to the guaranteed issue without evidence of insurability if the required forms are returned to the employee's employing agency or contracted vendor as required. An employee may apply for enrollment in supplemental life, supplemental AD&D, and supplemental LTD insurance over the guaranteed issue at any time during

the calendar year by submitting the required form to the contracted vendor for approval.

(ii) If an employee is eligible to participate in the salary reduction plan (see WAC 182-12-116), the employee will automatically enroll in the premium payment plan upon enrollment in PEBB medical allowing medical premiums to be taken on a pretax basis. To opt out of the premium payment plan, a new employee must complete the required form and return it to their state agency. The form must be received by their state agency no later than thirty-one days after the employee becomes eligible for PEBB benefits.

(iii) If an employee is eligible to participate in the salary reduction plan (see WAC 182-12-116), the employee may enroll in the state's medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP) or both, except as limited by subsection (4) of this section. To enroll in these supplemental PEBB benefits, the employee must return the required form to their state agency. The form must be received by the state agency no later than thirty-one days after the employee becomes eligible for PEBB benefits.

(b) If a newly eligible employee's employing agency, or the authority's contracted vendor in the case of life insurance and AD&D insurance, does not receive the employee's required forms indicating medical, dental, life insurance, AD&D insurance, and LTD insurance elections, and the employee's tobacco use status attestation within thirty-one days of the employee becoming eligible, their enrollment will be as follows for those elections not received within thirty-one days:

- (i) Uniform Medical Plan Classic;
- (ii) Uniform Dental Plan;
- (iii) Basic life insurance;
- (iv) Basic AD&D insurance;
- (v) Basic long-term disability insurance;
- (vi) Dependents will not be enrolled; and
- (vii) A tobacco use surcharge will be incurred as described in WAC 182-08-185 (1)(b).

(2) The employer contribution toward PEBB insurance coverage ends according to WAC 182-12-131. When an employee's employment ends, participation in the salary reduction plan ends.

(3) When an employee regains eligibility for the employer contribution toward PEBB insurance coverage following a period of leave (described in WAC 182-12-133(1) and 182-12-142 (1) and (2)), PEBB medical and dental begin on the first day of the month the employee is in pay status eight or more hours.

(a) The employee must complete the required forms indicating their enrollment elections, including an election to waive PEBB medical if the employee chooses to waive PEBB medical as described in WAC 182-12-128. The required forms must be returned to the employee's employing agency except as described in (d) of this subsection. Forms must be received by the employing agency, life insurance contracted vendor, or AD&D contracted vendor, if required, no later than thirty-one days after the employee regains eligibility, except as described in subsection (3)(b) of this section:

- (i) An employee who self-paid for supplemental life insurance or supplemental AD&D coverage after losing eligibility will have that level of coverage reinstated without evidence of insurability effective the first day of the month in which the employee is in pay status eight or more hours;

(ii) An employee who was eligible to continue supplemental life or supplemental AD&D but discontinued that PEBB insurance coverage must submit evidence of insurability to the contracted vendor if they choose to reenroll when they regain eligibility for the employer contribution;

(iii) An employee who was eligible to continue supplemental LTD insurance but discontinued that PEBB insurance coverage must submit evidence of insurability for supplemental LTD insurance to the contracted vendor when they regain eligibility for the employer contribution.

(b) An employee in any of the following circumstances does not have to return a form indicating supplemental LTD insurance elections. Their supplemental LTD insurance will be automatically reinstated effective the first day of the month they are in pay status eight or more hours:

(i) The employee continued to self-pay for their supplemental LTD insurance after losing eligibility for the employer contribution;

(ii) The employee was not eligible to continue supplemental LTD insurance after losing eligibility for the employer contribution.

(c) If an employee's employing agency, or contracted vendor accepting forms directly, does not receive the required forms within thirty-one days of the employee regaining eligibility, the employee's enrollment in PEBB insurance coverage will be as described in subsection (1)(b)(i) through (iv) and (vi) of this section, except as described in (b) of this subsection.

(d) If an employee is eligible to participate in the salary reduction plan (see WAC 182-12-116) the employee may enroll in the medical FSA or DCAP or both, except as limited by subsection (4) of this section. To enroll in these supplemental PEBB benefits, the employee must return the required form to the contracted vendor or their state agency. The contracted vendor or employee's state agency must receive the form no later than thirty-one days after the employee becomes eligible for PEBB benefits.

(4) If an employee who is eligible to participate in the salary reduction plan (see WAC 182-12-116) is hired into a new position that is eligible for PEBB benefits in the same year, the employee may not resume participation in DCAP or medical FSA until the beginning of the next plan year, unless the time between employments is thirty days or less and within the current plan year. The employee must notify their new state agency of the transfer by providing the new state agency's personnel, payroll, or benefits office the required form no later than thirty-one days after the employee's first day of work with the new state agency.

(5) An employee's PEBB insurance coverage elections remain the same when an employee transfers from one employing agency to another employing agency without a break in PEBB insurance coverage for one month or more. This includes movement of an employee between any entities described in WAC 182-12-111 and participating in PEBB benefits. PEBB insurance coverage elections also remain the same when an employee has a break in employment that does not interrupt their employer contribution toward PEBB insurance coverage.

[Statutory Authority: RCW 41.05.021, 41.05.160, and PEBB policy resolutions. WSR 19-17-073 (Admin #2019-01), § 182-08-197, filed 8/20/19, effective 1/1/20; WSR 18-20-117 (Admin #2018-02), § 182-08-197, filed 10/3/18, effective 1/1/19; WSR 17-19-077 (Order 2017-01), § 182-08-197, filed 9/15/17, effective 1/1/18. Statutory Authority: RCW

41.05.021, 41.05.160, 2016 c 67, and PEBB policy resolutions. WSR 16-20-080, § 182-08-197, filed 10/4/16, effective 1/1/17. Statutory Authority: RCW 41.05.160, 2015 c 116, and PEBB policy resolutions. WSR 15-22-099 (PEBB Admin # 2015-01 Rev 1), § 182-08-197, filed 11/4/15, effective 1/1/16. Statutory Authority: RCW 41.05.160 and 2013 2nd sp.s. c 4. WSR 14-20-058 (PEBB Admin 2014-02), § 182-08-197, filed 9/25/14, effective 1/1/15. Statutory Authority: RCW 41.05.160 and 2012 2nd sp.s. c 3. WSR 13-22-019 (Admin. 2013-01), § 182-08-197, filed 10/28/13, effective 1/1/14. Statutory Authority: RCW 41.05.160. WSR 12-20-022 (Order 2012-01), § 182-08-197, filed 9/25/12, effective 11/1/12. Statutory Authority: RCW 41.05.160 and 2011 c 8. WSR 11-22-036 (Order 11-02), § 182-08-197, filed 10/26/11, effective 1/1/12. Statutory Authority: RCW 41.05.160. WSR 10-20-147 (Order 10-02), § 182-08-197, filed 10/6/10, effective 1/1/11; WSR 09-23-102 (Order 09-02), § 182-08-197, filed 11/17/09, effective 1/1/10; WSR 08-20-128 (Order 08-03), § 182-08-197, filed 10/1/08, effective 1/1/09; WSR 07-20-129 (Order 07-01), § 182-08-197, filed 10/3/07, effective 11/3/07; WSR 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. WSR 05-16-046 (Order 05-01), § 182-08-197, filed 7/27/05, effective 8/27/05.]

***(Effective January 1, 2021)***

**WAC 182-08-197 When must a newly eligible employee, or an employee who regains eligibility for the employer contribution, elect public employees benefits board (PEBB) benefits and complete required forms?** An employee who is newly eligible or who regains eligibility for the employer contribution toward public employees benefits board (PEBB) benefits enrolls as described in this section.

(1) When an employee is newly eligible for PEBB benefits:

(a) An employee must complete the required forms indicating their enrollment elections, including an election to waive PEBB medical provided the employee is eligible to waive PEBB medical and elects to waive as described in WAC 182-12-128. The required forms must be returned to the employee's employing agency or contracted vendor. Their employing agency or contracted vendor must receive the forms no later than thirty-one days after the employee becomes eligible for PEBB benefits under WAC 182-12-114.

(i) An employee may enroll in supplemental life and supplemental long-term disability (LTD) insurance up to the guaranteed issue coverage amount without evidence of insurability if the required forms are returned to the employee's employing agency or contracted vendor as required. An employee may apply for enrollment in supplemental life and supplemental LTD insurance over the guaranteed issue coverage amount at any time during the calendar year by submitting the required form to the contracted vendor for approval. An employee may enroll in supplemental accidental death and dismemberment (AD&D) insurance at anytime during the calendar year without evidence of insurability by submitting the required form to the contracted vendor.

(ii) If an employee is eligible to participate in the salary reduction plan (see WAC 182-12-116), the employee will automatically enroll in the premium payment plan upon enrollment in PEBB medical allowing medical premiums to be taken on a pretax basis. To opt out of the premium payment plan, a new employee must complete the required form and return it to their state agency. The form must be received by

their state agency no later than thirty-one days after the employee becomes eligible for PEBB benefits.

(iii) If an employee is eligible to participate in the salary reduction plan (see WAC 182-12-116), the employee may enroll in the state's medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP) or both, except as limited by subsection (4) of this section. To enroll in these PEBB benefits, the employee must return the required form to their state agency. The form must be received by the state agency no later than thirty-one days after the employee becomes eligible for PEBB benefits.

(b) If a newly eligible employee's employing agency, or the authority's contracted vendor in the case of life insurance and AD&D insurance, does not receive the employee's required forms indicating medical, dental, life insurance, AD&D insurance, and LTD insurance elections, and the employee's tobacco use status attestation within thirty-one days of the employee becoming eligible, their enrollment will be as follows for those elections not received within thirty-one days:

- (i) A medical plan determined by the health care authority (HCA);
- (ii) A dental plan determined by the HCA;
- (iii) Basic life insurance;
- (iv) Basic AD&D insurance;
- (v) Basic LTD insurance;
- (vi) Dependents will not be enrolled; and
- (vii) A tobacco use premium surcharge will be incurred as described in WAC 182-08-185 (1)(b).

