WSR 11-21-025
PERMANENT RULES
DEPARTMENT OF
SOCIAL AND HEALTH SERVICES
(Economic Services Administration)
[Filed October 11, 2011, 11:20 a.m., effective October 29, 2011]

Effective Date of Rule: October 29, 2011.

Other Findings Required by Other Provisions of Law as Precondition to Adoption or Effectiveness of Rule: These rules become permanent effective October 29, 2011, which is less than thirty-one days after filing. RCW 34.05.380 (3)(a) states that a rule may become effective on an earlier date if the action is required by state or federal constitution, a statute or court order. The current emergency rule (WSR 11-14-078) that allows the department to disregard federal income tax refunds received after December 31, 2009, as income in the month received and as a resource for twelve months expires October 28, 2011. Without this rule, the department will not be able to disregard federal income tax refunds when determining eligibility for any program that is funded in whole or in part with federal funds. This will result in the department [being] out of compliance with federal requirements.

These changes are necessary to comply with "The Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010" announcement dated December 17, 2010, and in response to the United States Department of Health and Human Services instructions dated January 20, 2011, and the United States Department of Agriculture Food and Nutrition Services memo dated February 1, 2011, mandating the exclusion of income tax refunds from consideration as income in the month received and as a resource for twelve months in any program that is funded in whole or part with federal funds.

Purpose: The department is amending WAC 388-450-0015, 388-455-0005, 388-470-0045, 388-470-0055, 388-475-0550 and 388-475-0860, in order to disregard federal income tax refunds received after December 31, 2009, as income in the month received and as a resource for twelve months when determining eligibility for any program that is funded in whole or in part with federal funds.

Citation of Existing Rules Affected by this Order: Amending WAC 388-450-0015, 388-455-0005, 388-470-0045, 388-470-0055, 388-475-0550, and 388-475-0860.

Statutory Authority for Adoption: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and chapter 74.12 RCW.

Other Authority: "The Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010" announcement dated December 17, 2010.

Adopted under notice filed as WSR 11-16-100 on August 3, 2011.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 6, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 6, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 6, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: October 6, 2011.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 10-17-103, filed 8/17/10, effective 8/19/10)

WAC 388-450-0015 What types of income ((~~does~~)) are not used by the department ((~~not use~~)) to figure out my benefits? This section applies to cash assistance, children's, family, or pregnancy medical, and basic food benefits.

(1) There are some types of income we do not count to figure out if you can get benefits and the amount you can get. Some examples of income we do not count are:

(a) Bona fide loans as defined in WAC 388-470-0045, except certain student loans as specified under WAC 388-450-0035;

(b) Federal income tax refunds and earned income tax credit (EITC) payments in the month received;

(c) Federal economic stimulus payments that are excluded for federal and federally assisted state programs;

(d) Federal twenty-five dollar supplemental weekly unemployment compensation payment authorized by the American Recovery and Reinvestment Act of 2009;

(e) Title IV-E and state foster care maintenance payments if you choose not to include the foster child in your assistance unit;

(f) Energy assistance payments;

(g) Educational assistance we do not count under WAC 388-450-0035;

(h) Native American benefits and payments we do not count under WAC 388-450-0040;

(i) Income from employment and training programs we do not count under WAC 388-450-0045;

(j) Money withheld from a benefit to repay an overpayment from the same income source. For Basic Food, we **do not** exclude money that is withheld because you were overpaid for purposely not meeting requirements of a federal, state, or local means tested program such as TANF/SFA, GA, and SSI;

(k) Legally obligated child support payments received by someone who gets TANF/SFA benefits;

(l) One-time payments issued under the Department of State or Department of Justice Reception and Replacement Programs, such as Voluntary Agency (VOLAG) payments; and

(m) Payments we are directly told to exclude as income under state or federal law.

(n) **For cash and Basic Food:** Payments made to someone outside of the household for the benefits of the assistance unit using funds that are not owed to the household;

(o) **For Basic Food only:** The total monthly amount of all legally obligated current or back child support payments

paid by the assistance unit to someone outside of the assistance unit for:

(i) A person who is not in the assistance unit; or

(ii) A person who is in the assistance unit to cover a period of time when they were not living with the member of the assistance unit responsible for paying the child support on their behalf.

(p) **For medical assistance:** Only the portion of income used to repay the cost of obtaining that income source.

(2) For children's, family, or pregnancy medical, we also do not count any insurance proceeds or other income you have recovered as a result of being a Holocaust survivor.

AMENDATORY SECTION (Amending WSR 10-15-069, filed 7/16/10, effective 8/16/10)

WAC 388-455-0005 How do lump sum payments affect benefits? (1) A lump sum payment is money that someone receives but does not expect to receive on a continuing basis.

(2) For cash assistance and family medical programs, we count a lump sum payment:

(a) As a resource, under WAC 388-455-0010, if it was awarded for wrongful death, personal injury, damage, or loss of property.

(b) As income, under WAC 388-455-0015, if it was received for any other reason, with the exception of subsection (3) and (4) of this section.

(3) For medical programs, receipt of a lump sum by a member of a federally recognized tribe from exercising federally protected rights or extraction of exempt resources is considered an exempt resource in the month of receipt. Any amounts remaining on the first of the next month will be counted if they remain in the form of a countable resource. Any amounts remaining the first of the month after conversion will remain exempt if they are in the form of an exempt resource.

(4) For cash and family medical programs, tax refunds and earned income tax lump sums are excluded as income and excluded as a resource for twelve months from the date of receipt.

(5) For Basic Food, we count lump sum payments for a previous period as a resource under WAC 388-470-0055. We count any amount for current or future months as income to your assistance unit.

AMENDATORY SECTION (Amending WSR 10-15-069, filed 7/16/10, effective 8/16/10)

WAC 388-470-0045 How do my resources count toward the resource limits for cash assistance and family medical programs? (1) We count the following resources toward your assistance unit's resource limits for cash assistance and family medical programs to decide if you are eligible for benefits under WAC 388-470-0005:

(a) Liquid resources not specifically excluded in subsection (2) below. These are resources that are easily changed into cash. Some examples of liquid resources are:

(i) Cash on hand;

(ii) Money in checking or savings accounts;

(iii) Money market accounts or certificates of deposit (CDs) less any withdrawal penalty;

(iv) Available retirement funds or pension benefits, less any withdrawal penalty;

(v) Stocks, bonds, annuities, or mutual funds less any early withdrawal penalty;

(vi) Available trusts or trust accounts;

(vii) Lump sum payments as described in chapter 388-455 WAC; or

(viii) Any funds retained beyond the month of receipt from conversion of federally protected rights or extraction of exempt resources by members of a federally recognized tribe that are in the form of countable resources.

(b) The cash surrender value (CSV) of whole life insurance policies.

(c) The CSV over fifteen hundred dollars of revocable burial insurance policies or funeral agreements.

(d) The amount of a child's irrevocable educational trust fund that is over four thousand dollars per child.

(e) Funds withdrawn from an individual development account (IDA) if they were removed for a purpose other than those specified in RCW 74.08A.220.

(f) Any real property like a home, land or buildings not specifically excluded in subsection (3) below.

(g) The equity value of vehicles as described in WAC 388-470-0070.

(h) Personal property that is not:

(i) A household good;

(ii) Needed for self-employment; or

(iii) Of "great sentimental value," due to personal attachment or hobby interest.

(i) Resources of a sponsor as described in WAC 388-470-0060.

(j) For cash assistance only, sales contracts.

(2) The following types of liquid resources do not count when we determine your eligibility:

(a) Bona fide loans, including student loans;

(b) Basic Food benefits;

(c) Income tax refunds ((~~in the month~~)) for twelve months from the date of receipt;

(d) Earned income tax credit (EITC) in the month received and ((~~the following~~)) for up to twelve months;

(e) Advance earned income tax credit payments;

(f) Federal economic stimulus payments that are excluded for federal and federally assisted state programs;

(g) Individual development accounts (IDAs) established under RCW 74.08A.220;

(h) Retroactive cash benefits or TANF/SFA benefits resulting from a court order modifying a decision of the department;

(i) Underpayments received under chapter 388-410 WAC;

(j) Educational benefits that are excluded as income under WAC 388-450-0035;

(k) The income and resources of an SSI recipient;

(l) A bank account jointly owned with an SSI recipient if SSA already counted the money for SSI purposes;

(m) Foster care payments provided under Title IV-E and/or state foster care maintenance payments;

(n) Adoption support payments;

(o) Self-employment accounts receivable that the client has billed to the customer but has been unable to collect;

(p) Resources specifically excluded by federal law; and

(q) For medical benefits, receipts from exercising federally protected rights or extracted exempt resources (fishing, shell-fishing, timber sales, etc.) during the month of receipt for a member of a federally recognized tribe.

(3) The following types of real property do not count when we determine your eligibility:

(a) Your home and the surrounding property that you, your spouse, or your dependents live in;

(b) A house you do not live in, if you plan on returning to the home and you are out of the home because of:

(i) Employment;

(ii) Training for future employment;

(iii) Illness; or

(iv) Natural disaster or casualty.

(c) Property that:

(i) You are making a good faith effort to sell;

(ii) You intend to build a home on, if you do not already own a home;

(iii) Produces income consistent with its fair market value, even if used only on a seasonal basis; or

(iv) A household member needs for employment or self-employment. Property excluded under this section and used by a self-employed farmer or fisher retains its exclusion for one year after the household member stops farming or fishing.

(d) Indian lands held jointly with the tribe, or land that can be sold only with the approval of the Bureau of Indian Affairs.

(4) If you deposit excluded liquid resources into a bank account with countable liquid resources, we do not count the excluded liquid resources for six months from the date of deposit.

(5) If you sell your home, you have ninety days to reinvest the proceeds from the sale of a home into an exempt resource.

(a) If you do not reinvest within ninety days, we will determine whether there is good cause to allow more time. Some examples of good cause are:

(i) Closing on your new home is taking longer than anticipated;

(ii) You are unable to find a new home that you can afford;

(iii) Someone in your household is receiving emergent medical care; or

(iv) Your children are in school and moving would require them to change schools.

(b) If you have good cause, we will give you more time based on your circumstances.

(c) If you do not have good cause, we count the money you got from the sale as a resource.

AMENDATORY SECTION (Amending WSR 08-18-043, filed 8/29/08, effective 10/1/08)

WAC 388-470-0055 How do my resources count toward the resource limit for Basic Food? (1) For Basic Food, if your assistance unit (AU) is not categorically eligible (CE) under WAC 388-414-0001, we count the following resources toward your AU's resource limit to decide if you are eligible for benefits under WAC 388-470-0005:

(a) Liquid resources. These are resources that are easily changed into cash. Some examples of liquid resources are:

(i) Cash on hand;

(ii) Money in checking or savings accounts;

(iii) Money market accounts or certificates of deposit (CDs) less any withdrawal penalty;

(iv) Stocks, bonds, annuities, or mutual funds less any early withdrawal penalty;

(v) Available trusts or trust accounts; or

(vi) Lump sum payments. A lump sum payment is money owed to you from a past period of time that you get but do not expect to get on a continuing basis.

(b) Nonliquid resources, personal property, and real property not specifically excluded in subsection (2) below.

(c) Vehicles as described in WAC 388-470-0075.

(d) The resources of a sponsor as described in WAC 388-470-0060.

(2) The following resources do not count toward your resource limit:

(a) Your home and the surrounding property that you, your spouse, or your dependents live in;

(b) A house you do not live in, if you plan on returning to the home and you are out of the home because of:

(i) Employment;

(ii) Training for future employment;

(iii) Illness; or

(iv) Natural disaster or casualty.

(c) Property that:

(i) You are making a good faith effort to sell;

(ii) You intend to build a home on, if you do not already own a home;

(iii) Produces income consistent with its fair market value, even if used only on a seasonal basis;

(iv) Is essential to the employment or self-employment of a household member. Property excluded under this section and used by a self-employed farmer or fisher retains its exclusion for one year after the household member stops farming or fishing; or

(v) Is essential for the maintenance or use of an income-producing vehicle; or

(vi) Has an equity value equal to or less than half of the resource limit as described in WAC 388-470-0005.

(d) Household goods

(e) Personal effects;

(f) Life insurance policies, including policies with cash surrender value (CSV);

(g) One burial plot per household member;

(h) One funeral agreement per household member, up to fifteen hundred dollars;

(i) Pension plans or retirement funds not specifically counted in subsection (1) above;

(j) Sales contracts, if the contract is producing income consistent with its fair market value;

(k) Government payments issued for the restoration of a home damaged in a disaster;

(l) Indian lands held jointly with the Tribe, or land that can be sold only with the approval of the Bureau of Indian Affairs;

(m) Nonliquid resources that have a lien placed against them;

(n) Earned Income Tax Credits (EITC):

(i) For twelve months, if you were a Basic Food recipient when you got the EITC and you remain on Basic Food for all twelve months; or

(ii) The month you get it and the month after, if you were not getting Basic Food when you got the EITC.

(o) Energy assistance payments or allowances;

(p) The resources of a household member who gets SSI, TANF/SFA, or GA benefits;

(q) Retirement funds or accounts that are tax exempt under the Internal Revenue Code;

(r) Education funds or accounts in a tuition program under section 529 or 530 of the Internal Revenue Code; ((~~and~~))

(s) Resources specifically excluded by federal law; and

(t) Federal income tax refunds for twelve months whether or not you were receiving Basic Food assistance at the time you got the refund.