(2) The employer contribution toward PEBB benefits ends according to WAC 182-12-131. When an employee's employment ends, participation in the salary reduction plan ends.

(3) When an employee regains eligibility for the employer contribution toward PEBB benefits, including following a period of leave described in WAC 182-12-133(1), or after being between periods of leave as described in WAC 182-12-142 (1) and (2), or 182-12-131 (3)(e), PEBB medical and dental begin on the first day of the month the employee is in pay status eight or more hours.

(a) An employee must complete the required forms indicating their enrollment elections, including an election to waive PEBB medical if the employee chooses to waive PEBB medical as described in WAC 182-12-128. The required forms must be returned to the employee's employing agency except as described in (d) of this subsection. Forms must be received by the employing agency, life insurance contracted vendor, or AD&D contracted vendor, if required, no later than thirty-one days after the employee regains eligibility, except as described in (a)(i) and (b) of this subsection:

(i) An employee who self-paid for supplemental life insurance or supplemental AD&D coverage after losing eligibility will maintain that level of coverage upon return;

(ii) An employee who was eligible to continue supplemental life or supplemental AD&D but discontinued that supplemental coverage must submit evidence of insurability to the contracted vendor if they choose to reenroll when they regain eligibility for the employer contribution;

(iii) An employee who was eligible to continue supplemental LTD insurance but discontinued that supplemental coverage must submit evidence of insurability for supplemental LTD insurance to the contracted vendor when they regain eligibility for the employer contribution.

(b) An employee in any of the following circumstances does not have to return a form indicating supplemental LTD insurance elections. Their supplemental LTD insurance will be automatically reinstated effective the first day of the month they are in pay status eight or more hours:

(i) The employee continued to self-pay for their supplemental LTD insurance after losing eligibility for the employer contribution;

(ii) The employee was not eligible to continue supplemental LTD insurance after losing eligibility for the employer contribution.

(c) If an employee's employing agency, or contracted vendor accepting forms directly, does not receive the required forms within thirty-one days of the employee regaining eligibility, the employee's enrollment for those elections not received will be as described in subsection (1)(b)(i) through (vii) of this section, except as described in (a)(i) and (b) of this subsection.

(d) If an employee is eligible to participate in the salary reduction plan (see WAC 182-12-116) the employee may enroll in the medical FSA or DCAP or both, except as limited by subsection (4) of this section. To enroll in these PEBB benefits, the employee must return the required form to the contracted vendor or their state agency. The contracted vendor or employee's state agency must receive the form no later than thirty-one days after the employee becomes eligible for PEBB benefits.

(4) If an employee who is eligible to participate in the salary reduction plan (see WAC 182-12-116) is hired into a new position that is eligible for PEBB benefits in the same year, the employee may not resume participation in DCAP or medical FSA until the beginning of the next plan year, unless the time between employments is thirty days or less and within the current plan year. The employee must notify their new state agency of the transfer by providing the new state agency's personnel, payroll, or benefits office the required form no later than thirty-one days after the employee's first day of work with the new state agency.

(5) An employee's PEBB benefits elections remain the same when an employee transfers from one employing agency to another employing agency without a break in PEBB benefits for one month or more. This includes movement of an employee between any entities described in WAC 182-12-111 and participating in PEBB benefits. PEBB benefits elections also remain the same when an employee has a break in employment that does not interrupt their employer contribution toward PEBB benefits.

[Statutory Authority: RCW 41.05.021, 41.05.160 and PEBB policy resolution 2020-04. WSR 20-16-059 (Admin #2020-01), § 182-08-197, filed 7/28/20, effective 1/1/21. Statutory Authority: RCW 41.05.021, 41.05.160, and PEBB policy resolutions. WSR 19-17-073 (Admin #2019-01), § 182-08-197, filed 8/20/19, effective 1/1/20; WSR 18-20-117 (Admin #2018-02), § 182-08-197, filed 10/3/18, effective 1/1/19; WSR 17-19-077 (Order 2017-01), § 182-08-197, filed 9/15/17, effective 1/1/18. Statutory Authority: RCW 41.05.021, 41.05.160, 2016 c 67, and PEBB policy resolutions. WSR 16-20-080, § 182-08-197, filed 10/4/16, effective 1/1/17. Statutory Authority: RCW 41.05.160, 2015 c 116, and PEBB policy resolutions. WSR 15-22-099 (PEBB Admin # 2015-01 Rev 1), § 182-08-197, filed 11/4/15, effective 1/1/16. Statutory Authority: RCW 41.05.160 and 2013 2nd sp.s. c 4. WSR 14-20-058 (PEBB Admin 2014-02), § 182-08-197, filed 9/25/14, effective 1/1/15. Statutory Authority: RCW 41.05.160 and 2012 2nd sp.s. c 3. WSR 13-22-019 (Admin. 2013-01), § 182-08-197, filed 10/28/13, effective 1/1/14. Statutory



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

***(Effective until January 1, 2021)***

**WAC 182-08-198 When may a subscriber change health plans?** A subscriber may change health plans at the following times:

(1) **During the annual open enrollment:** A subscriber may change health plans during the public employees benefits board (PEBB) annual open enrollment period. A subscriber must submit the required enrollment forms to change their health plan. An employee submits the enrollment forms to their employing agency. Any other subscriber submits the enrollment forms to the PEBB program. The required enrollment forms must be received no later than the last day of the annual open enrollment. Enrollment in the new health plan will begin January 1st of the following year.

(2) **During a special open enrollment:** A subscriber may revoke their health plan election and make a new election outside of the annual open enrollment if a special open enrollment event occurs. A special open enrollment event must be an event other than an employee gaining initial eligibility for PEBB benefits. The change in enrollment must be allowable under Internal Revenue Code and Treasury regulations, and correspond to and be consistent with the event that creates the special open enrollment for the subscriber, the subscriber's dependent, or both. To make a health plan change, a subscriber must submit the required enrollment forms (and a completed disenrollment form, if required). The forms must be received no later than sixty days after the event occurs, except as described in (i) of this subsection. An employee submits the enrollment forms to their employing agency. Any other subscriber submits the enrollment forms to the PEBB program. In addition to the required forms, a subscriber must provide evidence of the event that created the special open enrollment. New health plan coverage will begin the first day of the month following the later of the event date or the date the form is received. If that day is the first of the month, the change in enrollment begins on that day.

**Exception:** When a subscriber or their dependent is enrolled in a medicare advantage plan, the new health plan coverage will begin the first day of the month following the date the medicare advantage plan disenrollment form is received.

If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, health plan coverage will begin the month in which the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption occurs. Any one of the following events may create a special open enrollment:

(a) Subscriber acquires a new dependent due to:

(i) Marriage or registering a state registered domestic partnership;

(ii) Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or

(iii) A child becoming eligible as an extended dependent through legal custody or legal guardianship.

(b) Subscriber or a subscriber's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);

(c) Subscriber has a change in employment status that affects the subscriber's eligibility for their employer contribution toward their employer-based group health plan;

(d) The subscriber's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan;

**Note:** As used in (d) of this subsection, "employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 26 C.F.R. 54.9801-6.

(e) Subscriber or a subscriber's dependent has a change in residence that affects health plan availability. If the subscriber moves and the subscriber's current health plan is not available in the new location the subscriber must select a new health plan, otherwise there will be limited accessibility to network providers and covered services;

**Exception:** A dental plan is considered available if a provider is located within fifty miles of the subscriber's new residence.

(f) A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state registered domestic partner is not an eligible dependent);

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

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

(i) Subscriber or a subscriber's dependent becomes entitled to coverage under medicare, or the subscriber or a subscriber's dependent loses eligibility for coverage under medicare, or enrolls in or terminates enrollment in a medicare Part D plan. If the subscriber's current health plan becomes unavailable due to the subscriber's or a subscriber's dependent's entitlement to medicare, the subscriber must select a new health plan as described in WAC 182-08-196 (2). A subscriber has six months from the date of their or their dependent's enrollment in medicare Part B to enroll in a PEBB medicare supplement plan for which they or their dependent is eligible. The forms must be received by the PEBB program no later than six months after the enrollment in medicare Part B for either the subscriber or the subscriber's dependent;

(j) Subscriber or a subscriber's dependent's current health plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA). The authority may require evidence that the subscriber or subscriber's dependent is no longer eligible for an HSA;

(k) Subscriber or a subscriber's dependent experiences a disruption of care for active and ongoing treatment, that could function as a reduction in benefits for the subscriber or the subscriber's dependent. A subscriber may not change their health plan election if the subscriber's or dependent's physician stops participation with the subscriber's health plan unless the PEBB program determines that a continuity of care issue exists. The PEBB program will consider but not limit its consideration to the following:

- (i) Active cancer treatment such as chemotherapy or radiation therapy;
  - (ii) Treatment following a recent organ transplant;
  - (iii) A scheduled surgery;
  - (iv) Recent major surgery still within the postoperative period;
- or
- (v) Treatment for a high-risk pregnancy.

(3) If the employee is having premiums taken from payroll on a pretax basis, a health 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 41.05.021, 41.05.160, and PEBB policy resolutions. WSR 19-17-073 (Admin #2019-01), § 182-08-198, filed 8/20/19, effective 1/1/20; WSR 18-20-117 (Admin #2018-02), § 182-08-198, filed 10/3/18, effective 1/1/19; WSR 17-19-077 (Order 2017-01), § 182-08-198, filed 9/15/17, effective 1/1/18. Statutory Authority: RCW 41.05.021, 41.05.160, 2016 c 67, and PEBB policy resolutions. WSR 16-20-080, § 182-08-198, filed 10/4/16, effective 1/1/17. Statutory Authority: RCW 41.05.160 and 2013 2nd sp.s. c 4. WSR 14-20-058 (PEBB Admin 2014-02), § 182-08-198, filed 9/25/14, effective 1/1/15. Statutory Authority: RCW 41.05.160, 2013 2nd sp.s. c 4 and PEBB policy resolutions. WSR 14-08-040, § 182-08-198, filed 3/26/14, effective 4/26/14. Statutory Authority: RCW 41.05.160 and 2012 2nd sp.s. c 3. WSR 13-22-019 (Admin. 2013-01), § 182-08-198, filed 10/28/13, effective 1/1/14. Statutory Authority: RCW 41.05.160. WSR 12-20-022 (Order 2012-01), § 182-08-198, filed 9/25/12, effective 11/1/12. Statutory Authority: RCW 41.05.160 and 2011 c 8. WSR 11-22-036 (Order 11-02), § 182-08-198, filed 10/26/11, effective 1/1/12. Statutory Authority: RCW 41.05.160. WSR 10-20-147 (Order 10-02), § 182-08-198, filed 10/6/10, effective 1/1/11; WSR 09-23-102 (Order 09-02), § 182-08-198, filed 11/17/09, effective 1/1/10; WSR 08-20-128 (Order 08-03), § 182-08-198, filed 10/1/08, effective 1/1/09; WSR 08-09-027 (Order 08-01), § 182-08-198, filed 4/8/08, effective 4/9/08; WSR 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. WSR 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. WSR 05-16-046 (Order 05-01), § 182-08-198, filed 7/27/05, effective 8/27/05.]

***(Effective January 1, 2021)***

**WAC 182-08-198 When may a subscriber change health plans?** A subscriber may change health plans at the following times:

(1) **During the annual open enrollment:** A subscriber may change health plans during the public employees benefits board (PEBB) annual open enrollment period. A subscriber must submit the required enrollment forms to change their health plan. An employee submits the en-

rollment forms to their employing agency. Any other subscriber submits the enrollment forms to the PEBB program. The required enrollment forms must be received no later than the last day of the annual open enrollment. Enrollment in the new health plan will begin January 1st of the following year.

(2) **During a special open enrollment:** A subscriber may revoke their health plan election and make a new election outside of the annual open enrollment if a special open enrollment event occurs. A special open enrollment event must be an event other than an employee gaining initial eligibility for PEBB benefits as described in WAC 182-12-114 or regaining eligibility for PEBB benefits as described in WAC 182-08-197. The change in enrollment must be allowable under Internal Revenue Code and Treasury regulations, and correspond to and be consistent with the event that creates the special open enrollment for the subscriber, the subscriber's dependent, or both. To disenroll from a medicare advantage plan or medicare advantage-prescription drug plan, the change in enrollment must be allowable under 42 C.F.R. Sec. 422.62(b) and 42 C.F.R. Sec. 423.38(c). To make a health plan change, a subscriber must submit the required enrollment forms (and a completed disenrollment form, if required). The forms must be received no later than sixty days after the event occurs, except as described in (i) of this subsection. An employee submits the enrollment forms to their employing agency. Any other subscriber submits the enrollment forms to the PEBB program. In addition to the required forms, a subscriber must provide evidence of the event that created the special open enrollment. New health plan coverage will begin the first day of the month following the later of the event date or the date the form is received. If that day is the first of the month, the change in enrollment begins on that day.

**Exception:** When a subscriber or their dependent is enrolled in a medicare advantage or medicare advantage-prescription drug plan, they may disenroll during a special enrollment period as allowed under Title 42 C.F.R. The new medical plan coverage will begin the first day of the month following the date the medicare advantage plan disenrollment form is received.

If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, health plan coverage will begin the month in which the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption occurs. If the special open enrollment is due to the enrollment of an extended dependent or a dependent with a disability, the change in health plan coverage will begin the first day of the month following the later of the event date or eligibility certification. Any one of the following events may create a special open enrollment:

(a) Subscriber acquires a new dependent due to:

(i) Marriage or registering a state registered domestic partnership;

(ii) Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or

(iii) A child becoming eligible as an extended dependent through legal custody or legal guardianship.

(b) Subscriber or a subscriber's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);

(c) Subscriber has a change in employment status that affects the subscriber's eligibility for their employer contribution toward their employer-based group health plan;

(d) The subscriber's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan;

**Note:** As used in (d) of this subsection, "employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 26 C.F.R. 54.9801-6.

(e) Subscriber or a subscriber's dependent has a change in residence that affects health plan availability. If the subscriber moves and the subscriber's current health plan is not available in the new location the subscriber must select a new health plan, otherwise there will be limited accessibility to network providers and covered services;

**Exception:** A dental plan is considered available if a provider is located within fifty miles of the subscriber's new residence.

(f) A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state registered domestic partner is not an eligible dependent);

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

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

(i) Subscriber or a subscriber's dependent enrolls in coverage under medicare, or the subscriber or a subscriber's dependent loses eligibility for coverage under medicare, or enrolls in or terminates enrollment in a medicare advantage-prescription drug or a Part D plan. If the subscriber's current medical plan becomes unavailable due to the subscriber's or a subscriber's dependent's enrollment in medicare, the subscriber must select a new medical plan as described in WAC 182-08-196(2).

(i) A subscriber enrolled in PEBB retiree insurance coverage or an eligible subscriber enrolled in Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage has six months from the date of their or their dependent's enrollment in medicare Part B to enroll in a PEBB medicare supplement plan for which they or their dependent is eligible. The forms must be received by the PEBB program no later than six months after the enrollment in medicare Part B for either the subscriber or the subscriber's dependent;

(ii) A subscriber enrolled in PEBB retiree insurance coverage or an eligible subscriber enrolled in Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage has seven months to enroll in a medicare advantage or medicare advantage-prescription drug plan that begins three months before they or their dependent first enrolled in both medicare Part A and Part B and ends three months after the month of medicare eligibility. A subscriber may also enroll themselves or their dependent in a medicare advantage or medicare advantage-prescription drug plan before their last day of the medicare Part B initial enrollment period. The forms must be received by the PEBB program no later than the last day of the month prior to the month the subscriber or the subscriber's dependent enrolls in the medicare advantage or medicare advantage-prescription drug plan.

(j) Subscriber or a subscriber's dependent's current medical plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA). The authority may

require evidence that the subscriber or subscriber's dependent is no longer eligible for an HSA;

(k) Subscriber or a subscriber's dependent experiences a disruption of care for active and ongoing treatment, that could function as a reduction in benefits for the subscriber or the subscriber's dependent. A subscriber may not change their health plan election if the subscriber's or dependent's physician stops participation with the subscriber's health plan unless the PEBB program determines that a continuity of care issue exists. The PEBB program will consider but not limit its consideration to the following:

(i) Active cancer treatment such as chemotherapy or radiation therapy;

(ii) Treatment following a recent organ transplant;

(iii) A scheduled surgery;

(iv) Recent major surgery still within the postoperative period;

or

(v) Treatment for a high-risk pregnancy.

(3) If the employee is having premiums taken from payroll on a pretax basis, a medical 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 41.05.021 and 41.05.160. WSR 20-16-062 (Admin #2020-03), § 182-08-198, filed 7/28/20, effective 1/1/21. Statutory Authority: RCW 41.05.021, 41.05.160, and PEBB policy resolutions. WSR 19-17-073 (Admin #2019-01), § 182-08-198, filed 8/20/19, effective 1/1/20; WSR 18-20-117 (Admin #2018-02), § 182-08-198, filed 10/3/18, effective 1/1/19; WSR 17-19-077 (Order 2017-01), § 182-08-198, filed 9/15/17, effective 1/1/18. Statutory Authority: RCW 41.05.021, 41.05.160, 2016 c 67, and PEBB policy resolutions. WSR 16-20-080, § 182-08-198, filed 10/4/16, effective 1/1/17. Statutory Authority: RCW 41.05.160 and 2013 2nd sp.s. c 4. WSR 14-20-058 (PEBB Admin 2014-02), § 182-08-198, filed 9/25/14, effective 1/1/15. Statutory Authority: RCW 41.05.160, 2013 2nd sp.s. c 4 and PEBB policy resolutions. WSR 14-08-040, § 182-08-198, filed 3/26/14, effective 4/26/14. Statutory Authority: RCW 41.05.160 and 2012 2nd sp.s. c 3. WSR 13-22-019 (Admin. 2013-01), § 182-08-198, filed 10/28/13, effective 1/1/14. Statutory Authority: RCW 41.05.160. WSR 12-20-022 (Order 2012-01), § 182-08-198, filed 9/25/12, effective 11/1/12. Statutory Authority: RCW 41.05.160 and 2011 c 8. WSR 11-22-036 (Order 11-02), § 182-08-198, filed 10/26/11, effective 1/1/12. Statutory Authority: RCW 41.05.160. WSR 10-20-147 (Order 10-02), § 182-08-198, filed 10/6/10, effective 1/1/11; WSR 09-23-102 (Order 09-02), § 182-08-198, filed 11/17/09, effective 1/1/10; WSR 08-20-128 (Order 08-03), § 182-08-198, filed 10/1/08, effective 1/1/09; WSR 08-09-027 (Order 08-01), § 182-08-198, filed 4/8/08, effective 4/9/08; WSR 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. WSR 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. WSR 05-16-046 (Order 05-01), § 182-08-198, filed 7/27/05, effective 8/27/05.]