(3) If you deposit excluded liquid resources into a bank account with countable liquid resources, we do not count the excluded liquid resources for six months from the date of deposit. **Exception:** Federal tax refunds are not counted for twelve months even when mixed with countable resources.

(4) If you sell your home, you have ninety days to reinvest the proceeds from the sale of a home into an exempt resource.

(a) If you do not reinvest within ninety days, we will determine whether there is good cause to allow more time. Some examples of good cause are:

(i) Closing on your new home is taking longer than anticipated;

(ii) You are unable to find a new home that you can afford;

(iii) Someone in your household is receiving emergent medical care; or

(iv) Your children are in school and moving would require them to change schools.

(b) If you have good cause, we will give you more time based on your circumstances.

(c) If you do not have good cause, we count the money you got from the sale as a resource.

AMENDATORY SECTION (Amending WSR 10-15-069, filed 7/16/10, effective 8/16/10)

WAC 388-475-0550 SSI-related medical—All other excluded resources. All resources described in this section are excluded resources for SSI-related medical programs. Unless otherwise stated, interest earned on the resource amount is counted as unearned income.

(1) Resources necessary for a client who is blind or disabled to fulfill a department approved self-sufficiency plan.

(2) Retroactive payments from SSI or RSDI, including benefits a client receives under the interim assistance reimbursement agreement with the Social Security Administration, are excluded for nine months following the month of receipt. This exclusion applies to:

(a) Payments received by the client, spouse, or any other person financially responsible for the client;

(b) SSI payments for benefits due for the month(s) before the month of continuing payment;

(c) RSDI payments for benefits due for a month that is two or more months before the month of continuing payment; and

(d) Proceeds from these payments as long as they are held as cash, or in a checking or savings account. The funds may be commingled with other funds, but must remain identifiable from the other funds for this exclusion to apply. This exclusion does not apply once the payments have been converted to any other type of resource.

(3) All resources specifically excluded by federal law, such as those described in subsections (4) through (12) as long as such funds are identifiable.

(4) Payments made under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.

(5) Payments made to Native Americans as listed in 20 CFR 416.1182, Appendix to subpart K, section IV, paragraphs (b) and (c), and in 20 CFR 416.1236.

(6) The following Native American/Alaska Native funds are excluded resources:

(a) Resources received from a native corporation under the Alaska Native Claims Settlement Act, including:

(i) Shares of stock held in a regional or village corporation;

(ii) Cash or dividends on stock received from the native corporation up to two thousand dollars per person per year;

(iii) Stock issued by a native corporation as a dividend or distribution on stock;

(iv) A partnership interest;

(v) Land or an interest in land; and

(vi) An interest in a settlement trust.

(b) All funds contained in a restricted individual Indian money (IIM) account.

(7) Exercise of federally protected rights, including extraction of exempt resources by a member of a federally recognized tribe during the month of receipt. Any funds from the conversion of the exempt resource which are retained on the first of the month after the month of receipt will be considered exempt if they are in the form of an exempt resource, and will be countable if retained in the form of a countable resource.

(8) Restitution payment and any interest earned from this payment to persons of Japanese or Aleut ancestry who were relocated and interned during war time under the Civil Liberties Act of 1988 and the Aleutian and Pribilof Islands Restitution Act.

(9) Funds received from the Agent Orange Settlement Fund or any other funds established to settle Agent Orange liability claims.

(10) Payments or interest accrued on payments received under the Radiation Exposure Compensation Act received by the injured person, the surviving spouse, children, grandchildren, or grandparents.

(11) Payments or interest accrued on payments received under the Energy Employees Occupational Illness Compensation Act of 2000 (EEOICA) received by the injured person, the surviving spouse, children, grandchildren, or grandparents.

(12) Payments from:

(a) The Dutch government under the Netherlands' Act on Benefits for Victims of Persecution (WUV).

(b) The Victims of Nazi Persecution Act of 1994 to survivors of the Holocaust.

(c) Susan Walker vs. Bayer Corporation, et al., 96-C-5024 (N.D. Ill.) (May 8, 1997) settlement funds.

(d) Ricky Ray Hemophilia Relief Fund Act of 1998 P.L. 105-369.

(13) The unspent social insurance payments received due to wage credits granted under sections 500 through 506 of the Austrian General Social Insurance Act.

(14) Tax refunds and earned income tax credit refunds and payments are excluded as resources for ((~~nine~~)) twelve months after the month of receipt.

(15) Payments from a state administered victim's compensation program for a period of nine calendar months after the month of receipt.

(16) Cash or in-kind items received as a settlement for the purpose of repairing or replacing a specific excluded resource are excluded:

(a) For nine months. This includes relocation assistance provided by state or local government.

(b) Up to a maximum of thirty months, when:

(i) The client intends to repair or replace the excluded resource; and

(ii) Circumstances beyond the control of the settlement recipient prevented the repair or replacement of the excluded resource within the first or second nine months of receipt of the settlement.

(c) For an indefinite period, if the settlement is from federal relocation assistance.

(d) Permanently, if the settlement is assistance received under the Disaster Relief and Emergency Assistance Act or other assistance provided under a federal statute because of a catastrophe which is declared to be a major disaster by the President of the United States, or is comparable assistance received from a state or local government or from a disaster assistance organization. Interest earned on this assistance is also excluded from resources. Any cash or in-kind items received as a settlement and excluded under this subsection are considered as available resources when not used within the allowable time periods.

(17) Insurance proceeds or other assets recovered by a Holocaust survivor as defined in WAC 388-470-0026(4).

(18) Pension funds owned by an ineligible spouse. Pension funds are defined as funds held in a(n):

(a) Individual retirement account (IRA) as described by the IRS code; or

(b) Work-related pension plan (including plans for self-employed individuals, known as Keogh plans).

(19) Cash payments received from a medical or social service agency to pay for medical or social services are excluded for one calendar month following the month of receipt.

(20) SSA- or DVR-approved plans for achieving self-support (PASS) accounts, allowing blind or disabled individuals to set aside resources necessary for the achievement of the plan's goals, are excluded.

(21) Food and nutrition programs with federal involvement. This includes Washington Basic Food, school reduced and free meals and milk programs and WIC.

(22) Gifts to, or for the benefit of, a person under eighteen years old who has a life-threatening condition, from an organization described in section 501 (c)(3) of the Internal Revenue Code of 1986 which is exempt from taxation under section 501(a) of that code, as follows:

(a) In-kind gifts that are not converted to cash; or

(b) Cash gifts up to a total of two thousand dollars in a calendar year.

(23) Veteran's payments made to, or on behalf of, natural children of Vietnam veterans regardless of their age or marital status, for any disability resulting from spina bifida suffered by these children.

(24) The following are among assets that are not considered resources and as such are neither excluded nor counted:

(a) Home energy assistance/support and maintenance assistance;

(b) Retroactive in-home supportive services payments to ineligible spouses and parents; and

(c) Gifts of domestic travel tickets. For a more complete list please see POMS @ http://policy.ssa.gov/poms.nsf/lnx/0501130050.

AMENDATORY SECTION (Amending WSR 06-04-046, filed 1/26/06, effective 2/26/06)

WAC 388-475-0860 SSI-related medical—Income exclusions under federal statute or other state laws. The Social Security Act and other federal statutes or state laws list income that the department excludes when determining eligibility for SSI-related medical programs. These exclusions include, but are not limited to:

(1) Income tax refunds;

(2) Federal earned income tax credit (EITC) payments for ((~~nine~~)) twelve months after the month of receipt;

(3) Compensation provided to volunteers in the Corporation for National and Community Service (CNCS), formerly known as ACTION programs established by the Domestic Volunteer Service Act of 1973. P.L. 93-113;

(4) Assistance to a person (other than wages or salaries) under the Older Americans Act of 1965, as amended by section 102 (h)(1) of Pub. L. 95-478 (92 Stat. 1515, 42 U.S.C. 3020a);

(5) Federal, state and local government payments including assistance provided in cash or in-kind under any government program that provides medical or social services;

(6) Certain cash or in-kind payments a client receives from a governmental or nongovernmental medical or social service agency to pay for medical or social services;

(7) Value of food provided through a federal or nonprofit food program such as WIC, donated food program, school lunch program;

(8) Assistance based on need, including:

(a) Any federal SSI income or state supplement payment (SSP) based on financial need;

(b) Food stamps;

(c) GA-U;

(d) CEAP;

(e) TANF; and

(f) Bureau of Indian Affairs (BIA) general assistance.

(9) Housing assistance from a federal program such as HUD if paid under:

(a) United States Housing Act of 1937 (section 1437 et seq. of 42 U.S.C.);

(b) National Housing Act (section 1701 et seq. of 12 U.S.C.);

(c) Section 101 of the Housing and Urban Development Act of 1965 (section 1701s of 12 U.S.C., section 1451 of 42 U.S.C.);

(d) Title V of the Housing Act of 1949 (section 1471 et seq. of 42 U.S.C.); or

(e) Section 202(h) of the Housing Act of 1959;

(f) Weatherization provided to low-income homeowners by programs that consider income in the eligibility determinations;

(10) Energy assistance payments including:

(a) Those to prevent fuel cutoffs, and

(b) To promote energy efficiency.

(11) Income from employment and training programs as specified in WAC 388-450-0045.

(12) Foster grandparents program;

(13) Title IV-E and state foster care maintenance payments if the foster child is not included in the assistance unit;

(14) The value of any childcare provided or arranged (or any payment for such care or reimbursement for costs incurred for such care) under the Child Care and Development Block Grant Act, as amended by section 8(b) of P.L. 102-586 (106 Stat. 5035).

(15) Educational assistance as specified in WAC 388-450-0035.

(16) Up to two thousand dollars per year derived from an individual's interest in Indian trust or restricted land.

(17) Native American benefits and payments as specified in WAC 388-450-0040 and other Native American payments excluded by federal statute. For a complete list of these payments, see 20 CFR 416, Subpart K, Appendix, IV.

(18) Payments from Susan Walker v. Bayer Corporation, et al., 96-c-5024 (N.D. Ill) (May 8, 1997) settlement funds;

(19) Payments from Ricky Ray Hemophilia Relief Fund Act of 1998, P.L. 105-369;

(20) Disaster assistance paid under Federal Disaster Relief P.L. 100-387 and Emergency Assistance Act, P.L. 93-288 amended by P.L. 100-707 and for farmers P.L. 100-387;

(21) Payments to certain survivors of the Holocaust as victims of Nazi persecution; payments excluded pursuant to section 1(a) of the Victims of Nazi Persecution Act of 1994, P.L. 103-286 (108 Stat. 1450);

(22) Payments made under section 500 through 506 of the Austrian General Social Insurance Act;

(23) Payments made under the Netherlands' Act on Benefits for Victims of Persecution (WUV);

(24) Restitution payments and interest earned to Japanese Americans or their survivors, and Aleuts interned during World War II, established by P.L. 100-383;

(25) Payments made from the Agent Orange Settlement Funds or any other funds to settle Agent Orange liability claims established by P.L. 101-201;

(26) Payments made under section six of the Radiation Exposure Compensation Act established by P.L. 101-426;

(27) Any interest or dividend is excluded as income, except for the community spouse of an institutionalized individual.

WSR 11-22-002
PERMANENT RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 11-282—Filed October 19, 2011, 5:23 p.m., effective November 19, 2011]

Effective Date of Rule: Thirty-one days after filing.

Purpose: Update the rules regarding issuing licenses by the department, and eliminate those rules that are no longer applicable. Provide clarification of licensing regulations and make the rules consistent with changes made by the legislature earlier this year in SSB 5385.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-55-120, 220-55-132 and 220-55-175; and amending WAC 220-55-040, 220-55-115, 220-55-180, 220-55-200, and 232-12-168.

Statutory Authority for Adoption: RCW 77.08.045, 77.12.170, 77.12.177, 77.32.050, 77.32.240, 77.32.350, 77.32.370, 77.32.430, 77.32.450, 77.32.460, 77.32.470, 77.32.520, 77.32.580, 77.65.020, 77.65.090, 77.65.110, 77.65.150, 77.65.160, 77.65.170, 77.65.190, 77.65.200, 77.65.210, 77.65.220, 77.65.280, 77.65.340, 77.65.390, 77.65.440, 77.65.450, 77.65.480, 77.65.510, 77.70.080, 77.70.190, 77.70.220, 77.70.260, 77.70.490, 77.115.040, and 43.84.092.

Adopted under notice filed as WSR 11-17-139 on August 24, 2011.

Changes Other than Editing from Proposed to Adopted Version: **Changes from the Text of the Proposed Rules and Reasons for Difference: WAC 220-55-040 Recreational license, tag, permit, and stamp refunds and exchanges.**

- Throughout the rule, all references to the licensing division of the department or Olympia were changed to "the Olympia office of the department" for clarity and consistency.
- In subsection (2)(a), the term "clerical error" was undefined and subject to multiple interpretations. Therefore, this term was replaced with "dealer error" to identify the source of the error.
- In subsection (2)(b), language was change[d] from: "A license purchaser can obtain a refund from the Olympia office of the department at any time during the licensing year if a document has been issued in

error, and the error was not caused by the purchaser."

to:

"A license purchaser can obtain a refund from the Olympia office of the department at any time during the licensing year if an incorrect document has been issued due to a department, a dealer, or licensing system error, as verified by the department."