***(Effective until January 1, 2021)***

**WAC 182-08-199 When may an employee enroll, or revoke an election and make a new election under the premium payment plan, medical**

**flexible spending arrangement (FSA), or dependent care assistance program (DCAP)?** An employee who is eligible to participate in the salary reduction plan as described in WAC 182-12-116 may enroll, or revoke their election and make a new election under the premium payment plan, medical flexible spending arrangement (FSA), or dependent care assistance program (DCAP) at the following times:

(1) When newly eligible under WAC 182-12-114 and enrolling as described in WAC 182-08-197(1).

(2) **During annual open enrollment:** An eligible employee may elect to enroll in or opt out of participation under the premium payment plan during the annual open enrollment by submitting the required form to their employing agency. An eligible employee may elect to enroll or reenroll in the medical FSA, DCAP, or both during the annual open enrollment by submitting the required forms to their employing agency or applicable contracted vendor as instructed. All required forms must be received no later than the last day of the annual open enrollment. The enrollment or new election becomes effective January 1st of the following year.

**Note:** Employees enrolled in a consumer directed health plan (CDHP) with a health savings account (HSA) cannot also enroll in a medical FSA in the same plan year. Employees who elect both will only be enrolled in the CDHP with a HSA.

(3) **During a special open enrollment:** An employee who is eligible to participate in the salary reduction plan may enroll or revoke their election and make a new election under the premium payment plan, medical FSA, or DCAP outside of the annual open enrollment if a special open enrollment event occurs. The enrollment or change in election must be allowable under Internal Revenue Code (IRC) and Treasury regulations, and correspond to and be consistent with the event that creates the special open enrollment. To make a change or enroll, the employee must submit the required form to their employing agency. The employing agency must receive the required form and evidence of the event that created the special open enrollment no later than sixty days after the event occurs.

For purposes of this section, an eligible dependent includes any person who qualifies as a dependent of the employee for tax purposes under IRC 26 U.S.C. Sec. 152 without regard to the income limitations of that section. It does not include a state registered domestic partner unless the state registered domestic partner otherwise qualifies as a dependent for tax purposes under IRC 26 U.S.C. Sec. 152.

(a) **Premium payment plan.** An employee may enroll or revoke their election and elect to opt out of the premium payment plan when any of the following special open enrollment events occur, if the requested change corresponds to and is consistent with the event. The enrollment or election to opt out will be effective the first day of the month following the later of the event date or the date the required form is received. If that day is the first of the month, the enrollment or change in election begins on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, the enrollment or change in election will begin the first of the month in which the event occurs.

(i) Employee acquires a new dependent due to:

- Marriage;
- Registering a state registered domestic partnership when the dependent is a tax dependent of the employee;
- Birth, adoption, or when the employee has assumed a legal obligation for total or partial support in anticipation of adoption; or

- A child becoming eligible as an extended dependent through legal custody or legal guardianship.

- (ii) Employee's dependent no longer meets public employee benefits board (PEBB) eligibility criteria because:

- Employee has a change in marital status;
- Employee's domestic partnership with a state registered domestic partner who is a tax dependent is dissolved or terminated;
- An eligible dependent child turns age twenty-six or otherwise does not meet dependent child eligibility criteria;
- An eligible dependent ceases to be eligible as an extended dependent or as a dependent with a disability; or
- An eligible dependent dies.

- (iii) Employee or an employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);

- (iv) Employee has a change in employment status that affects the employee's eligibility for their employer contribution toward their employer-based group health plan;

- (v) The employee's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan;

**Note:** As used in (a)(v) of this subsection, "employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 26 C.F.R. 54.9801-6.

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

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

- (viii) Employee's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States and that change in residence resulted in the dependent losing their health insurance;

- (ix) A court order requires the employee or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state registered domestic partner is not an eligible dependent);

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

- (xi) Employee or an employee's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from medicaid or CHIP;

- (xii) Employee or an employee's dependent becomes entitled to coverage under medicare or the employee or an employee's dependent loses eligibility for coverage under medicare;

- (xiii) Employee or an employee's dependent's current health plan becomes unavailable because the employee or enrolled dependent is no longer eligible for a health savings account (HSA). The health care authority (HCA) requires evidence that the employee or employee's dependent is no longer eligible for an HSA;

- (xiv) Employee or an employee's dependent experiences a disruption of care for active and ongoing treatment, that could function as a reduction in benefits for the employee or the employee's dependent. The employee may not change their health plan election if the employee's or dependent's physician stops participation with the employee's



health plan unless the PEBB program determines that a continuity of care issue exists. The PEBB program will consider but not limit its consideration to the following:

- Active cancer treatment such as chemotherapy or radiation therapy;
- Treatment following a recent organ transplant;
- A scheduled surgery;
- Recent major surgery still within the postoperative period; or
- Treatment for a high-risk pregnancy.

(xv) Employee or employee's dependent becomes eligible and enrolls in a TRICARE plan, or loses eligibility for a TRICARE plan.

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

(b) **Medical FSA.** An employee may enroll or revoke their election and make a new election under the medical FSA when any one of the following special open enrollment events occur, if the requested change corresponds to and is consistent with the event. The enrollment or new election will be effective the first day of the month following the later of the event date or the date the required form and evidence of the event that created the special open enrollment is received by the employing agency. If that day is the first of the month, the enrollment or change in election begins on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, the enrollment or change in election will begin the first of the month in which the event occurs.

(i) Employee acquires a new dependent due to:

- Marriage;
- Registering a state registered domestic partnership if the domestic partner qualifies as a tax dependent of the employee;
- Birth, adoption, or when the employee has assumed a legal obligation for total or partial support in anticipation of adoption; or
- A child becoming eligible as an extended dependent through legal custody or legal guardianship.

(ii) Employee's dependent no longer meets PEBB eligibility criteria because:

- Employee has a change in marital status;
- Employee's domestic partnership with a state registered domestic partner who qualifies as a tax dependent is dissolved or terminated;
- An eligible dependent child turns age twenty-six or otherwise does not meet dependent child eligibility criteria;
- An eligible dependent ceases to be eligible as an extended dependent or as a dependent with a disability; or
- An eligible dependent dies.

(iii) Employee or an employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);

(iv) Employee or an employee's dependent has a change in employment status that affects the employee's or a dependent's eligibility for the medical FSA;

(v) A court order requires the employee or any other individual to provide insurance coverage for an eligible dependent of the sub-

scriber (a former spouse or former state registered domestic partner is not an eligible dependent);

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

(vii) Employee or an employee's dependent becomes entitled to coverage under medicare.

(c) **DCAP.** An employee may enroll or revoke their election and make a new election under the DCAP when any one of the following special open enrollment events occur, if the requested change corresponds to and is consistent with the event. The enrollment or new election will be effective the first day of the month following the later of the event date or the date the required form and evidence of the event that created the special open enrollment is received by the employing agency. If that day is the first of the month, the enrollment or change in election begins on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, the enrollment or change in election will begin the first of the month in which the event occurs.

(i) Employee acquires a new dependent due to:

- Marriage;
- Registering a state registered domestic partnership if the domestic partner qualifies as a tax dependent of the employee;
- Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or
- A child becoming eligible as an extended dependent through legal custody or legal guardianship.

(ii) Employee or an employee's dependent has a change in employment status that affects the employee's or a dependent's eligibility for DCAP;

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

(iv) Employee changes dependent care provider; the change to the DCAP election amount can reflect the cost of the new provider;

(v) Employee or the employee's spouse experiences a change in the number of qualifying individuals as defined in IRC 26 U.S.C. Sec. 21 (b) (1);

(vi) Employee's dependent care provider imposes a change in the cost of dependent care; employee may make a change in the DCAP election amount to reflect the new cost if the dependent care provider is not a qualifying relative of the employee as defined in IRC 26 U.S.C. Sec. 152.

[Statutory Authority: RCW 41.05.021, 41.05.160, and PEBB policy resolutions. WSR 19-17-073 (Admin #2019-01), § 182-08-199, filed 8/20/19, effective 1/1/20; WSR 18-20-117 (Admin #2018-02), § 182-08-199, filed 10/3/18, effective 1/1/19; WSR 17-19-077 (Order 2017-01), § 182-08-199, filed 9/15/17, effective 1/1/18. Statutory Authority: RCW 41.05.021, 41.05.160, 2016 c 67, and PEBB policy resolutions. WSR 16-20-080, § 182-08-199, filed 10/4/16, effective 1/1/17. Statutory Authority: RCW 41.05.160, 2015 c 116, and PEBB policy resolutions. WSR 15-22-099 (PEBB Admin # 2015-01 Rev 1), § 182-08-199, filed 11/4/15, effective 1/1/16. Statutory Authority: RCW 41.05.160 and 2013 2nd sp.s. c 4. WSR 14-20-058 (PEBB Admin 2014-02), § 182-08-199, filed

9/25/14, effective 1/1/15. Statutory Authority: RCW 41.05.160, 2013 2nd sp.s. c 4 and PEBB policy resolutions. WSR 14-08-040, § 182-08-199, filed 3/26/14, effective 4/26/14. Statutory Authority: RCW 41.05.160 and 2012 2nd sp.s. c 3. WSR 13-22-019 (Admin. 2013-01), § 182-08-199, filed 10/28/13, effective 1/1/14. Statutory Authority: RCW 41.05.160. WSR 12-20-022 (Order 2012-01), § 182-08-199, filed 9/25/12, effective 11/1/12. Statutory Authority: RCW 41.05.160 and 2011 c 8. WSR 11-22-036 (Order 11-02), § 182-08-199, filed 10/26/11, effective 1/1/12. Statutory Authority: RCW 41.05.160. WSR 10-20-147 (Order 10-02), § 182-08-199, filed 10/6/10, effective 1/1/11; WSR 09-23-102 (Order 09-02), § 182-08-199, filed 11/17/09, effective 1/1/10; WSR 08-20-128 (Order 08-03), § 182-08-199, filed 10/1/08, effective 1/1/09.]

***(Effective January 1, 2021)***

**WAC 182-08-199** When may an employee enroll, or revoke an election and make a new election under the premium payment plan, medical flexible spending arrangement (FSA), or dependent care assistance program (DCAP)? An employee who is eligible to participate in the salary reduction plan as described in WAC 182-12-116 may enroll, or revoke their election and make a new election under the premium payment plan, medical flexible spending arrangement (FSA), or dependent care assistance program (DCAP) at the following times:

(1) When newly eligible under WAC 182-12-114 and enrolling as described in WAC 182-08-197(1).

(2) **During annual open enrollment:** An eligible employee may elect to enroll in or opt out of participation under the premium payment plan during the annual open enrollment by submitting the required form to their employing agency. An eligible employee may elect to enroll or reenroll in the medical FSA, DCAP, or both during the annual open enrollment by submitting the required forms to their employing agency or applicable contracted vendor as instructed. All required forms must be received no later than the last day of the annual open enrollment. The enrollment or new election becomes effective January 1st of the following year.

**Note:** Employees enrolled in a consumer directed health plan (CDHP) with a health savings account (HSA) cannot also enroll in a medical FSA in the same plan year. Employees who elect both will only be enrolled in the CDHP with a HSA.

(3) **During a special open enrollment:** An employee who is eligible to participate in the salary reduction plan may enroll or revoke their election and make a new election under the premium payment plan, medical FSA, or DCAP outside of the annual open enrollment if a special open enrollment event occurs. The enrollment or change in election must be allowable under Internal Revenue Code (IRC) and Treasury regulations, and correspond to and be consistent with the event that creates the special open enrollment. To make a change or enroll, the employee must submit the required form to their employing agency. The employing agency must receive the required form and evidence of the event that created the special open enrollment no later than sixty days after the event occurs.

For purposes of this section, an eligible dependent includes any person who qualifies as a dependent of the employee for tax purposes under IRC 26 U.S.C. Sec. 152 without regard to the income limitations of that section. It does not include a state registered domestic partner unless the state registered domestic partner otherwise qualifies as a dependent for tax purposes under IRC 26 U.S.C. Sec. 152.

(a) **Premium payment plan.** An employee may enroll or revoke their election and elect to opt out of the premium payment plan when any of the following special open enrollment events occur, if the requested change corresponds to and is consistent with the event. The enrollment or election to opt out will be effective the first day of the month following the later of the event date or the date the required form is received. If that day is the first of the month, the enrollment or change in election begins on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, the enrollment or change in election will begin the first of the month in which the event occurs.

(i) Employee acquires a new dependent due to:

- Marriage;
- Registering a state registered domestic partnership when the dependent is a tax dependent of the employee;
- Birth, adoption, or when the employee has assumed a legal obligation for total or partial support in anticipation of adoption; or
- A child becoming eligible as an extended dependent through legal custody or legal guardianship.

(ii) Employee's dependent no longer meets public employee benefits board (PEBB) eligibility criteria because:

- Employee has a change in marital status;
- Employee's domestic partnership with a state registered domestic partner who is a tax dependent is dissolved or terminated;
- An eligible dependent child turns age twenty-six or otherwise does not meet dependent child eligibility criteria;
- An eligible dependent ceases to be eligible as an extended dependent or as a dependent with a disability; or
- An eligible dependent dies.

(iii) Employee or an employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);

(iv) Employee has a change in employment status that affects the employee's eligibility for their employer contribution toward their employer-based group health plan;

(v) The employee's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan;

**Note:** As used in (a)(v) of this subsection, "employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 26 C.F.R. 54.9801-6.

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

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

(viii) Employee's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States and that change in residence resulted in the dependent losing their health insurance;

(ix) A court order requires the employee or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state registered domestic partner is not an eligible dependent);

(x) Employee or an employee's dependent enrolls in coverage under medicaid or a state children's health insurance program (CHIP), or the

subscriber or a subscriber's dependent loses eligibility for coverage under medicaid or CHIP;

(xi) Employee or an employee's dependent becomes eligible for state premium assistance subsidy for PEBB medical plan coverage from medicaid or CHIP;

(xii) Employee or an employee's dependent enrolls in coverage under medicare or the employee or an employee's dependent loses eligibility for coverage under medicare;

(xiii) Employee or an employee's dependent's current medical plan becomes unavailable because the employee or enrolled dependent is no longer eligible for a health savings account (HSA). The health care authority (HCA) requires evidence that the employee or employee's dependent is no longer eligible for an HSA;

(xiv) Employee or an employee's dependent experiences a disruption of care for active and ongoing treatment, that could function as a reduction in benefits for the employee or the employee's dependent. The employee may not change their health plan election if the employee's or dependent's physician stops participation with the employee's health plan unless the PEBB program determines that a continuity of care issue exists. The PEBB program will consider but not limit its consideration to the following:

- Active cancer treatment such as chemotherapy or radiation therapy;

- Treatment following a recent organ transplant;

- A scheduled surgery;

- Recent major surgery still within the postoperative period; or

- Treatment for a high-risk pregnancy.

(xv) Employee or employee's dependent becomes eligible and enrolls in a TRICARE plan, or loses eligibility for a TRICARE plan.

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

(b) **Medical FSA.** An employee may enroll or revoke their election and make a new election under the medical FSA when any one of the following special open enrollment events occur, if the requested change corresponds to and is consistent with the event. The enrollment or new election will be effective the first day of the month following the later of the event date or the date the required form and evidence of the event that created the special open enrollment is received by the employing agency. If that day is the first of the month, the enrollment or change in election begins on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, the enrollment or change in election will begin the first of the month in which the event occurs.

(i) Employee acquires a new dependent due to:

- Marriage;

- Registering a state registered domestic partnership if the domestic partner qualifies as a tax dependent of the employee;

- Birth, adoption, or when the employee has assumed a legal obligation for total or partial support in anticipation of adoption; or

- A child becoming eligible as an extended dependent through legal custody or legal guardianship.

(ii) Employee's dependent no longer meets PEBB eligibility criteria because:

- Employee has a change in marital status;

- Employee's domestic partnership with a state registered domestic partner who qualifies as a tax dependent is dissolved or terminated;

- An eligible dependent child turns age twenty-six or otherwise does not meet dependent child eligibility criteria;

- An eligible dependent ceases to be eligible as an extended dependent or as a dependent with a disability; or

- An eligible dependent dies.

(iii) Employee or an employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the HIPAA;

(iv) Employee or an employee's dependent has a change in employment status that affects the employee's or a dependent's eligibility for the medical FSA;

(v) A court order requires the employee or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state registered domestic partner is not an eligible dependent);

(vi) Employee or an employee's dependent enrolls in coverage under medicaid or a state children's health insurance program (CHIP), or the employee or an employee's dependent loses eligibility for coverage under medicaid or CHIP;

(vii) Employee or an employee's dependent enrolls in coverage under medicare.

(c) **DCAP.** An employee may enroll or revoke their election and make a new election under the DCAP when any one of the following special open enrollment events occur, if the requested change corresponds to and is consistent with the event. The enrollment or new election will be effective the first day of the month following the later of the event date or the date the required form and evidence of the event that created the special open enrollment is received by the employing agency. If that day is the first of the month, the enrollment or change in election begins on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, the enrollment or change in election will begin the first of the month in which the event occurs.

(i) Employee acquires a new dependent due to:

- Marriage;

- Registering a state registered domestic partnership if the domestic partner qualifies as a tax dependent of the employee;

- Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or

- A child becoming eligible as an extended dependent through legal custody or legal guardianship.

(ii) Employee or an employee's dependent has a change in employment status that affects the employee's or a dependent's eligibility for DCAP;

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

(iv) Employee changes dependent care provider; the change to the DCAP election amount can reflect the cost of the new provider;

(v) Employee or the employee's spouse experiences a change in the number of qualifying individuals as defined in IRC 26 U.S.C. Sec. 21 (b) (1);

(vi) Employee's dependent care provider imposes a change in the cost of dependent care; employee may make a change in the DCAP election amount to reflect the new cost if the dependent care provider is not a qualifying relative of the employee as defined in IRC 26 U.S.C. Sec. 152.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 20-16-062 (Admin #2020-03), § 182-08-199, filed 7/28/20, effective 1/1/21. Statutory Authority: RCW 41.05.021, 41.05.160, and PEBB policy resolutions. WSR 19-17-073 (Admin #2019-01), § 182-08-199, filed 8/20/19, effective 1/1/20; WSR 18-20-117 (Admin #2018-02), § 182-08-199, filed 10/3/18, effective 1/1/19; WSR 17-19-077 (Order 2017-01), § 182-08-199, filed 9/15/17, effective 1/1/18. Statutory Authority: RCW 41.05.021, 41.05.160, 2016 c 67, and PEBB policy resolutions. WSR 16-20-080, § 182-08-199, filed 10/4/16, effective 1/1/17. Statutory Authority: RCW 41.05.160, 2015 c 116, and PEBB policy resolutions. WSR 15-22-099 (PEBB Admin # 2015-01 Rev 1), § 182-08-199, filed 11/4/15, effective 1/1/16. Statutory Authority: RCW 41.05.160 and 2013 2nd sp.s. c 4. WSR 14-20-058 (PEBB Admin 2014-02), § 182-08-199, filed 9/25/14, effective 1/1/15. Statutory Authority: RCW 41.05.160, 2013 2nd sp.s. c 4 and PEBB policy resolutions. WSR 14-08-040, § 182-08-199, filed 3/26/14, effective 4/26/14. Statutory Authority: RCW 41.05.160 and 2012 2nd sp.s. c 3. WSR 13-22-019 (Admin. 2013-01), § 182-08-199, filed 10/28/13, effective 1/1/14. Statutory Authority: RCW 41.05.160. WSR 12-20-022 (Order 2012-01), § 182-08-199, filed 9/25/12, effective 11/1/12. Statutory Authority: RCW 41.05.160 and 2011 c 8. WSR 11-22-036 (Order 11-02), § 182-08-199, filed 10/26/11, effective 1/1/12. Statutory Authority: RCW 41.05.160. WSR 10-20-147 (Order 10-02), § 182-08-199, filed 10/6/10, effective 1/1/11; WSR 09-23-102 (Order 09-02), § 182-08-199, filed 11/17/09, effective 1/1/10; WSR 08-20-128 (Order 08-03), § 182-08-199, filed 10/1/08, effective 1/1/09.]