These changes further clarify the source of the document error and identify the party to verify the occurrence of an error.

- In subsections (2)(e) and (f), the word "verifying" was added to stipulate that the documentation provided would need to confirm that the license purchaser is active duty military personnel, was transferred or otherwise obligated by the military, and was unable to use the license purchased.
- In subsection (2)(e), "by the military" was added to clarify that the obligation would need to be associated with the license purchaser's military service.
- In subsections (2)(e) and (f), the timeframe in which a refund request must be made was changed from "… prior to the opening of the applicable general hunting season." to "… within the license year." This change was due to the fact that the department would have already received verification that the requester was unable to participate in the hunts for which the tag was issued.
- In subsection (3)(a), the verbiage "… or a permit could have been used, regardless of whether the person used the permit." was struck from the last sentence because it was redundant and confusing.
- In subsection (4)(a), specific dates, by which tag holders for each weapon type would be eligible for an exchange, were added to simplify the determination of eligibility and to exclude early muzzleloader and modern firearm hunts in limited geographic areas.
- In subsection (4)(c), "… as verified by the department." was added to identify the party to verify the occurrence and the source of an error.
- In subsection (5), "Except as otherwise provided, …" was added to clarify eligibility and ensure there is not a discrepancy in criteria.
- In subsection (5)(a), language was change[d] from:

  "It is unlawful to exchange a big game transport tag ((~~during or~~)) after the submission date has passed for a drawing for a special hunting season permit ((~~has occurred~~)), if the drawing requires the hunter to have the big game transport tag."

  to:

  "If a special hunt permit application was submitted by the tag holder and that application required a big game transport tag, it is unlawful to exchange the transport tag after the application submission deadline date has passed."

These changes were made for clarification and readability.

- In subsection (5)(a), "However, if the tag holder's request for a tag exchange was made prior to the application submission deadline date, as verified by the department, an exchange can be made." was added to allow the department, during periods of high volume workloads, to assist tag holders who requested exchanges before the deadlines provided in this rule.
- In subsection (5)(a), the verbiage, "regardless of the submission method" was added to clarify that the exception applied to both tag holders who submitted their special hunt applications with the ghost points option and tag holders for which the drawing system submitted their application for the ghost points option.
- Subsection (5)(b) was changed to subsection (6)(a) and the language was changed from:
  "It is unlawful to exchange a big game transport tag after the opening of the season for the tag is valid."
  to:
  "Except as otherwise provided, it is unlawful to possess a big game transport tag that was exchanged after the opening of the season for which the original tag was valid."
- The verbiage "Except as otherwise provided, …" was added to clarify tag exchange eligibility and ensure there is not a discrepancy in criteria. The remaining changes were to clarify who was subject to the penalties associated with a violation of RCW 77.15.410.

WAC 220-55-115 Recreational license dealer's fees.

- In subsection (1)(d), the temporary fishing license was changed from a two-day license to a one, two, or three day license.
- Subsections (2)(d) through (i) were added to reflect all applicable hunting licenses.
- Subsections (3)-(5) were renumbered to accommodate the changes below. The number references below reflect the renumeration.
- Subsection (3) was deleted as these items are no longer issued as separate documents.
- Subsection (4) was altered from "a discover pass" to "an annual discover pass" to distinguish between the annual pass and a one day pass.
- Subsection (5)(b) was deleted as the western Washington pheasant permit is currently a standalone license document that has a two dollar fee.
- Subsection (5)(c) was changed to clarify that the fifty cent fee applied to the harvest cards issued with a hunt authorization rather than to the hunt authorization itself.
- Subsections (5)(e) through (l) were added to reflect all items to which a fifty cent fee is applied.

WAC 220-55-180 Point-of-sale transaction fee.

- The word "recreational" was deleted from the first sentence of the rule due to the fact that the license

system is used for both recreational and commercial transactions.

WAC 220-55-200 Duplicate license fees.

- In subsection (3), "two-day fishing licenses" was changed to "one-day fishing licenses" and "additional access decals" was changed to "special hunt applications." These changes were made to bring the rule into compliance with recent legislation.

WAC 232-12-168 Fishing contests.

- None.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 5, Repealed 3.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 5, Repealed 3.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: October 19, 2011.

Miranda Wecker, Chair
Fish and Wildlife Commission

AMENDATORY SECTION (Amending Order 06-73, filed 4/11/06, effective 5/12/06)

WAC 220-55-040 Recreational license, tag, permit, and stamp refunds and exchanges. (1) For purposes of this section:

(a) "Refund" means the return of money received for a license, stamp, tag, or permit purchase. Refunds may be made by license dealers or the Olympia office of the department ((~~licensing office in Olympia~~)).

(b) "Exchange" means the surrendering of a transport tag (such as archery deer or Eastern Washington elk archery) and the reissuing of a different transport tag (such as muzzleloader deer or Western Washington muzzleloader elk).

(2) Refunds will be made for the following:

(a) A license purchaser can obtain a refund from a license dealer for sixty minutes after the purchase of the license if a ((~~clerical~~)) dealer error is made or the dealer issues the wrong license. License dealers can correct ((~~clerical~~)) dealer errors after sixty minutes, but may not refund license purchases.

(b) A license purchaser can obtain a refund from the Olympia office of the department at any time during the licensing year if ((~~a~~)) an incorrect document has been issued ((~~in~~)) due to a department, a dealer, or licensing system error, ((~~and the error was not caused by the purchaser~~)) as verified by the department.

(c) A license purchaser can obtain a refund from the Olympia office of the department if the purchase of a second license was made on behalf of the licensee by someone other than the licensee.

(d) A license purchaser can obtain a refund from the Olympia office of the department if the licensee qualifies for a reduced fee license, but the refund amount will be the difference between the license purchased and the reduced fee license.

(e) A license purchaser who is active duty military and is transferred or otherwise obligated by the military and unable to use a license can obtain a refund from the Olympia office of the department after providing verifying documentation, provided that the request for refund is made ((~~prior to the opening of the applicable general hunting season~~)) within the license year.

(f) A license purchaser who is hospitalized or severely injured and provides a physician's statement that the person was incapable of participating in hunting can obtain a refund from the Olympia office of the department after providing verifying documentation, provided that the request for refund is made ((~~prior to the opening of the applicable general hunting season~~)) within the license year.

(g) The personal representative of a deceased license purchaser, who dies prior to the opening of the applicable general hunting season, can obtain a refund from Olympia after providing documentation of the death of the purchaser.

(3) Except as otherwise provided, refunds will not be made for the following:

(a) The department will not refund any recreational license or permit purchase for which a season or hunt has been scheduled, and the licensee could have participated in the season or hunt, regardless of whether the licensee did in fact participate ((~~or a permit could have been used, regardless of whether the person used the permit~~)).

(b) The department will not refund purchases of raffle tickets((~~,~~)) or special hunt permit applications ((~~or collector bird stamps~~)).

(4) Transport tag exchanges will be allowed for the following:

(a) The season for which the tag was issued has not opened, and the hunter wishes to exchange the tag for a different area or a different weapon type. In these instances archery tag holders must request a tag exchange before September 1st, muzzleloader tag holders must request a tag exchange before September 20th, and modern firearm tag holders must request a tag exchange before October 10th, as verified by the department.

(b) The hunter has killed an animal that is unfit for human consumption and the department has authorized issuance of an exchange tag.

(c) The tag was issued in error((~~,~~)) and the error was not caused by the person applying for the tag, as verified by the department.

(5) Except as otherwise provided, transport tag exchanges will not be allowed for the following:

((~~(a) It is unlawful to exchange a big game transport tag during or after a drawing for a special hunting season permit has occurred, if the drawing requires the hunter to have the big game transport tag.~~

~~(b)~~)) If a special hunt permit application was submitted by the tag holder and that application required a big game transport tag, it is unlawful to exchange the transport tag after the application submission deadline date has passed. However, if the tag holder's request for a tag exchange was made prior to the application submission deadline date, as verified by the department, an exchange can be made. Special permit applications for ghost hunts, regardless of the submission method, are not applicable to this subsection.

(6)(a) Except as otherwise provided, it is unlawful to ((~~exchange~~)) possess a big game transport tag that was exchanged after the opening of the season for which the original tag ((~~is~~)) was valid.

(((~~c~~))) (b) Violation of this subsection is punishable under RCW 77.15.410 Unlawful hunting of big game.

AMENDATORY SECTION (Amending Order 10-94, filed 4/30/10, effective 5/31/10)

WAC 220-55-115 Recreational license dealer's fees. The department and license dealers may charge a license issuance fee as follows:

(1) Two dollars for the issuance of any of the following fishing licenses:

(a) A combination license.

(b) A saltwater license.

(c) A freshwater license.

(d) A ((~~two-day~~)) one-, two-, or three-day temporary fishing license.

(e) A family fishing weekend license.

(f) A shellfish and seaweed license.

(g) A razor clam license.

(2) Two dollars for the issuance of any of the following hunting licenses:

(a) A big game combination license.

(b) A small game license.

(c) A three-consecutive day small game license.

(((~~(3) Two dollars for the issuance of a fish and wildlife lands vehicle use permit when issued separately from an annual freshwater, saltwater or combination fishing license, or separately from an annual small game hunting license, big game combination license, or trapping license.~~

~~(4)~~)) (d) A hunter education deferral for a big game license.

(e) A hunter education deferral for a small game license.

(f) A second animal license.

(g) A special hunt license for mountain goat, bighorn sheep, or moose.

(h) A Western Washington pheasant license.

(i) A three-day Western Washington pheasant license.

(3) Notwithstanding the provisions of this section, if any two or more licenses are issued at the same time, or the fish and wildlife lands vehicle ((~~use permit~~)) access pass is issued with any recreational license, the license issuance fee for the document is two dollars.

(((~~5~~))) (4) Two dollars for the issuance of an annual discover pass.

(5) Fifty cents for the issuance of any of the following:

(a) A deer, elk, bear, cougar, mountain goat, mountain sheep, moose, or turkey transport tag.

(b) ((~~A state of Washington migratory bird stamp.~~

~~(c) A Western Washington pheasant permit.~~

~~(d)~~)) An application for a special permit hunt.

(((~~(e) A~~))) (c) Migratory bird ((~~hunting authorization (including~~)) harvest report ((~~card~~))) cards issued with a hunt authorization.

(((~~(f)~~))) (d) A replacement of substitute special hunting season permit.

(e) A migratory bird permit.

(f) Additional fishing catch record cards.

(g) A Puget Sound crab endorsement.

(h) A temporary Puget Sound crab endorsement.

(i) A two-pole endorsement.

(j) A Columbia River salmon/steelhead endorsement.

(k) A one-day discover pass.

(l) Raffle tickets.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 220-55-120	Recreational licenses, stamps and tags—Inventory return.
WAC 220-55-132	Migratory bird validations and stamps.
WAC 220-55-175	Special license application for permanent annual combination licenses.

AMENDATORY SECTION (Amending Order 05-273, filed 12/9/05, effective 1/9/06)

WAC 220-55-180 Point-of-sale transaction fee. The point-of-sale transaction fee shall be used to operate an automated ((~~recreational~~)) licensing system. This fee shall be applied to all automated licensing system purchases of recreational and commercial documents. The transaction fee shall be ten percent of the value of the document transaction, excluding any applicable dealer fees ((~~except through June 30, 2007, the transaction fee shall be nine and one-half percent of the value of the document transaction, excluding any applicable dealer fee~~)).

AMENDATORY SECTION (Amending Order 02-153, filed 7/11/02, effective 8/11/02)

WAC 220-55-200 Duplicate license fees. (1) The cost of a duplicate license document is seven dollars, plus the automated licensing system processing fee and dealer fee, unless the cost of all licenses on the original license document was less than seven dollars, then the license document cost is the same as the original cost, plus the automated licensing system processing fee and dealer fee. The duplicate license document shall contain all licenses purchased at the time the original license document was issued, including a migratory waterfowl ((~~validation~~)) permit if such ((~~validation~~)) permit was purchased, but shall not include any game tags issued with the original license.

(2) The cost of a duplicate game tag is seven dollars per game tag, plus the automated licensing system processing fee and the dealer fee.

(3) The department will not issue duplicate ((~~two~~)) one-day fishing licenses issued as a charter stamp, ((~~duplicate collector migratory waterfowl stamps,~~)) duplicate ((~~additional access decals~~)) special hunt applications, or duplicate game raffle tickets.

AMENDATORY SECTION (Amending Order 09-27, filed 2/25/09, effective 5/1/09)

WAC 232-12-168 Fishing contests. (1) Contest defined: By definition, a fishing contest exists when 6 or more licensed persons fish competitively and determine winners, regardless of prize value.

(2) Application:

(a) Fishing contest permit applications should be submitted to the department by July 1 of each year for contests that are to take place the following calendar year. After July 1, applications must be submitted not less than 30 days prior to the date for which the contest is proposed.

(b) Applications must include the permit fee required by RCW 77.65.480. The fee will be returned if the permit is denied. No more than seven permits will be issued to any one permittee during a calendar year. ((~~The fee is $24 per permit.~~))

(c) For purposes of application for a fishing contest permit, "permittee" means a "person" as defined in RCW 77.08.010. All applications from a permittee must be in a single name.