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

(1) **For eligible employees changing agencies:** When an eligible employee's employment relationship terminates with an employing agency at any time during the month for which a premium contribution is due and that employee transfers to another agency, the agency losing the employee is responsible for the payment of the employer contribution for the employee for that month. The receiving agency is liable for any employer contribution for the eligible employee beginning the first day of the month following the transfer.

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

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

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

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

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

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

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

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

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

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

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

[Statutory Authority: RCW 41.05.021, 41.05.160, and PEBB policy resolutions. WSR 19-17-073 (Admin #2019-01), § 182-08-200, filed 8/20/19, effective 1/1/20; WSR 18-20-117 (Admin #2018-02), § 182-08-200, filed 10/3/18, effective 1/1/19. Statutory Authority: RCW 41.05.160 and 2013 2nd sp.s. c 4. WSR 14-20-058 (PEBB Admin 2014-02), § 182-08-200, filed 9/25/14, effective 1/1/15. Statutory Authority: RCW 41.05.160. WSR 09-23-102 (Order 09-02), § 182-08-200, filed 11/17/09, effective 1/1/10; WSR 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. WSR 04-18-039, § 182-08-200, filed 8/26/04, effective 1/1/05. Statutory Authority: Chapter 41.05 RCW. WSR 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 public employees benefits board (PEBB) benefit plans.** (1) In order to assure equal and unbiased representation of public employees benefits board (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 health care authority (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 includes any mention of the "public employees benefits board," "PEBB," "health care authority," "HCA," any reference to benefits for



"state employees," or "retirees," or any group of enrollees 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 41.05.021, 41.05.160, 2016 c 67, and PEBB policy resolutions. WSR 16-20-080, § 182-08-220, filed 10/4/16, effective 1/1/17. Statutory Authority: RCW 41.05.160, 2015 c 116, and PEBB policy resolutions. WSR 15-22-099 (PEBB Admin # 2015-01 Rev 1), § 182-08-220, filed 11/4/15, effective 1/1/16. Statutory Authority: RCW 41.05.160. WSR 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. WSR 03-17-031 (Order 02-07), § 182-08-220, filed 8/14/03, effective 9/14/03. Statutory Authority: Chapter 41.05 RCW. WSR 96-08-042, § 182-08-220, filed 3/29/96, effective 4/29/96; WSR 91-20-163, § 182-08-220, filed 10/2/91, effective 11/2/91; WSR 86-16-061 (Resolution No. 86-3), § 182-08-220, filed 8/5/86.]

***(Effective until January 1, 2021)***

**WAC 182-08-235 Employer group application process.** This section applies to employer groups as defined in WAC 182-08-015. An employer group may apply to obtain public employees benefits board (PEBB) insurance coverage through a contract with the health care authority (HCA).

(1) Employer groups with less than five hundred employees must apply at least sixty days before the requested coverage effective date. Employer groups with five hundred or more employees but with less than five thousand employees must apply at least ninety days before the requested effective date.

Employer groups with five thousand or more employees must apply at least one hundred twenty days before the requested coverage effective date. To apply, employer groups must submit the documents and information described in subsection (2) of this section to the PEBB program as follows:

(a) Educational service districts applying for its nonrepresented employees are required to provide the documents described in subsections (2)(a) through (c) of this section;

**Exception:** Educational service districts required by the superintendent of public instruction to purchase PEBB insurance coverage provided by the authority are required to submit documents and information described in subsection (2)(a)(iii), (b), and (c) of this section.

(b) Counties, municipalities, political subdivisions, and tribal governments with fewer than five thousand employees are required to provide the documents and information described in subsection (2)(a) through (f) of this section;

(c) Counties, municipalities, political subdivisions, and tribal governments with five thousand or more employees will have their application approved or denied through the evaluation criteria described in WAC 182-08-240 and are required to provide the documents and information described in subsection (2)(a) through (d), (f), and (g) of this section; and

(d) All employee organizations representing state civil services employees and the Washington health benefit exchange, regardless of the number of employees, will have their application approved or denied through the evaluation criteria described in WAC 182-08-240 and

are required to provide the documents and information described in subsection (2)(a) through (d), (f), and (g) of this section.

(2) Documents and information required with application:

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

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

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

(iii) Employer group tax ID number (TIN); and

(iv) A statement of whether the group is applying to obtain only medical or all available PEBB insurance coverages. Educational service districts applying for its nonrepresented employees must purchase medical, dental, life, and long-term disability insurance.

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

(c) A signed governmental function attestation document that attests to the fact that employees for whom the group is applying are governmental employees whose services are substantially all in the performance of essential governmental functions.

(d) A member level census file for all of the employees for whom the group is applying. The file must be provided in the format required by the authority and contain the following demographic data, by member, with each member classified as employee, spouse or state registered domestic partner, or child:

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

(ii) Age;

(iii) Gender;

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

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

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

(e) Historical claims and cost information that include the following:

(i) Large claims history for twenty-four months by quarter that excludes the most recent three months;

(ii) Ongoing large claims management report for the most recent quarter provided in the large claims history;

(iii) Summary of historical plan costs; and

(iv) The director or the director's designee may make an exception to the claims and cost information requirements based on the size of the group, except that the current health plan does not have a case management program, then the primary diagnosis code designated by the authority must be reported for each large claimant. If the code indicates a condition which is expected to continue into the next quarter, the claim is counted as an ongoing large claim. If historical claims and cost information as described in (e)(i) through (iii) of this subsection are unavailable, the director or the director's designee may make an exception to allow all of the following alternative requirements:

- A letter from their carrier indicating they will not or cannot provide claims data.

- Provide information about the health plan most employees are enrolled in by completing the actuarial calculator authorized by the PEBB program.

- Current premiums for the health plan.

(f) If the application is for a subset of the group's employees (e.g., bargaining unit), the group must provide a member level census file of all employees eligible under their current health plan who are not included on the member level census file in (d) of this subsection. This includes retired employees participating under the group's current health plan. The file must include the same demographic data by member.

(g) Employer groups described in subsection (1)(c) and (d) of this section must submit to an actuarial evaluation of the group provided by an actuary designated by the PEBB program. The group must pay for the cost of the evaluation. This cost is nonrefundable. A group that is approved will not have to pay for an additional actuarial evaluation if it applies to add another bargaining unit within two years of the evaluation. Employer groups of this size must provide the following:

- (i) Large claims history for twenty-four months, by quarter that excludes the most recent three months;
- (ii) Ongoing large claims management report for the most recent quarter provided in the large claims history;
- (iii) Executive summary of benefits;
- (iv) Summary of benefits and certificate of coverage; and
- (v) Summary of historical plan costs.

**Exception:** If the current health plan does not have a case management program then the primary diagnosis code designated by the authority must be reported for each large claimant. If the code indicates a condition which is expected to continue into the next quarter, the claim is counted as an ongoing large claim.

(3) The authority may automatically deny a group application if the group fails to provide the required information and documents described in this section.

[Statutory Authority: RCW 41.05.021, 41.05.160, and PEBB policy resolutions. WSR 19-17-073 (Admin #2019-01), § 182-08-235, filed 8/20/19, effective 1/1/20; WSR 18-20-117 (Admin #2018-02), § 182-08-235, filed 10/3/18, effective 1/1/19; WSR 17-19-077 (Order 2017-01), § 182-08-235, filed 9/15/17, effective 1/1/18. Statutory Authority: RCW 41.05.021, 41.05.160, 2016 c 67, and PEBB policy resolutions. WSR 16-20-080, § 182-08-235, filed 10/4/16, effective 1/1/17. Statutory Authority: RCW 41.05.160, 2015 c 116, and PEBB policy resolutions. WSR 15-22-099 (PEBB Admin # 2015-01 Rev 1), § 182-08-235, filed 11/4/15, effective 1/1/16. Statutory Authority: RCW 41.05.160 and 2013 2nd sp.s. c 4. WSR 14-20-058 (PEBB Admin 2014-02), § 182-08-235, filed 9/25/14, effective 1/1/15. Statutory Authority: RCW 41.05.160 and 2012 2nd sp.s. c 3. WSR 13-22-019 (Admin. 2013-01), § 182-08-235, filed 10/28/13, effective 1/1/14. Statutory Authority: RCW 41.05.160. WSR 12-20-022 (Order 2012-01), § 182-08-235, filed 9/25/12, effective 11/1/12.]

***(Effective January 1, 2021)***

**WAC 182-08-235 Employer group and board of directors for school districts and educational service districts application process.** This section applies to employer groups as defined in WAC 182-08-015 and board members of school districts and educational service districts. An employer group or board member of a school district or an educational service district may apply to obtain public employees benefits

board (PEBB) insurance coverage through a contract with the health care authority (HCA).

(1) Employer groups and board members of school districts and educational service districts with less than five hundred employees must apply at least sixty days before the requested coverage effective date. Employer groups with five hundred or more employees but with less than five thousand employees must apply at least ninety days before the requested effective date.

Employer groups with five thousand or more employees must apply at least one hundred twenty days before the requested coverage effective date. To apply, employer groups must submit the documents and information described in subsection (2) of this section to the PEBB program as follows:

(a) Board members of school districts and educational service districts and educational service districts applying for their nonrepresented employees are required to provide the documents described in subsection (2)(a) through (c) of this section;

**Exception:** Educational service districts required by the superintendent of public instruction to purchase PEBB insurance coverage provided by the authority are required to submit documents and information described in subsection (2)(a)(iii), (b), and (c) of this section.

(b) Counties, municipalities, political subdivisions, and tribal governments with fewer than five thousand employees are required to provide the documents and information described in subsection (2)(a) through (f) of this section;

(c) Counties, municipalities, political subdivisions, and tribal governments with five thousand or more employees will have their application approved or denied through the evaluation criteria described in WAC 182-08-240 and are required to provide the documents and information described in subsection (2)(a) through (d), (f), and (g) of this section; and

(d) All employee organizations representing state civil services employees and the Washington health benefit exchange, regardless of the number of employees, will have their application approved or denied through the evaluation criteria described in WAC 182-08-240 and are required to provide the documents and information described in subsection (2)(a) through (d), (f), and (g) of this section.

(2) Documents and information required with application:

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

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

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

(iii) Employer group or board members of school district or educational service district tax ID number (TIN); and

(iv) A statement of whether the group is applying to obtain only medical or all available PEBB insurance coverages. Educational service districts applying for its nonrepresented employees must purchase medical, dental, life, and long-term disability insurance. Board members of school districts or educational service districts must provide a statement of whether the group is applying to obtain medical, dental, and life insurance.

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

(c) A signed governmental function attestation document that attests to the fact that employees for whom the group is applying are governmental employees whose services are substantially all in the performance of essential governmental functions.

(d) A member level census file for all of the employees for whom the group is applying. The file must be provided in the format required by the authority and contain the following demographic data, by member, with each member classified as employee, spouse or state registered domestic partner, or child:

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

(ii) Age;

(iii) Birth sex;

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

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

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

(e) Historical claims and cost information that include the following:

(i) Large claims history for twenty-four months by quarter that excludes the most recent three months;

(ii) Ongoing large claims management report for the most recent quarter provided in the large claims history;

(iii) Summary of historical plan costs; and

(iv) The director or the director's designee may make an exception to the claims and cost information requirements based on the size of the group, except that the current health plan does not have a case management program, then the primary diagnosis code designated by the authority must be reported for each large claimant. If the code indicates a condition which is expected to continue into the next quarter, the claim is counted as an ongoing large claim. If historical claims and cost information as described in (e)(i) through (iii) of this subsection are unavailable, the director or the director's designee may make an exception to allow all of the following alternative requirements:

- A letter from their carrier indicating they will not or cannot provide claims data.

- Provide information about the health plan most employees are enrolled in by completing the actuarial calculator authorized by the PEBB program.

- Current premiums for the health plan.

(f) If the application is for a subset of the group's employees (e.g., bargaining unit), the group must provide a member level census file of all employees eligible under their current health plan who are not included on the member level census file in (d) of this subsection. This includes retired employees participating under the group's current health plan. The file must include the same demographic data by member.

(g) Employer groups described in subsection (1)(c) and (d) of this section must submit to an actuarial evaluation of the group provided by an actuary designated by the PEBB program. The group must pay for the cost of the evaluation. This cost is nonrefundable. A group that is approved will not have to pay for an additional actuarial evaluation if it applies to add another bargaining unit within two years of the evaluation. Employer groups of this size must provide the following:

(i) Large claims history for twenty-four months, by quarter that excludes the most recent three months;

(ii) Ongoing large claims management report for the most recent quarter provided in the large claims history;

- (iii) Executive summary of benefits;
- (iv) Summary of benefits and certificate of coverage; and
- (v) Summary of historical plan costs.

**Exception:** If the current health plan does not have a case management program then the primary diagnosis code designated by the authority must be reported for each large claimant. If the code indicates a condition which is expected to continue into the next quarter, the claim is counted as an ongoing large claim.

(3) The authority may automatically deny a group application if the group fails to provide the required information and documents described in this section.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 20-16-062 (Admin #2020-03), § 182-08-235, filed 7/28/20, effective 1/1/21. Statutory Authority: RCW 41.05.021, 41.05.160, and PEBB policy resolutions. WSR 19-17-073 (Admin #2019-01), § 182-08-235, filed 8/20/19, effective 1/1/20; WSR 18-20-117 (Admin #2018-02), § 182-08-235, filed 10/3/18, effective 1/1/19; WSR 17-19-077 (Order 2017-01), § 182-08-235, filed 9/15/17, effective 1/1/18. Statutory Authority: RCW 41.05.021, 41.05.160, 2016 c 67, and PEBB policy resolutions. WSR 16-20-080, § 182-08-235, filed 10/4/16, effective 1/1/17. Statutory Authority: RCW 41.05.160, 2015 c 116, and PEBB policy resolutions. WSR 15-22-099 (PEBB Admin # 2015-01 Rev 1), § 182-08-235, filed 11/4/15, effective 1/1/16. Statutory Authority: RCW 41.05.160 and 2013 2nd sp.s. c 4. WSR 14-20-058 (PEBB Admin 2014-02), § 182-08-235, filed 9/25/14, effective 1/1/15. Statutory Authority: RCW 41.05.160 and 2012 2nd sp.s. c 3. WSR 13-22-019 (Admin. 2013-01), § 182-08-235, filed 10/28/13, effective 1/1/14. Statutory Authority: RCW 41.05.160. WSR 12-20-022 (Order 2012-01), § 182-08-235, filed 9/25/12, effective 11/1/12.]

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

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

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

(b) Eligibility for coverage under the local government's or tribal government's retiree health plan must have required immediate enrollment in retiree health plan coverage upon termination of employee coverage; and

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

(2) If the local government's or tribal government's application is for a subset of their employees (e.g., bargaining unit) only retirees previously within the bargaining unit may be included in the transfer.

(3) 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.

(4) 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.

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

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

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

[Statutory Authority: RCW 41.05.021, 41.05.160, 2016 c 67, and PEBB policy resolutions. WSR 16-20-080, § 182-08-237, filed 10/4/16, effective 1/1/17. Statutory Authority: RCW 41.05.160. WSR 12-20-022 (Order 2012-01), § 182-08-237, filed 9/25/12, effective 11/1/12.]

**WAC 182-08-240 How will the health care authority (HCA) decide to approve or deny a group application?** This section applies to counties, municipalities, political subdivisions, and tribal governments with five thousand or more employees. This section also applies to employee organizations representing state civil service employees and the Washington health benefit exchange, regardless of the number of employees. Group applications for participation in public employees benefits board (PEBB) insurance coverage provided through the PEBB program are approved or denied by the health care authority (HCA) based upon the information and documents submitted by the group and the employer group evaluation (EGE) criteria described in this rule.

(1) Groups are evaluated as a single unit. To support this requirement the group must provide a census file, as described in WAC 182-08-235 (2)(d), and additional information as described in WAC 182-08-235 (2)(g) for all employees eligible to participate under the group's current health plan. If the group's application is for both employees and retirees, the census file data and additional information for retired employees participating under the group's current health plan must also be included.

(a) If the group's application is only for participation of its employees, the PEBB enrollment data used to evaluate the group will be state agency employee data.

(b) If a group's application is for participation of both its employees and retirees, the PEBB enrollment data used to evaluate the group will include data from the PEBB nonmedicare risk pool limited to state retiree enrollment data and state agency employee data.

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

(3) The authority will use the following criteria to evaluate the group.

(a) The member level census file demographic data must indicate a relative underwriting factor that is equal to or better than the rela-

tive underwriting factor as determined by the authority for the like population within the nonmedicare PEBB risk pool as described in subsection (1) of this section;

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

(i) The frequency of large claims must be less than or equal to the PEBB historical benchmark frequency for the PEBB like population within the nonmedicare population as described in subsection (1) of this section;

(ii) The ongoing large claims management report must demonstrate that the frequency of ongoing large claims is less than or equal to the recurring benchmark frequency for the PEBB like population within the nonmedicare population as described in subsection (1) of this section.

(c) Provide an executive summary of benefits;

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

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

(f) The evaluation of criteria in (c), (d), and (e) of this subsection must indicate that the historical cost of benefits for the group is equal to or less than the historical cost of the PEBB like population within the nonmedicare population as described in subsection (1) of this section for a comparable plan design.

(4) An approved group application is valid for three hundred sixty-five calendar days after the date the application is approved by the authority. If a group applies to add additional bargaining units after the three hundred sixty-five calendar day period has ended, the group must be reevaluated.

(5) An entity whose group application is denied may appeal the authority's decision to the PEBB appeals unit through the process described in WAC 182-16-2060.

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

[Statutory Authority: RCW 41.05.021, 41.05.160 and PEBB policy resolutions. WSR 18-20-117 (Admin #2018-02), § 182-08-240, filed 10/3/18, effective 1/1/19. Statutory Authority: RCW 41.05.021, 41.05.160, 2016 c 67, and PEBB policy resolutions. WSR 16-20-080, § 182-08-240, filed 10/4/16, effective 1/1/17. Statutory Authority: RCW 41.05.160, 2015 c 116, and PEBB policy resolutions. WSR 15-22-099 (PEBB Admin # 2015-01 Rev 1), § 182-08-240, filed 11/4/15, effective 1/1/16. Statutory Authority: RCW 41.05.160 and 2012 2nd sp.s. c 3. WSR 13-22-019 (Admin. 2013-01), § 182-08-240, filed 10/28/13, effective 1/1/14. Statutory Authority: RCW 41.05.160. WSR 12-20-022 (Order 2012-01), § 182-08-240, filed 9/25/12, effective 11/1/12.]

***(Effective until January 1, 2021)***

**WAC 182-08-245 Employer group participation requirements.** This section applies to an employer group as defined in WAC 182-08-015 that is approved to purchase insurance for its employees through a contract with the health care authority (HCA).