(3) Approval:

(a) Fishing contests which adversely affect fish or wildlife resources or other recreational opportunity may be denied.

(b) Contests will not be allowed on sea-run cutthroat trout, wild steelhead, Dolly Varden or bull trout.

(c) During fishing contests, where anglers target tiger muskies, no retention of caught fish is allowed. Tiger muskies may be caught, measured for length, photographed and all fish must be immediately released alive.

(4) Prize value: Total prize value per contest will not exceed $5,000 when trout, steelhead, char, whitefish, grayling, tiger muskie, or kokanee are included as target species; provided that contests wherein other species not listed above are targeted, or where bass or walleye are the targeted species and at least 90 percent of bass or walleye are released alive and in good condition after the contest, may qualify for no limitation on amount of prize.

(5) Legal requirements, all contests:

(a) Fishing contest permits must be in the possession of the contest sponsor or official at the contest site.

(b) Contests are restricted to the species and waters approved on the permit. Only those species listed as a target of the contest may be retained by contest participants during bass or walleye contests where all contestants fish at the same time and place.

(c) Sponsors must report contest information requested by the department within 30 days after the contest has ended. Subsequent contest permits will not be issued for one year after the date of the contest for which the report was not returned if this requirement is not fulfilled.

(d) Contest participants may not restrict public access at boat launches.

(e) Contests for bass and walleye where participants expect to fish at the same time from boats on lakes or reservoirs will not last longer than four consecutive days and have the following limits per water:

ACRES	CONTESTS PER DAY	BOATS PER CONTEST DAY
Less than 300	1	15
301 - 3,000	1	35
3,001 - 6,000	2	75
6,001 - 10,000	2	120
More than 10,000	3	250

* No more than four weekend days per month nor more than two weekends per month may be scheduled on any water when contestants fish at the same time, and are allowed to fish from boats.

(f) It is unlawful for the fishing contest permittee or any of the contest participants to fail to comply with the conditions of the fishing contest permit, or of general fishing rules not specifically exempted by this permit. Failure of the permittee or any of the contestants to comply with all provisions of the contest permit or of other fishing regulations during a contest may lead to revocation of the permit and result in denial of fishing contest permits to the permittee and related organizations or individuals sponsoring contests for two years.

(6) Special regulations, bass and walleye contests:

(a) In any contest targeting either bass or walleye, all live bass or walleye must be released alive into the water from which they were caught after being weighed and/or measured. At the end of each day's competition, if the mortality of target fish caught that day exceeds 10%, the contest will be suspended. Suspended contests may be continued (within assigned permit dates) only if the cause of the high mortality can be positively identified, and the cause of the mortality (high waves, equipment deficiency, etc.) ceases or is corrected by contest officials.

(b) During bass and walleye contests only, participants may continue to fish while holding up to five fish in possession, as long as one fish is released immediately upon catching a fish which would make the angler in excess of five fish if kept. The fish released may come either from the one just caught, or from the livewell, but at no time may the angler have more than five fish in the livewell.

(c) During bass contests, contestants may not use live bait.

(d) During bass and walleye contests participants may retain up to five bass and walleye of any size to be weighed in. A tournament angler may not be in possession of more than five bass or walleye from the water being fished, except as authorized under (6)(e) below.

(e) The contest director or director designee may exceed possession limits for bass or walleye for the purpose of transporting fish from a weigh-in site to an open-water area. During transportation, the transport boat must not leave the water the fish were caught from and a copy of the contest permit must be on board during actual fish transport.

(f) Boat identification: All boats used for fishing in bass and walleye contests must be clearly identified according to criteria established by the department.

(7) Aquatic invasive species decontamination. Prior to launching into any Washington state body of water:

(a) All contest participants are required to sign an aquatic invasive species decontamination statement that their boats and/or boat trailers have or have not been in physical contact with any waters outside of Washington state for thirty days immediately preceding the contest and, if the boat and/or trailer has been in contact with such waters, the participant must complete an aquatic invasive species decontamination report indicating that the following actions have been taken:

(i) A physical inspection has been made of the hull, motor, trailer, livewell and bilge by the contest director or designee, according to criteria established by the department; and

(ii) Any aquatic invasive species, if found, have been disposed of in a garbage container; and

(iii) The hull, motor, trailer, livewell, and bilge have been decontaminated according to criteria established by the department.

(b) The aquatic invasive species decontamination statement and decontamination report shall be submitted to the department as part of the fishing contest report.

WSR 11-22-022
PERMANENT RULES
DEPARTMENT OF FINANCIAL INSTITUTIONS
(Consumer Services Division)

[Filed October 25, 2011, 9:48 a.m., effective November 25, 2011]

Effective Date of Rule: Thirty-one days after filing.

Purpose: Amending the rules in chapter 208-660 WAC for consistency with the Consumer Loan Act, the federal SAFE Act, and to protect consumers.

Citation of Existing Rules Affected by this Order: Amending WAC 208-660-350.

Statutory Authority for Adoption: RCW 43.320.040.

Other Authority: RCW 19.146.223.

Adopted under notice filed as WSR 11-17-146 on August 24, 2011.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 1, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 1, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 1, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 1, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: October 25, 2011.

Deborah Bortner, Director
Division of Consumer Services

AMENDATORY SECTION (Amending WSR 10-20-125, filed 10/5/10, effective 11/5/10)

WAC 208-660-350 Loan originators—Licensing. (1) **How do I apply for a loan originator license? Your application consists of an on-line filing through the NMLSR and Washington specific requirements provided directly to DFI. You must pay an application fee through the NMLSR system. You also must:**

(a) **Be eighteen years or older.**

(b) **Have a high school diploma, an equivalent to a high school diploma, or three years experience in the industry. The experience must meet the criteria in WAC 208-660-250 (1)(e)(i) and (ii).**

(c) **Pass a licensing test.** You must take and pass the national and state components of the NMLSR tests. See WAC 208-660-360, Loan originators—Testing.

(d) **Submit an application.** You must submit an on-line application through the NMLSR.

(e) **Prove your identity.** You must provide information to prove your identity.

(f) **Pay the application fee.** You must pay an application fee for your application, as well as an administrative fee to the NMLSR. See WAC 208-660-550, Department fees and costs.

(g) **Complete prelicensing education.** You must complete prelicensing education. See WAC 208-660-355.

(2) **In addition to reviewing my application, what else will the department consider to determine if I qualify for a loan originator license?**

(a) **General fitness and prior compliance actions.** The department will investigate your background to see that you demonstrate the experience, character, and general fitness that commands the confidence of the community and creates a belief that you will conduct business honestly and fairly within the purposes of the act. This investigation may include a review of the number and severity of complaints filed against you, or any person you were responsible for, and a review of any investigation or enforcement activity taken against you, or any person you were responsible for, in this state, or any jurisdiction. This investigation may also include a review of whether you have had a license issued under the act or any similar state statute suspended.

(b) **License suspensions or revocations.**

(i) You are not eligible for a loan originator license if you have been found to be in violation of the act or the rules.

(ii) You are not eligible for a loan originator license if you have ever had a license issued under the Mortgage Bro-

ker Practices Act or the Consumer Loan Act or any similar state statute revoked.

(iii) For purposes of (b) and (c) of this subsection, a "similar statute" may include statutes involving other financial services, such as insurance, securities, escrow or banking.

(c) **Criminal history.**

(i) You are not eligible for a loan originator license if you have ever been convicted of a felony involving an act of fraud, dishonesty, breach of trust, or money laundering.

(ii) You are not eligible for a loan originator license if you have been convicted of a gross misdemeanor involving dishonesty or financial misconduct, or a felony not involving fraud, dishonesty, breach of trust, or money laundering, within seven years of the filing of the present application.

(d) **Financial background.**

(i) The department will investigate your financial background including a review of your credit report to determine if you have demonstrated financial responsibility including, but not limited to, an assessment of your current outstanding judgments (except judgments solely as a result of medical expenses); current outstanding tax liens or judgments or other government liens or filings; foreclosure within the last three years; or a pattern of seriously delinquent accounts within the past three years.

(ii) Specifically, you are not eligible to receive a loan originator license if you have one hundred thousand dollars or more of tax liens against you at the time of appointment by a licensed mortgage broker.

(3) **What will happen if my loan originator license application is incomplete?** After submitting your on-line application through the NMLSR, the department will notify you of any application deficiencies.

(4) **How do I withdraw my application for a loan originator license?** Once you have submitted the on-line application through NMLSR you may withdraw the application through NMLSR. You will not receive a refund of the NMLSR application fee but you may receive a partial refund of your licensing fee if the fee exceeds the department's actual cost to investigate the license application.

(5) **When will the department consider my loan originator license application to be abandoned?** If you do not respond as directed by the department's request for information and within fifteen business days, your loan originator license application is considered abandoned and you forfeit all fees paid. Failure to provide the requested information will not affect new applications filed after the abandonment. You may reapply by submitting a new application package and new application fee.

(6) **What happens if the department denies my application for a loan originator license, and what are my rights if the license is denied?** Under the Administrative Procedure Act, chapter 34.05 RCW, you have the right to request a hearing. To request a hearing, notify the department, in writing, within twenty days from the date of the director's notice to you notifying you your license application has been denied. **See also WAC 208-660-009.**

(7) **How will the department provide me with my loan originator license?** The department may use any of the following methods to provide you with your loan originator license:

(a) A license sent to you electronically that you may print.

(b) A license verification available on the department's web site and accessible for viewing by the public.

(8) **May I transfer, sell, trade, assign, loan, share, or give my loan originator license to someone else?** No. A loan originator license authorizes only the individual named on the license to conduct the business at the location listed on the license.

(9) **How do I change information on my loan originator license?** You must submit an amendment to your license through the NMLSR. You may be charged a fee.

(10) **What is an inactive loan originator license?** When a licensed loan originator is not sponsored by a licensed or exempt company, the license is inactive. If a licensed loan originator works for a consumer loan company (chapter 31.04 RCW) as a W-2 employee, they may continue to do business under their inactive license until June 30, 2010, or until the company goes onto the NMLSR and sponsors their license.

(11) **When my loan originator license is inactive, must I continue to pay annual fees, and complete continuing education for that year?** Yes. You must comply with all the annual licensing requirements or you will be unable to renew your inactive loan originator license.

(12) **How do I activate my loan originator license?** The sponsoring company must submit a sponsorship request for your license through the NMLSR. The department will notify you and all the companies you are working with of the new working relationship if approved.

(13) **When may the department issue interim loan originator licenses?** To prevent an undue delay, the director may issue interim loan originator licenses with a fixed expiration date. The license applicant must have substantially met the initial licensing requirements, as determined by the director, to receive an interim license. In no case shall these requirements be less than the minimum requirements to obtain a license under the S.A.F.E. Act.

(14) **When does my loan originator license expire?** The loan originator license expires annually on December 31st. If the license is an interim license, it may expire in less than one year.

(15) **How do I renew my loan originator license?**

(a) You must continue to meet the minimum standards for license issuance. See RCW 19.146.310.

(b) Before the license expiration date you must renew your license through the NMLSR. Renewal consists of:

(i) Pay the annual assessment fee; and

(ii) Meet the continuing education requirement. You will not have a continuing education requirement in the year in which you complete prelicensing education. See WAC 208-660-370.

((~~(b)~~)) (c) The renewed license is valid until it expires, or is surrendered, suspended or revoked.

(16) **If I let my loan originator license expire, must I apply to get a new license?** If you complete all the requirements for renewal on or before February 28th each year, you may renew an existing license. However, if you renew your

license during this two-month period, in addition to paying the annual assessment on your license, you must pay an additional fifty percent of your annual assessment. See subsection (15) of this section for the license renewal requirements.

During this two-month period, your license is expired and you must not conduct any business under the act that requires a license.

Any renewal requirements received by the department must be evidenced by either a United States Postal Service postmark or department "date received" stamp prior to March 1st each year. If you fail to comply with the renewal request requirements prior to March 1st, you must apply for a new license.

(17) **If I let my loan originator license expire and then apply for a new loan originator license within one year of the expiration, must I comply with the continuing education requirements from the prior license period?** Yes. Before the department will consider your new loan originator application complete, you must provide proof of satisfying the continuing education requirements from the prior license period.

(18) **May I still originate loans if my loan originator license has expired?** No. Once your license has expired you may no longer conduct the business of a loan originator, or hold yourself out as a licensed loan originator, as defined in the act and these rules.

(19) **What happens to the loan applications I originated before my loan originator license expired?** Existing loan applications must be processed by the licensed mortgage broker or another licensed loan originator working for the mortgage broker.

(20) **May I surrender my loan originator's license?** Yes. Only you may surrender your license before the license expires through the NMLSR.

Surrendering your loan originator license does not change your civil or criminal liability, or your liability for any administrative actions arising from acts or omission occurring before the license surrender.

(21) **Must I display my loan originator license where I work as a loan originator?** No. Neither you nor the mortgage broker company is required to display your loan originator license. However, evidence that you are licensed as a loan originator must be made available to anyone who requests it.

(22) **If I operate as a loan originator on the internet, must I display my license number on my web site?** Yes. You must display your license number, and the license number and name as it appears on the license of the licensed mortgage broker you represent, on the web site.