(1) Prior to enrollment of employees in public employees benefits board (PEBB) insurance coverage, the employer group must:

(a) Remit to the authority the required start-up fee in the amount publicized by the PEBB program;

(b) Sign a contract with the authority;



(c) Determine employee and dependent eligibility and terms of enrollment for PEBB insurance coverage by the criteria outlined in this chapter and chapter 182-12 WAC unless otherwise approved by the authority in the employer group's contract with the authority;

(d) Determine eligibility in order to ensure the PEBB program's continued status as a governmental plan under Section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA) as amended. This means the employer group may only consider 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 to be eligible; and

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

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

(a) The premium rate structure for educational service districts purchasing PEBB insurance coverage for nonrepresented employees will be a composite rate equal to the rate charged to state agencies plus an amount equal to the employee premium based on health plan election and family enrollment. Educational service districts must collect an amount equal to the premium surcharges applied to an employee's account by the authority from their nonrepresented employees and include the funds in their payment to the authority.

**Exception:** The authority will allow educational service districts that enrolled prior to September 1, 2002, to continue participation based on a tiered rate structure. The authority may require the district to change to a composite rate structure with ninety days advance written notice.

(b) The premium rate structure for employer groups other than educational service districts described in (a) of this subsection will be a tiered rate based on health plan election and family enrollment. Employer groups must collect an amount equal to the premium surcharges applied to an employee's account by the authority from their employees and include the funds in their payment to the authority.

**Exception:** The authority will allow employer groups that enrolled prior to January 1, 1996, to continue to participate based on a composite rate structure. The authority may require the employer group to change to a tiered rate structure with ninety days advance written notice.

(3) Counties, municipalities, political subdivisions, and tribal governments must pay the monthly employer group rate surcharge in the amount invoiced by the authority.

(4) If an employer group wants to make subsequent changes to the contract, the changes must be submitted to the authority for approval.

(5) The employer group must maintain participation in PEBB insurance coverage for at least one full year. An employer group may only end participation at the end of a plan year unless the authority approves a mid-year termination. To end participation, an employer group must provide written notice to the PEBB program at least sixty days before the requested termination date.

(6) Upon approval to purchase insurance through a contract with the authority, the employer group must provide a list of employees and dependents that are enrolled in Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage and the remaining number of months available to them based on their qualifying event. These employees and dependents may enroll in a PEBB health plan as COBRA subscribers for the remainder of the months available to them based on their qualifying event.

(7) Enrollees in PEBB insurance coverage under one of the continuation of coverage provisions allowed under chapter 182-12 WAC or retirees included in the transfer unit as allowed under WAC 182-08-237

cease to be eligible as of the last day of the contract and may not continue enrollment beyond the end of the month in which the contract is terminated.

**Exception:** If an employer group, other than an educational service district, ends participation, retired and disabled employees who began participation before September 15, 1991, are eligible to continue enrollment in PEBB insurance coverage if the employee continues to meet the procedural and eligibility requirements of WAC 182-12-171. Employees who enrolled after September 15, 1991, who are enrolled in PEBB retiree insurance coverage cease to be eligible under WAC 182-12-171, but may continue health plan enrollment under COBRA (see WAC 182-12-146).

[Statutory Authority: RCW 41.05.021, 41.05.160, and PEBB policy resolutions. WSR 19-17-073 (Admin #2019-01), § 182-08-245, filed 8/20/19, effective 1/1/20; WSR 17-19-077 (Order 2017-01), § 182-08-245, filed 9/15/17, effective 1/1/18. Statutory Authority: RCW 41.05.021, 41.05.160, 2016 c 67, and PEBB policy resolutions. WSR 16-20-080, § 182-08-245, filed 10/4/16, effective 1/1/17. Statutory Authority: RCW 41.05.160, 2015 c 116, and PEBB policy resolutions. WSR 15-22-099 (PEBB Admin # 2015-01 Rev 1), § 182-08-245, filed 11/4/15, effective 1/1/16. Statutory Authority: RCW 41.05.160 and 2013 2nd sp.s. c 4. WSR 14-20-058 (PEBB Admin 2014-02), § 182-08-245, filed 9/25/14, effective 1/1/15. Statutory Authority: RCW 41.05.160, 2013 2nd sp.s. c 4 and PEBB policy resolutions. WSR 14-08-040, § 182-08-245, filed 3/26/14, effective 4/26/14. Statutory Authority: RCW 41.05.160 and 2012 2nd sp.s. c 3. WSR 13-22-019 (Admin. 2013-01), § 182-08-245, filed 10/28/13, effective 1/1/14. Statutory Authority: RCW 41.05.160. WSR 12-20-022 (Order 2012-01), § 182-08-245, filed 9/25/12, effective 11/1/12.]

***(Effective January 1, 2021)***

**WAC 182-08-245 Employer group and board members of school districts and educational service districts participation requirements.** This section applies to an employer group as defined in WAC 182-08-015 or board members of school districts or educational service districts that is approved to purchase insurance for its employees through a contract with the health care authority (HCA).

(1) Prior to enrollment of employees in public employees benefits board (PEBB) insurance coverage, the employer group or board members of school districts or educational service districts must:

(a) Remit to the authority the required start-up fee in the amount publicized by the PEBB program;

(b) Sign a contract with the authority;

(c) Determine employee and dependent eligibility and terms of enrollment for PEBB insurance coverage by the criteria outlined in this chapter and chapter 182-12 WAC unless otherwise approved by the authority in the employer group's contract with the authority;

(d) Determine eligibility in order to ensure the PEBB program's continued status as a governmental plan under Section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA) as amended. This means the employer group may only consider 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 to be eligible; and

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

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

(a) The premium rate structure for educational service districts purchasing PEBB insurance coverage for nonrepresented employees will be a composite rate equal to the rate charged to state agencies plus an amount equal to the employee premium based on health plan election and family enrollment. Educational service districts must collect an amount equal to the premium surcharges applied to an employee's account by the authority from their nonrepresented employees and include the funds in their payment to the authority.

**Exception:** The authority will allow educational service districts that enrolled prior to September 1, 2002, to continue participation based on a tiered rate structure. The authority may require the district to change to a composite rate structure with ninety days advance written notice.

(b) The premium rate structure for employer groups other than educational service districts described in (a) of this subsection and board members of school districts and educational service districts will be a tiered rate based on health plan election and family enrollment. Employer groups must collect an amount equal to the premium surcharges applied to an employee's account by the authority from their employees and include the funds in their payment to the authority.

**Exception:** The authority will allow employer groups that enrolled prior to January 1, 1996, to continue to participate based on a composite rate structure. The authority may require the employer group to change to a tiered rate structure with ninety days advance written notice.

(3) Counties, municipalities, political subdivisions, and tribal governments must pay the monthly employer group rate surcharge in the amount invoiced by the authority.

(4) If an employer group or board member of school districts and educational service districts want to make subsequent changes to the contract, the changes must be submitted to the authority for approval.

(5) The employer group or board members of school districts and educational service districts must maintain participation in PEBB insurance coverage for at least one full year. An employer group or board members of school districts and educational service districts may only end participation at the end of a plan year unless the authority approves a mid-year termination. To end participation, an employer group or member of school districts and educational service districts must provide written notice to the PEBB program at least sixty days before the requested termination date.

(6) Upon approval to purchase insurance through a contract with the authority, the employer group must provide a list of employees and dependents that are enrolled in Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage and the remaining number of months available to them based on their qualifying event. These employees and dependents may enroll in a PEBB health plan as COBRA subscribers for the remainder of the months available to them based on their qualifying event.

(7) Enrollees in PEBB insurance coverage under one of the continuation of coverage provisions allowed under chapter 182-12 WAC or retirees included in the transfer unit as allowed under WAC 182-08-237 cease to be eligible as of the last day of the contract and may not continue enrollment beyond the end of the month in which the contract is terminated.

**Exception:** If an employer group, other than an educational service district, ends participation, retired and disabled employees who began participation before September 15, 1991, are eligible to continue enrollment in PEBB insurance coverage if the employee continues to meet the procedural and eligibility requirements of WAC 182-12-171. Employees who enrolled after September 15, 1991, who are enrolled in PEBB retiree insurance coverage cease to be eligible under WAC 182-12-171, but may continue health plan enrollment under COBRA (see WAC 182-12-146).

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 20-16-062 (Admin #2020-03), § 182-08-245, filed 7/28/20, effective 1/1/21. Statuto-

ry Authority: RCW 41.05.021, 41.05.160, and PEBB policy resolutions. WSR 19-17-073 (Admin #2019-01), § 182-08-245, filed 8/20/19, effective 1/1/20; WSR 17-19-077 (Order 2017-01), § 182-08-245, filed 9/15/17, effective 1/1/18. Statutory Authority: RCW 41.05.021, 41.05.160, 2016 c 67, and PEBB policy resolutions. WSR 16-20-080, § 182-08-245, filed 10/4/16, effective 1/1/17. Statutory Authority: RCW 41.05.160, 2015 c 116, and PEBB policy resolutions. WSR 15-22-099 (PEBB Admin # 2015-01 Rev 1), § 182-08-245, filed 11/4/15, effective 1/1/16. Statutory Authority: RCW 41.05.160 and 2013 2nd sp.s. c 4. WSR 14-20-058 (PEBB Admin 2014-02), § 182-08-245, filed 9/25/14, effective 1/1/15. Statutory Authority: RCW 41.05.160, 2013 2nd sp.s. c 4 and PEBB policy resolutions. WSR 14-08-040, § 182-08-245, filed 3/26/14, effective 4/26/14. Statutory Authority: RCW 41.05.160 and 2012 2nd sp.s. c 3. WSR 13-22-019 (Admin. 2013-01), § 182-08-245, filed 10/28/13, effective 1/1/14. Statutory Authority: RCW 41.05.160. WSR 12-20-022 (Order 2012-01), § 182-08-245, filed 9/25/12, effective 11/1/12.]