(23) **Must I include my license number on any documents?** You must include your license number immediately following your name on solicitations, including business cards, advertisements, and residential mortgage loan applications.

(24) **When must I disclose my loan originator license number?** In the following situations you must disclose your loan originator license number and the name and license number of the mortgage broker you are associated with:

(a) When asked by any party to a loan transaction, including third party providers;

(b) When asked by any person you have solicited for business, even if the solicitation is not directly related to a mortgage transaction;

(c) When asked by any person who contacts you about a residential mortgage loan;

(d) When taking a residential mortgage loan application.

(25) **May I conduct business under a name other than the name on my loan originator license?** No. You must only use the name on your license when conducting business. If you use a nickname for your first name, you must use your name like this: "FirstName "Nickname" LastName."

(26) **Will I have to obtain an individual bond if the company I work for is exempt from licensing?** Reserved.

(27) **Will I have to file quarterly call reports if I have an individual bond?** Reserved.

WSR 11-22-034
PERMANENT RULES
DEPARTMENT OF LICENSING

[Filed October 26, 2011, 10:55 a.m., effective November 26, 2011]

Effective Date of Rule: Thirty-one days after filing.

Purpose: According to RCW 46.12.005 and 46.12.600, if, for any year beginning with 2002, the consumer price index (CPI) for all urban consumers, compiled by the Bureau of Labor Statistics, United States Department of Labor, or its successor, for the west region, in the expenditure category "used cars and trucks," shows an increase in the annual average for that year compared to that of the year immediately prior, the department shall, **by rule**, increase the then market value threshold amount by the same percentage as the percentage increase of the annual average, with the increase of the market value threshold amount to be effective on July 1st of the year immediately after the year with the increase of the annual average. The CPI showed an increase this previous year and the market value threshold amount was increased from $6790 to $7660. For this reason, WAC 308-56A-460 needs to be changed (and should have been changed effective July 1, 2011) to reflect this increase in the market value threshold amount.

Citation of Existing Rules Affected by this Order: Amending WAC 308-56A-460.

Statutory Authority for Adoption: RCW 46.01.110.

Other Authority: RCW 46.12.600.

Adopted under notice filed as WSR 11-17-110 (a CR-105) on August 23, 2011.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 1, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: October 26, 2011.

Ben T. Shomshor
Rules Coordinator

AMENDATORY SECTION (Amending WSR 10-19-045, filed 9/13/10, effective 10/14/10)

WAC 308-56A-460 Destroyed or wrecked vehicle—Reporting—Rebuilt. (1) **What are total loss, destroyed, salvage, and wrecked vehicles?** For the purposes of this section:

(a) A total loss vehicle is one whose destruction has been reported to the department as described in RCW ((~~46.12.070~~)) 46.12.600 by an insurer (insurance companies and self-insurers as described in RCW 46.29.630);

(b) A destroyed vehicle is one whose destruction has been reported to the department as described in RCW ((~~46.12.070~~)) 46.12.600 by the vehicle's owner;

(c) A salvage vehicle as defined in RCW ((~~46.12.005~~)) 46.04.514;

Note: When used in this section, the terms "destroyed" and "destroyed vehicle" include total loss, destroyed, and salvage vehicles.

(d) A wrecked vehicle as defined in RCW 46.80.010(6).

Note: A vehicle may be considered destroyed or wrecked when the evidence of ownership is a salvage certificate/title, insurance company bill of sale, or wrecker bill of sale from any jurisdiction, or when the evidence of ownership indicates the vehicle may be a destroyed vehicle not reported to the department.

(2) **How are vehicles reported to the department as total loss, destroyed, salvage, or wrecked?**

(a) Insurers may report total loss vehicles to the department:

(i) Electronically through the department's on-line reporting system. Insurers must destroy ownership documents for a vehicle reported this way; or

(ii) By submitting the certificate of ((~~ownership~~)) title or affidavit in lieu of title indicating the vehicle is "DESTROYED"; or

(iii) By submitting a completed total loss claim settlement form (TD 420-074).

Note: Reports of total loss vehicles must include the insurer's name, address, and the date of loss.

(b) Registered or legal owners report a vehicle as destroyed by submitting the certificate of ((~~ownership~~)) title or affidavit in lieu of title indicating the vehicle is "DESTROYED," and must include the registered owner's name, address, and date of loss.

(c) Licensed wreckers report wrecked vehicles as required in RCW 46.80.090.

(d) For vehicles six through twenty years old a statement whether or not the vehicle meets the market value threshold amount as defined in RCW ((~~46.12.005~~)) 46.12.600 is also required.

(3) **What is the current market value threshold amount?** The current market value threshold amount is ((~~six thousand seven hundred ninety dollars~~)) seven thousand six hundred sixty dollars.

(4) **How is the market value threshold amount determined?** Using the current market value threshold amount described in RCW ((~~46.12.005~~)) 46.12.600 each year the department will add the increased value if the increase is equal to or greater than fifty dollars.

(5) **What if the "market value threshold amount" is not provided as required?** If the market value threshold amount is not provided when required, the department would treat the report of destruction as if the market value threshold as described in RCW ((~~46.12.005~~)) 46.12.600 has been met. The certificate of ((~~ownership~~)) title will be branded according to WAC 308-56A-530**.**

(6) **What documentation is required to obtain a certificate of ((~~ownership~~)) title after a vehicle is destroyed?** After a vehicle has been reported destroyed or wrecked and is rebuilt, you must submit the following documentation to the department in order to obtain a new certificate of ((~~ownership~~)) title:

(a) Application for certificate of ((~~ownership~~)) title as described in RCW ((~~46.12.030~~)) 46.12.530;

(b) Certificate of vehicle inspection as described in WAC 308-56A-150;

(c) Bill of sale from the insurer, owner, or wrecker who reported the vehicle's destruction to the department.

(i) Bills of sale from insurers must include a representative's signature and title of office;

(ii) Bills of sale from insurers and wreckers do not need to be notarized;

(iii) Bills of sale from owners shown on department records must be notarized or certified;

(iv) A bill of sale is not required when owners shown on department records retain a destroyed vehicle and apply for a new certificate of ownership;

(v) Releases of interest from lien holder(s) or proof of payment such as a canceled check bearing a notation that it has been paid by the bank on which it was drawn or a notarized statement on a receipt from the legal owner that the debt is satisfied are required when the vehicle is retained by the registered owner(s).

(d) Odometer disclosure statement, if applicable.

(7) **What is required of a Washington licensed vehicle dealer prior to selling a destroyed or wrecked vehicle?** Except as permitted by RCW 46.70.101 (1)(b)(viii), before a dealer may sell a destroyed or wrecked vehicle under their Washington vehicle dealer license, the dealer must:

(a) Rebuild the vehicle to standards set by the state of Washington or the federal government pertaining to the construction and safety of vehicles; and

(b) Obtain a vehicle inspection by the Washington state patrol; and

(c) Apply for and receive a certificate of ownership for the vehicle, issued in the name of the vehicle dealer.

(8) **Once a destroyed or wrecked vehicle is rebuilt, do the license plates remain with the vehicle?** Whether or not the license plates remain with the vehicle depends on the circumstance:

(a) Standard issue license plates may remain with a destroyed vehicle unless they are severely damaged or the

vehicle was issued a department temporary permit described in WAC 308-56A-140;

(b) Replacement license plates are required for wrecked vehicles since Washington licensed wreckers are required by WAC 308-63-070 to remove them;

(c) Special license plates may remain with or be transferred to a destroyed or wrecked vehicle;

(d) Applicants may retain the current license plate number as provided for in RCW ((~~46.16.233~~)) 46.16A.200, unless the vehicle was issued a department temporary permit as described in WAC 308-56A-140.

(9) **Will the certificate of ownership or registration certificate indicate "WA REBUILT"?** Salvage or wrecked vehicles meeting the criteria described in WAC 308-56A-530 will be branded "WA REBUILT."

WSR 11-22-035
PERMANENT RULES
LIQUOR CONTROL BOARD

[Filed October 26, 2011, 11:24 a.m., effective November 26, 2011]

Effective Date of Rule: Thirty-one days after filing.

Purpose: At the request of stakeholders, the board revised WAC 314-11-015 to allow entertainers to drink while performing at a liquor licensed premises. This change will make Washington state consistent with most other states and allow licensees to choose from a larger group of entertainers to perform at their venues.

Citation of Existing Rules Affected by this Order: Amending WAC 314-11-015.

Statutory Authority for Adoption: RCW 66.08.030.

Adopted under notice filed as WSR 11-17-142 on August 24, 2011.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 1, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 1, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: October 26, 2011.

Sharon Foster
Chairman

AMENDATORY SECTION (Amending WSR 10-01-090, filed 12/16/09, effective 1/16/10)

WAC 314-11-015 What are my responsibilities as a liquor licensee? (1)(a) Liquor licensees are responsible for the operation of their licensed premises in compliance with the liquor laws and rules of the board (Title 66 RCW and Title 314 WAC). Any violations committed or permitted by employees will be treated by the board as violations committed or permitted by the licensee.

(b) The penalties for violations of liquor laws or rules are in: WAC 314-29-015 through 314-29-035, as now or hereafter amended, for licensees; and WAC 314-17-105 and 314-17-110, as now or hereafter amended, for employees who hold mandatory alcohol server training permits. These rules also outline aggravating and mitigating circumstances that may affect what penalty is applied if a licensee or employee violates a liquor law or rule.

(2) Licensees and their employees also have the responsibility to conduct the licensed premises in compliance with the following laws, as they now exist or may later be amended:

- Titles 9 and 9A RCW, the criminal code laws;
- Title 69 RCW, which outlines the laws regarding controlled substances; and
- Titles 70.155, 82.24 RCW, and RCW 26.28.080 which outline laws regarding tobacco.

(3) Licensees have the responsibility to control their conduct and the conduct of employees and patrons on the premises at all times. Except as otherwise provided by law, licensees or employees may not:

(a) Be disorderly or apparently intoxicated on the licensed premises;

(b) Permit any disorderly person to remain on the licensed premises;

(c) Engage in or allow behavior that provokes conduct which presents a threat to public safety;

(d) Consume liquor of any kind while working on the licensed premises; except that:

(i) Entertainers per WAC 314-02-010 may drink while performing under the following conditions:

(A) Alcohol service must be monitored by MAST servers;

(B) Drinks must be served in unlabeled containers;

(C) Entertainers may not advertise any alcohol brands or products;

(D) Entertainers may not promote drink specials; and

(E) If any member of the entertainment group is under twenty-one years of age, alcohol may not be consumed by any member of the group while performing.

(ii) Licensed beer manufacturers and their employees may sample beer of their own manufacture for manufacturing, evaluating or pricing product in areas where the public is not served, so long as the licensee or employee does not become apparently intoxicated;

((~~(ii)~~)) (iii) Licensed wine manufacturers and their employees may:

(A) Sample wine for manufacturing, evaluating, or pricing product, so long as the licensee or employee does not become apparently intoxicated; and the licensee or employee who is sampling for these purposes is not also engaged in serving alcohol to the public; and

(B) Sample wine of their own manufacture for quality control or consumer education purposes, so long as the

licensee or employee does not become apparently intoxicated.

(e) Engage in, or permit any employee or other person to engage in, conduct on the licensed premises which is prohibited by any portion of Titles 9, 9A, or 69 RCW; or

(f) Sell or serve liquor by means of "drive-in" or by "curb service."

(4) Licensees have the responsibility to control the interaction between the licensee or employee and their patrons. At a minimum, licensees or employees may not:

(a) Solicit any patron to purchase any beverage for the licensee or employee, or allow a person to remain on the premises for such purpose;

(b) Spend time or dance with, or permit any person to spend time or dance with, any patron for direct or indirect compensation by a patron.

(c) See WAC 314-11-050 for further guidelines on prohibited conduct.

WSR 11-22-036
PERMANENT RULES
HEALTH CARE AUTHORITY
(Public Employees Benefits Board)

[Order 11-02—Filed October 26, 2011, 5:10 a.m., effective January 1, 2012]

Effective Date of Rule: January 1, 2012.

Purpose: To amend public employees benefits board (PEBB) rules in Title 182 WAC in order to accomplish the following:

1. Clarify the administration of premium refunds and the disposition of employee premiums if a state agency does not provide notice of eligibility to an employee or fails to enroll an employee as required and add instruction for making the correction.

2. Align administration of special open enrollment rules and the date coverage begins or ends to federal regulations and the state of Washington salary reduction plan.

3. Implement state legislation, including implementation of a health savings account.

4. Implement the PEBB policy designating Uniform Medical Plan (UMP) Classic as the medical plan employees will be enrolled in if they fail to select a medical plan when newly eligible.

5. Provide a deadline for employees to notify the dependent care assistance program (DCAP) or medical flexible spending arrangement (FSA) administrator if they transfer to another state agency.

6. Remove the requirement for a retiree to maintain enrollment in retiree life insurance while eligible for the employer contribution toward PEBB active employee life insurance.

7. Make minor edits so the rules are clearer and technically correct.

Citation of Existing Rules Affected by this Order: Amending chapters 182-08, 182-12, and 182-16 WAC.

Statutory Authority for Adoption: RCW 41.05.160.

Other Authority: Chapter 8, Laws of 2011 (2ESB 5773).

Adopted under notice filed as WSR 11-19-107 on September 21, 2011.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 7, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 8, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 17, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 15, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: October 26, 2011.

Kevin M. Sullivan
Rules Coordinator

AMENDATORY SECTION (Amending Order 10-02, filed 10/6/10, effective 1/1/11)

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

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

"Agency" means the health care authority.

"Benefits eligible position" means any position held by an employee who is eligible for benefits under WAC 182-12-114, with the exception of employees who establish eligibility under WAC 182-12-114 (2) or (3)(a)(ii).

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

"Comprehensive employer sponsored medical" includes insurance coverage continued by the employee or their dependent under COBRA. It does not include an employer's retiree coverage, with the exception of a federal retiree plan.

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

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

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

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

"Director" means the director of the health care authority (HCA) or designee.

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

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

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

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

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

"Health plan" or "plan" means a medical or dental plan developed by the public employees benefits board and provided by a contracted vendor or self-insured plans administered by the HCA.

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

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

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

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

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

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

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

"PEBB" means the public employees benefits board.

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

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

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

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

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

"Seasonal employee" means an employee hired to work during a recurring, annual season with a duration of three months or more, and anticipated to return each season to perform similar work.

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

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

"Termination of the employment relationship" means that an employee resigns or an employee is terminated and the employing agency has no anticipation that the employee will be rehired.

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

"Waive" means to interrupt an eligible employee's enrollment in a PEBB health plan because the employee is enrolled in other comprehensive group coverage or is on approved educational leave (see WAC 182-12-128 and 182-12-136).

AMENDATORY SECTION (Amending Order 10-02, filed 10/6/10, effective 1/1/11)

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

Premium payments. PEBB premiums ((~~for retiree, COBRA or PEBB continuation coverage~~)) begin to accrue the first of the month in which PEBB insurance coverage is effective.

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

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

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

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

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

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

(i) Correct the enrollment error; and

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

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

Premium refunds. PEBB premiums ((~~for employees, retirees, COBRA, or PEBB continuation coverage~~)) will be refunded using the following method:

(((~~(1)~~))) (2) When ((~~any PEBB~~)) a subscriber submits an enrollment change affecting subscriber or dependent eligibility, ((~~such as for example: Death, divorce, or when no longer an eligible dependent as defined at WAC 182-12-260 no more than~~)) HCA may allow up to three months of accounting adjustments ((~~and~~)). HCA will refund to the individual or the employing agency any excess premium paid ((~~will be refunded to any individual or employing agency~~)) during the three month adjustment period, except as indicated in WAC 182-12-148(4).

(((~~(2) Notwithstanding subsection (1) of this section, the PEBB assistant administrator~~))) (3) If a PEBB subscriber, dependent, or beneficiary submits a written appeal as described in WAC 182-16-025, the PEBB assistant director or the PEBB appeals committee may approve a refund which does not exceed twelve months of premium ((~~if both~~)). The written appeal must provide proof of the following ((~~occur~~)):

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

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

(((~~(3) Errors resulting in~~))) (4) If a federal government entity retroactively determines that an enrollee is enrolled in coverage (for example medicare) the subscriber or beneficiary may be eligible for a refund of all premiums paid during the time he or she was enrolled under the federal program if approved by the PEBB assistant director or designee.

(5) Accounts reflecting an underpayment to HCA must be ((~~reimbursed by~~)) paid, and are due from the employing agency ((~~or~~)), subscriber or beneficiary to the HCA. Upon request ((~~of an employing agency, subscriber, or beneficiary, as appropriate~~)), the HCA ((~~will~~)) may develop a repayment plan designed ((~~not~~)) to ((~~create undue~~)) reduce hardship ((~~on the employing agency or subscriber~~)).

(((~~(4)~~))) (6) HCA errors will be ((~~adjusted~~)) corrected by returning ((~~the~~)) all excess premiums paid((~~, if any, to~~)) by the employing agency, subscriber, or beneficiary((~~, as appropriate~~)).

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

AMENDATORY SECTION (Amending Order 10-02, filed 10/6/10, effective 1/1/11)

WAC 182-08-196 What happens if my health plan becomes unavailable? ((~~Employees, retirees and survivors, and enrollees in PEBB continuation coverage for whom the~~)) (1) Subscribers must select a new health plan within sixty days of their chosen health plan ((~~becomes~~)) becoming unavailable due to a change in contracting service area or the ((~~retiree's entitlement to~~)) subscriber or subscriber's dependent ceasing to be eligible because of his or her enrollment in medicare ((~~must select a new health plan within sixty days after notification by the PEBB program.~~

(~~1~~))) (a) Employees must notify their employing agency of their new health plan choice.

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

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

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

(a) Employees who fail to select a new ((~~medical or dental~~)) health plan within the ((~~prescribed~~)) required time period will be enrolled in a successor plan if one is available or will be enrolled in ((~~the Uniform Medical Plan, the Uniform Dental Plan, or~~)) a plan ((~~selected~~)) designated by the

((~~administrator, along with the employee's existing dependent enrollment~~)) director.

(((~~(2) Retirees and survivors eligible under WAC 182-12-250 or 182-12-265~~)) (b) All other subscribers who fail to select a new health plan within the ((~~prescribed~~)) required time period will be enrolled in a successor plan if one is available ((~~or will be enrolled in the Uniform Medical Plan, and the Uniform Dental Plan,~~)) or a plan ((~~selected~~)) designated by the ((~~administrator~~)) director.

(3) Any subscriber ((~~assigned to~~)) enrolled in a health plan as described in subsection (2) of this ((~~rule~~)) section may not change health plans ((~~until the next open enrollment~~)) except as allowed in WAC 182-08-198.

(((~~(3) Enrollees in PEBB continuation coverage under WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, or 182-12-270(2) must select a new health plan no later than sixty days after notification by the PEBB program. If enrollees fail to select a new health plan within sixty days of the notification, health plan coverage will end as of the last day of the month in which the plan is available.~~))

AMENDATORY SECTION (Amending Order 10-02, filed 10/6/10, effective 1/1/11)

WAC 182-08-197 When must newly eligible employees select PEBB benefits and complete enrollment forms? (1) Employees who are newly eligible for PEBB benefits must complete the appropriate forms indicating enrollment and their health plan choice, or their decision to waive medical under WAC 182-12-128. Employees must return the forms to their employing agency no later than thirty-one days after they become eligible for PEBB benefits under WAC 182-12-114. Newly eligible employees who do not return an enrollment form to their employing agency indicating their medical and dental choice within thirty-one days will be enrolled in a health plan as follows:

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

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

(c) Dependents will not be enrolled.

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

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

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

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

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

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

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

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

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

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

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

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

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

(((~~(4)~~))) (5) Employees who are eligible to participate in the state's salary reduction plan may enroll in the state's medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP) or both. To enroll in these optional PEBB benefits, employees must return the appropriate enrollment forms to their ((~~employing~~)) state agency or PEBB designee no later than thirty-one days after becoming eligible for PEBB benefits.

(((~~(5)~~))) (6) The employer contribution toward insurance coverage ends according to WAC 182-12-131. Employees who become newly eligible for the employer contribution enroll as described in subsections (1) and (2) of this section, with the following exceptions in which insurance coverage elections stay the same:

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

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

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

(((~~(6)~~))) (7) When an employee's employment ends, participation in the state's salary reduction plan ends. If the employee is hired into a new position that is eligible for PEBB benefits in the same year, the employee may not resume participation in DCAP or medical FSA until the beginning of the next plan year, unless the time between employments is less than thirty days and the employee notifies the new state agency and the DCAP or FSA administrator of his or her employment transfer within the current plan year.

AMENDATORY SECTION (Amending Order 10-02, filed 10/6/10, effective 1/1/11)

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

(1) **During annual open enrollment:** Subscribers may change health plans during the annual open enrollment. The subscriber must submit the appropriate enrollment forms to change health plan no later than the end of the annual open enrollment. Enrollment in the new health plan will begin January 1st of the following year.

(2) **During a special open enrollment:** Subscribers may change health plans outside of the annual open enrollment if a special open enrollment event occurs. The change in enrollment must be allowable under Internal Revenue Code (IRC) and correspond to the event that creates the special open enrollment for either the subscriber or the subscriber's dependents or both. To make a health plan change, the subscriber must submit the appropriate enrollment forms (and a completed disenrollment form, if required) no later than sixty days after the event occurs. Employees submit the enrollment forms to their employing agency. All other subscribers((~~, including retirees, COBRA, and other self-pay subscribers,~~)) submit the enrollment forms to the PEBB program. Insurance coverage in the new health plan will begin the first day of the month following the ((~~event that created the special open enrollment; or in cases where the event occurs on the first day of the month, insurance coverage will begin on that date~~)) later of the event date or the date the form is received. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, insurance coverage will begin the month in which the ((~~event~~)) 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's~~)) Subscriber acquires a new dependent ((~~becomes eligible under PEBB rules~~)) due to:

(i) ((~~Through~~)) Marriage or registering a domestic partnership with Washington's secretary of state;

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

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

(iv) ((~~When~~)) A child ((~~becomes~~)) becoming eligible as ((~~an extended~~)) a dependent with a disability;

(b) ((~~Subscriber's dependent no longer meets PEBB eligibility criteria because:~~

~~(i) Subscriber has a change in marital status or Washington state registered domestic partnership status, including legal separation documented by a court order;~~

~~(ii) A child dependent turns age twenty-six;~~

~~(iii) A child dependent ceases to be eligible as an extended dependent or as a dependent with disabilities; or~~

~~(iv) A dependent dies;~~

~~(c)~~)) 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);

(((~~d~~))) (c) Subscriber or a subscriber's dependent has a change in employment status that affects the subscriber's or ((~~a~~)) the subscriber's dependent's eligibility for the employer contribution toward group health coverage ((~~or the employer contribution toward insurance coverage~~));

(((~~e~~))) (d) Subscriber or a subscriber's dependent has a change in residence that affects health plan availability. If the subscriber moves and the subscriber's current health plan is not available in the new location ((~~but~~)) the subscriber ((~~does not~~)) must select a new health plan. If the subscriber does not select a new health plan, the PEBB program may ((~~enroll~~)) change the ((~~subscriber in the Uniform Medical Plan or Uniform Dental Plan~~)) subscriber's health plan as described in WAC 182-08-196;

(((~~f~~))) (e) Subscriber receives a court order or medical support order requiring the subscriber, the subscriber's spouse, or the subscriber's Washington state registered domestic partner to provide insurance coverage for an eligible dependent (a former spouse or former registered domestic partner is not an eligible dependent);

(((~~g~~))) (f) Subscriber or a subscriber's dependent becomes eligible for ((~~a medical~~)) state premium assistance ((~~program under the department of social and health services, including~~)) through medicaid or ((~~the~~)) a state children's health insurance program (CHIP), or the subscriber or a subscriber's dependent loses eligibility ((~~a medical assistance program~~)) for coverage under medicaid or CHIP;

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

~~(i)~~))) (g) Subscriber or ((~~an eligible~~)) a subscriber's dependent becomes entitled to medicare, enrolls in or disenrolls from a medicare Part D plan. If the subscriber's current health plan becomes unavailable due to the subscriber's or a

subscriber's dependent's entitlement to medicare, the subscriber must select a new health plan as described in WAC 182-08-196;

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

(((j))) (i) Subscriber experiences a disruption that could function as a reduction in benefits for the subscriber or the subscriber's dependent(s) due to a specific condition or ongoing course of treatment. A subscriber may not change their health plan if the subscriber's or an enrolled dependent's physician stops participation with the subscriber's health plan unless the PEBB program determines that a continuity of care issue exists. The PEBB program criteria used will include, but is not limited to, the following in determining if a continuity of care issue exists:

(i) Active cancer treatment; or

(ii) Recent transplant (within the last twelve months); or

(iii) Scheduled surgery within the next sixty days; or

(iv) Major surgery within the previous sixty days; or

(v) Third trimester of pregnancy; or

(vi) Language barrier.

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

AMENDATORY SECTION (Amending Order 10-02, filed 10/6/10, effective 1/1/11)

WAC 182-08-199 When may an employee enroll in or change his or her election under the premium payment plan, medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP)? An eligible employee (as described in WAC 182-12-116) may enroll in or change his or her election under the premium payment plan, medical flexible spending arrangement (FSA), or dependent care assistance program (DCAP) at the following times:

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

(2) **During annual open enrollment:** An eligible employee (as described in WAC 182-12-116) may enroll in or change their election under the state's premium payment plan, medical FSA or DCAP during the annual open enrollment. Employees must submit, in paper or on-line, the appropriate enrollment form to enroll or reenroll no later than the last day of the annual open enrollment. The enrollment or new election will be effective January 1st of the following year.

(3) **During a special open enrollment:** Employees may enroll or change their election under the state's premium payment plan, medical FSA or DCAP outside of the annual open enrollment if a special open enrollment event occurs. The enrollment or change in enrollment must be allowable under Internal Revenue Code (IRC) and correspond to and be consistent with the event that creates the special open enrollment. To make a change or enroll, the employee must submit the appropriate forms as instructed on the forms no later than sixty days after the event occurs. ((~~Enrollment will be effective the first day of the month following approval by the administrator.~~))

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

((~~The following events create a special open enrollment for purposes of an eligible employee making a change:~~

~~(a) Employee's~~)) (a) An employee may enroll or change his or her election under the premium payment plan when any of the following special open enrollment events occur, if the requested change corresponds to and is consistent with the event. Enrollment will be effective the first day of the month following the later of the event date or the date the form is received.

(i) Employee acquires a new dependent ((~~becomes eligible under PEBB rules~~)) due to:

(((~~(i) Through~~)) • Marriage;

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

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

(((~~(iv) When~~)) • A child ((~~becomes~~)) becoming eligible as ((~~an extended eligible~~)) a dependent with a disability;

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

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

~~(ii) An eligible dependent child turns age twenty-six;~~

~~(iii) An eligible dependent ceases to be eligible as an extended dependent or as a dependent with disabilities; or~~

~~(iv) An eligible dependent dies;~~

~~(c)~~)) (ii) Employee or an ((~~eligible~~)) 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);

(((~~(d)~~))) (iii) Employee or an ((~~eligible~~)) employee's dependent has a change in employment status that affects the employee's or a dependent's eligibility for the employer contribution toward group health coverage ((~~or the employer contribution toward insurance coverage~~));

(((~~(e)~~))) (iv) Employee receives a court order or medical support order requiring the employee or the employee's spouse to provide insurance coverage for an eligible dependent;

(((~~(f)~~))) (v) Employee or ((~~an eligible~~)) employee's dependent becomes eligible for ((~~a medical~~)) state premium assistance ((~~program under the department of social and health services, including~~)) through medicaid or ((~~the~~)) a state children's health insurance program (CHIP), or the ((~~subscriber~~)) employee or employee's dependent loses eligibility ((~~in such a medical assistance program~~)) for coverage under medicaid or CHIP;

(((~~(g) Seasonal employees whose off-season occurs during the annual open enrollment may enroll in the plan upon their return to work;~~

~~(h)~~)) (vi) Employee or ((~~an eligible~~)) employee's dependent gains or loses eligibility for medicare;

(((~~(i) In addition to (a) through (h) of this section, the following are events that create a special open enrollment for purposes of an eligible employee making a change in his or her DCAP:~~

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

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

~~(iii) If an employee's dependent care provider imposes a change in the cost of dependent care, the employee may make a change in the DCAP to reflect the new cost if the dependent care provider is not a relative as defined in Section 152 (a)(1) through (8), incorporating the rules of Section 152 (b)(1) and (2) of the IRC.~~)) (vii) Employee or employee's dependent's current health plan becomes unavailable because the employee or enrolled dependent is no longer eligible for a health savings account (HSA). HCA may require evidence that the employee or employee's dependent is no longer eligible for an HSA;

(viii) Employee experiences a disruption that could function as a reduction in benefits for the employee or the employee's dependent(s) due to a specific condition or ongoing course of treatment. An employee may not change their health plan if the employee's or an enrolled 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 criteria used will include, but is not limited to, the following in determining if a continuity of care issue exists:

(A) Active cancer treatment; or

(B) Recent transplant (within the last twelve months); or

(C) Scheduled surgery within the next sixty days; or

(D) Major surgery within the previous sixty days; or

(E) Third trimester of pregnancy; or

(F) Language barrier.

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

(b) An employee may enroll or change his or her election under the medical FSA when any one of the following special open enrollment events occur, if the requested change corresponds to and is consistent with the event. Enrollment will be effective the first day of the month following approval by the FSA administrator.

(i) Employee acquires a new dependent due to:

• Marriage;

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

• A child becoming eligible as an extended dependent through legal custody or legal guardianship; or

• A child becoming eligible as a dependent with a disability;

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

(iii) Employee receives a court order or medical support order requiring the employee or the employee's spouse to provide insurance coverage for an eligible dependent;

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

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

(c) An employee may enroll or change his or her election under the DCAP when any one of the following special open enrollment events occur, if the requested change corresponds to and is consistent with the event. Enrollment will be effective the first day of the month following approval by the DCAP administrator.

(i) Employee acquires a new dependent due to:

• Marriage;

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

• A child becoming eligible as an extended dependent through legal custody or legal guardianship; or

• A child becoming eligible as a dependent with a disability;

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

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

(iv) Employee or the employee's spouse experiences a change in the number of qualifying individuals as defined in IRC Section 21 (b)(1);

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

AMENDATORY SECTION (Amending Order 10-02, filed 10/6/10, effective 1/1/11)

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

((~~"Administrator" means the administrator of the HCA or designee.~~))

"Agency" means the health care authority.

"Benefits eligible position" means any position held by an employee who is eligible for benefits under WAC 182-12-114, with the exception of employees who establish eligibility under WAC 182-12-114(2) or (3)(a)(ii).

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

"Comprehensive employer sponsored medical" includes insurance coverage continued by the employee or their

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

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

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

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

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

"Director" means the director of the HCA or designee.

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

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

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

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

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

"Health plan" or "plan" means a medical or dental plan developed by the public employees benefits board and provided by a contracted vendor or self-insured plans administered by the HCA.

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

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

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

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

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

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

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

"PEBB" means the public employees benefits board.

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

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

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

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

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

"Seasonal employee" means an employee hired to work during a recurring, annual season with a duration of three months or more, and anticipated to return each season to perform similar work.

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

"Subscriber" means the employee, retiree, COBRA beneficiary or eligible survivor who has been designated by the HCA as the individual to whom the HCA and contracted ven-

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

"Termination of the employment relationship" means that an employee resigns or an employee is terminated and the employing agency has no anticipation that the employee will be rehired.

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

"Waive" means to interrupt an eligible employee's enrollment in a PEBB health plan because the employee is enrolled in other comprehensive group coverage or is on approved educational leave (see WAC 182-12-128 and 182-12-136).

AMENDATORY SECTION (Amending Order 10-02, filed 10/6/10, effective 1/1/11)

WAC 182-12-128 May an employee waive health plan enrollment? Employees must enroll in dental, life and long-term disability insurance (unless the employing agency does not participate in these PEBB insurance coverages). However, employees may waive PEBB medical if they have other comprehensive group medical coverage.

(1) Employees may waive enrollment in PEBB medical by submitting the appropriate enrollment form to their employing agency during the following times:

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

(b) **During the annual open enrollment:** Employees may waive medical during the annual open enrollment if they submit the appropriate enrollment form to their employing agency before the end of the annual open enrollment. Medical will be waived beginning January 1st of the following year.

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

(2) If an employee waives medical, the employee's eligible dependents may not be enrolled in medical.

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

(a) During the annual open enrollment;

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

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

(a) ((~~Employee's~~)) Employee acquires a new dependent ((~~becomes eligible under PEBB rules~~)) due to:

(i) ((~~Through~~)) Marriage or registering a domestic partnership with Washington state;

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

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

(iv) ((~~When~~)) A child ((~~becomes~~)) becoming eligible as ((~~an extended~~)) a dependent with a disability;

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

~~(i) Employee has a change in marital status or Washington state registered domestic partnership status, including legal separation documented by a court order;~~

~~(ii) A child dependent turns age twenty-six;~~

~~(iii) A child dependent ceases to be eligible as an extended dependent or as a dependent with disabilities; or~~

~~(iv) A dependent dies;~~

~~(c)~~)) Employee or a 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);

(((~~(d)~~))) (c) Employee or ((~~a~~)) an employee's dependent has a change in employment status that affects the employee's or ((~~a~~)) employee's dependent's eligibility for the employer contribution toward group health coverage ((~~or the employer contribution toward insurance coverage;~~

~~(e) Employee or a dependent has a change in residence that affects health plan availability~~));

(((~~(f)~~))) (d) Employee receives a court order or medical support order requiring the employee, spouse, or Washington state registered domestic partner to provide insurance coverage for an eligible dependent (a former spouse or former registered domestic partner is not an eligible dependent);

(((~~(g)~~))) (e) Employee or dependent becomes eligible for ((~~a medical~~)) state premium assistance ((~~program under the department of social and health services, including~~)) through medicaid or ((~~the~~)) a state children's health insurance program (CHIP), or the employee or dependent loses eligibility ((~~in a medical assistance program~~)) for coverage under medicaid or CHIP.

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

Medical will be waived the end of the month following the later of the event date or the date the form is received. If the special open enrollment is due to the birth, adoption or assumption of legal obligation for total or partial support in anticipation of adoption of a child, medical will be waived the first of the month in which the event occurs.

Enrollment in ((~~insurance coverage~~)) medical will begin the first day of the month following the later of the event ((~~that created the special open enrollment; or in cases where the event occurs on the first day of a month, enrollment will~~

~~begin on that~~)) date or the date the form is received. If the special open enrollment is due to the birth, adoption or assumption of legal obligation for total or partial support in anticipation of adoption of a child, ((~~insurance coverage~~)) enrollment in medical will begin the first of the month in which the event occurs.

AMENDATORY SECTION (Amending Order 10-02, filed 10/6/10, effective 1/1/11)

WAC 182-12-131 How do eligible employees maintain the employer contribution toward insurance coverage? The employer contribution toward insurance coverage begins on the day that PEBB benefits begin under WAC 182-12-114. This section describes under what circumstances an employee maintains eligibility for the employer contribution toward PEBB benefits.

(1) **Maintaining the employer contribution.** Except as described in subsections (2), (3) and (4) of this section, an employee who has established eligibility for benefits under WAC 182-12-114 is eligible for the employer contribution each month in which he or she is in pay status eight or more hours per month.

(2) **Maintaining the employer contribution - Benefits-eligible seasonal employees.**

(a) A benefits-eligible seasonal employee (eligible under WAC 182-12-114(2)) who works a season of less than nine months is eligible for the employer contribution in any month of his or her season in which he or she is in pay status eight or more hours during that month. The employer contribution toward PEBB benefits for seasonal employees returning after their off season begins on the first day of the first month of the season in which they are in pay status eight hours or more.

(b) A benefits-eligible seasonal employee (eligible under WAC 182-12-114(2)) who works a season of nine months or more is eligible for the employer contribution:

(i) In any month of his or her season in which he or she is in pay status eight or more hours during that month; and

(ii) Through the off season following each season worked.

(3) **Maintaining the employer contribution - Eligible faculty.**

(a) Benefits-eligible faculty anticipated to work the entire instructional year or equivalent nine-month period (eligible under WAC 182-12-114 (3)(a)(i)) are eligible for the employer contribution each month of the instructional year, except as described in subsection (7) of this section.

(b) Benefits-eligible faculty who are hired on a quarter/semester to quarter/semester basis (eligible under WAC 182-12-114 (3)(a)(ii)) are eligible for the employer contribution each quarter or semester in which the employee works half-time or more.

(c) Summer or off-quarter/semester coverage: All benefits-eligible faculty (eligible under WAC 182-12-114(3)) who work an average of half-time or more throughout the entire instructional year or equivalent nine-month period and work each quarter/semester of the instructional year or equivalent nine-month period are eligible for the employer contribution toward summer or off-quarter/semester insurance coverage.

Exception: Eligibility for the employer contribution toward summer or off-quarter/semester insurance coverage ends on the end date specified in an employing agency's termination notice or an employee's resignation letter, whichever is earlier, if the employing agency has no anticipation that the employee will be returning as faculty at any institution of higher education where the employee has employment. If the employing agency deducted the employee's premium for insurance coverage after the employee was no longer eligible for the employer contribution, insurance coverage ends the last day of the month for which employee premiums were deducted.

(d) Two-year averaging: All benefits-eligible faculty (eligible under WAC 182-12-114(3)) who worked an average of half-time or more in each of the two preceding academic years are potentially eligible to receive uninterrupted employer contribution to PEBB benefits. "Academic year" means summer, fall, winter, and spring quarters or summer, fall, and spring semesters and begins with summer quarter/semester. In order to be eligible for the employer contribution through two-year averaging, the faculty must provide written notification of his or her potential eligibility to his or her employing agency or agencies within the deadlines established by the employing agency or agencies. Faculty continue to receive uninterrupted employer contribution for each academic year in which they:

(i) Are employed on a quarter/semester to quarter/semester basis and work at least two quarters or two semesters; and

(ii) Have an average workload of half-time or more for three quarters or two semesters.

Eligibility for the employer contribution under two-year averaging ceases immediately if the eligibility criteria is not met or if the eligibility criteria becomes impossible to meet.

(e) Faculty ((~~with gaps of~~)) who lose eligibility for the employer contribution: All benefits-eligible faculty (eligible under WAC 182-12-114(3)) who lose eligibility for the employer contribution will regain it if they return to a faculty position where it is anticipated that they will work half-time or more for the quarter/semester no later than the twelfth month after the month in which they lost eligibility for the employer contribution. The employer contribution begins on the first day of the month in which the quarter/semester begins.

(4) **Maintaining the employer contribution - Employees on leave and under the special circumstances listed below.**

(a) Employees who are on approved leave under the federal Family and Medical Leave Act (FMLA) continue to receive the employer contribution as long as they are approved under the act.

(b) Unless otherwise indicated in this section, employees in the following circumstances receive the employer contribution only for the months they are in pay status eight hours or more:

(i) Employees on authorized leave without pay;

(ii) Employees on approved educational leave;

(iii) Employees receiving time-loss benefits under workers' compensation;

(iv) Employees called to active duty in the uniformed services as defined under the Uniformed Services Employment and Reemployment Rights Act (USERRA); or

(v) Employees applying for disability retirement.

(5) **Maintaining the employer contribution - Employees who move from an eligible to an otherwise ineligible position due to a layoff** maintain the employer contribution toward insurance coverage under the criteria in WAC 182-12-129.

(6) **Employees who are in pay status less than eight hours in a month.** Unless otherwise indicated in this ((~~rule~~)) section, when there is a month in which an employee is not in pay status for at least eight hours, the employee:

(a) Loses eligibility for the employer contribution for that month; and

(b) Must reestablish eligibility for PEBB benefits under WAC 182-12-114 in order to be eligible for the employer contribution again.

(7) **The employer contribution to PEBB insurance coverage ends** in any one of these circumstances for all employees:

(a) When the employee fails to maintain eligibility for the employer contribution as indicated in the criteria in subsection (1) through (6) of this section.

(b) When the employment relationship is terminated. As long as the employing agency has no anticipation that the employee will be rehired, the employment relationship is terminated:

(i) On the date specified in an employee's letter of resignation; or

(ii) On the date specified in any contract or hire letter or on the effective date of an employer-initiated termination notice.

(c) When the employee moves to a position that is not anticipated to be eligible for benefits under WAC 182-12-114, not including changes in position due to a layoff.

The employer contribution toward PEBB medical, dental and life insurance for an employee, spouse, Washington state registered domestic partner, or child ceases at 12:00 midnight, the last day of the month in which the employee is eligible for the employer contribution under this ((~~rule~~)) section.

Exception: If the employing agency deducted the employee's premium for insurance coverage after the employee was no longer eligible for the employer contribution, insurance coverage ends the last day of the month for which employee premiums were deducted.

(8) **Options for continuation coverage by self-paying.** During temporary or permanent loss of the employer contribution toward insurance coverage, employees have options for providing continuation coverage for themselves and their dependents by self-paying the full premium set by the HCA. These options are available according to WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, and 182-12-270.

AMENDATORY SECTION (Amending Order 09-02, filed 11/17/09, effective 1/1/10)

WAC 182-12-138 What options are available if an employee is approved for the federal Family and Medical Leave Act (FMLA)? (1) Employees on approved leave under the federal Family and Medical Leave Act (FMLA) may continue to receive the employer contribution toward insurance coverage in accordance with the federal FMLA. These employees may also continue current optional life and long-term disability. The employee's employing agency is responsible for determining if the employee is eligible for leave under FMLA and the duration of such leave. If the employee's contribution toward premiums ((~~are~~)) is more than sixty days delinquent, insurance coverage will end as of the last day of the month for which a full premium was paid.

(2) If an employee exhausts the period of leave approved under FMLA, insurance coverage may be continued by self-paying the full premium set by the HCA, with no contribution from the employer, under WAC 182-12-133(1) while on approved leave.

AMENDATORY SECTION (Amending Order 10-02, filed 10/6/10, effective 1/1/11)

WAC 182-12-141 If an employee reverts from an eligible position ((~~to another position~~)), what happens to his or her insurance coverage? (1) If an employee reverts for reasons other than a layoff and is not eligible for the employer contribution toward insurance coverage under this chapter, he or she may continue PEBB insurance coverage by self-paying the full premium set by the HCA for up to eighteen months under the same terms as an employee who is granted leave without pay under WAC 182-12-133(1).

(2) If an employee is reverted due to a layoff, the employee may be eligible for the employer contribution toward insurance coverage under the criteria of WAC 182-12-129. If determined not to be eligible under WAC 182-12-129, the employee may continue PEBB insurance coverage by self-paying the full premium set by the HCA under WAC 182-12-133.

AMENDATORY SECTION (Amending Order 10-02, filed 10/6/10, effective 1/1/11)

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

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

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

Employees who do not enroll in a PEBB health plan at retirement are only eligible to enroll at a later date if they have deferred enrollment as identified in WAC 182-12-200 or 182-12-205 and maintained comprehensive employer sponsored medical as defined in WAC 182-12-109.

(b) The employee and enrolled dependents who are entitled to medicare must enroll and maintain enrollment in both medicare parts A and B if the employee retired after July 1,

1991. If the employee or an enrolled dependent becomes entitled to medicare after enrollment in PEBB retiree insurance, he or she must enroll and maintain enrollment in medicare.

(2) **Eligibility requirements.** Eligible employees (as defined in WAC 182-12-114 and 182-12-131) who end public employment after becoming vested in a Washington state-sponsored retirement plan (as defined in subsection (4) of this section) are eligible to continue PEBB insurance coverage as a retiree if they meet procedural and eligibility requirements. To be eligible to continue PEBB insurance coverage as a retiree, the employee must be eligible to retire under a Washington state-sponsored retirement plan when the employee's employer paid or COBRA coverage ends.

Employees who do not meet their Washington state-sponsored retirement plan's age requirements when their employer paid or COBRA coverage ends, but who meet the age requirement within sixty days of coverage ending, may request that their eligibility be reviewed by the PEBB appeals committee to determine eligibility (see WAC 182-16-032). Employees must meet ((~~other~~)) retiree insurance election procedural requirements.

• Employees must immediately begin to receive a monthly retirement plan payment, with exceptions described below.

• Employees who receive a lump-sum payment instead of a monthly retirement plan payment are only eligible if this is required by department of retirement systems because their monthly retirement plan payment is below the minimum payment that can be paid.

• Employees who are members of a Plan 3 retirement, also called separated employees (defined in RCW 41.05.011 ((~~(13)~~)) (15)), are eligible if they meet their Plan 3 retirement plan's ((~~age requirement and length of service~~)) eligibility criteria when PEBB employee insurance coverage ends. They do not have to receive a retirement plan payment.

• Employees who are members of a Washington higher education retirement plan are eligible if they immediately begin to receive a monthly retirement plan payment, or meet their plan's ((~~age requirement~~)) retirement eligibility criteria, or are at least age fifty-five with ten years of state service.

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

• Employees not retiring under a Washington state-sponsored retirement plan must meet the same age and years of service ((~~had~~)) as if the person had been employed as a member of either public employees retirement system Plan 1 or Plan 2 for the same period of employment.

• Employees who retire from a local government or tribal government that participates in PEBB insurance coverage for their employees are eligible to continue PEBB insurance coverage as retirees if the employees meet the procedural and eligibility requirements under this section.

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

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

(c) **Washington state K-12 school district and educational service district employees for districts that do not participate in PEBB benefits.** Employees of Washington state K-12 school districts and educational service districts who separate from employment after becoming vested in a Washington state-sponsored retirement system are eligible to enroll in PEBB health plans when retired or permanently and totally disabled.

Except for employees who are members of a retirement Plan 3, employees who separate on or after October 1, 1993, must immediately begin to receive a monthly retirement plan payment from a Washington state-sponsored retirement system. Employees who receive a lump-sum payment instead of a monthly retirement plan payment are only eligible if department of retirement systems requires this because their monthly retirement plan payment is below the minimum payment that can be paid or they enrolled before 1995.

Employees who are members of a Plan 3 retirement, also called separated employees (defined in RCW 41.05.011 ((~~(13)~~)) (15)), are eligible if they meet their Plan 3 retirement plan's ((~~age requirement and length of service~~)) eligibility criteria when employer paid or COBRA coverage ends.

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

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

(3) **Elected and full-time appointed officials of the legislative and executive branches.** Employees who are elected and full-time appointed state officials (as defined under WAC 182-12-114(4)) who voluntarily or involuntarily leave public office are eligible to continue PEBB insurance coverage as a retiree if they meet procedural and eligibility requirements. They do not have to receive a retirement plan payment from a state-sponsored retirement system.

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

• Higher education retirement plans;

• Law enforcement officers' and firefighters' retirement system;

• Public employees' retirement system;

• Public safety employees' retirement system;

• School employees' retirement system;

• State judges/judicial retirement system;

• ((~~Teacher's~~)) Teachers' retirement system; and

• State patrol retirement system.

The two federal retirement systems, Civil Service Retirement System and Federal Employees' Retirement System, are

considered a Washington state-sponsored retirement system for Washington State University Extension employees covered under the PEBB insurance coverage at the time of retirement or disability.

AMENDATORY SECTION (Amending Order 10-02, filed 10/6/10, effective 1/1/11)

WAC 182-12-205 May a retiree defer enrollment in a PEBB health plan at or after retirement? Except as stated in subsection (1)(c) of this section, if retirees defer enrollment in a PEBB health plan, they also defer enrollment for all eligible dependents. Retirees may not defer their retiree term life insurance, even if they have other life insurance, except as allowed in WAC 182-12-209(3).

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

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

(b) Beginning January 1, 2001, retirees may defer enrollment if they are enrolled in medical as a retiree or the dependent of a retiree enrolled in a federal retiree plan.

(c) Beginning January 1, 2006, retirees may defer enrollment if they are enrolled in medicare Parts A and B and a medicaid program that provides creditable coverage as defined in this chapter. The retiree's dependents may continue their PEBB health plan enrollment if they meet PEBB eligibility criteria and are not eligible for creditable coverage under a medicaid program.

(2) To defer health plan enrollment, the retiree must submit the appropriate forms to the PEBB program requesting to defer. The PEBB program must receive the form before health plan enrollment is deferred or no later than sixty days after the date the retiree becomes eligible to apply for PEBB retiree insurance coverage.

(3) Retirees who defer may enroll in a PEBB health plan as follows:

(a) Retirees who defer while enrolled in comprehensive employer-sponsored medical may enroll in a PEBB health plan by submitting the appropriate forms and evidence of continuous enrollment in comprehensive employer-sponsored medical to the PEBB program:

(i) During annual open enrollment. (PEBB health plan will begin January 1st after the annual open enrollment.); or

(ii) No later than sixty days after their comprehensive employer-sponsored medical ends. (PEBB health plan will begin the first day of the month after the comprehensive employer-sponsored medical ends.)

(b) Retirees who defer enrollment while enrolled as a retiree or dependent of a retiree in a federal retiree medical plan will have a one-time opportunity to enroll in a PEBB health plan by submitting the appropriate forms and evidence of continuous enrollment in a federal retiree medical plan to the PEBB program:

(i) During annual open enrollment. (PEBB health plan will begin January 1st after the annual open enrollment.); or

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

(c) Retirees who defer enrollment while enrolled in medicare Parts A and B and medicaid may enroll in a PEBB health plan by submitting the appropriate forms and evidence of continuous enrollment in creditable coverage to the PEBB program:

(i) During annual open enrollment. (Enrollment in the PEBB health plan will begin January 1st after the annual open enrollment.); or

(ii) No later than sixty days after their medicaid coverage ends (Enrollment in the PEBB health plan will begin the first day of the month after the medicaid coverage ends.); or

(iii) No later than the end of the calendar year when their medicaid coverage ends if the retiree was also determined eligible under 42 U.S.C. § 1395w-114 and subsequently enrolled in a medicare Part D plan. (Enrollment in the PEBB health plan will begin January 1st following the end of the calendar year when the medicaid coverage ends.)

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

AMENDATORY SECTION (Amending Order 09-02, filed 11/17/09, effective 1/1/10)

WAC 182-12-208 ((~~May a~~)) What are the requirements regarding enrollment in retiree ((~~enroll only in~~)) dental? (1) If ((~~an enrollee~~)) a subscriber is enrolled in retiree insurance coverage, he or she may not enroll in dental unless he or she is also enrolled in medical.

(2) A subscriber enrolling in dental must stay enrolled in dental for at least two years before dental can be dropped.

AMENDATORY SECTION (Amending Order 09-02, filed 11/17/09, effective 1/1/10)

WAC 182-12-209 Who is eligible for retiree life insurance? Eligible employees who participate in PEBB life insurance as an employee and meet qualifications for retiree insurance coverage as provided in WAC 182-12-171 are eligible for PEBB retiree life insurance. They must submit the appropriate forms to the PEBB program no later than sixty days after the date their PEBB employee life insurance ends.

(1) Employees whose life insurance premiums are being waived under the terms of the life insurance contract are not eligible for retiree term life insurance until their waiver of premium benefit ends.

(2) Retirees may not defer enrollment in retiree term life insurance.

(3) If a retiree returns to active ((~~employee~~)) employment status ((~~in an employing agency~~)) and becomes eligible for the employer contribution toward PEBB employee life insurance, he or she ((~~must~~)) may choose:

(a) To continue to self-pay premiums and keep retiree life insurance ((~~premiums~~)) in ((~~order to maintain retiree term life insurance (even while participating in PEBB employee~~

~~life insurance)~~))) place during the period he or she is eligible for employee life insurance; or

(b) To stop self-paying premiums during the period he or she is eligible for employee life insurance and resume self-paying premiums for retiree life insurance when he or she is no longer eligible for the employer contribution toward PEBB employee life insurance.

AMENDATORY SECTION (Amending Order 09-02, filed 11/17/09, effective 1/1/10)

WAC 182-12-211 If department of retirement systems makes a formal determination of retroactive eligibility, may the retiree enroll in PEBB retiree insurance coverage? (1) When the Washington state department of retirement systems (DRS) makes a formal determination that a person is retroactively eligible for pension benefits that person may apply for enrollment in a PEBB health plan only if application is made within sixty days after the date of notice from DRS.

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

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

AMENDATORY SECTION (Amending Order 10-02, filed 10/6/10, effective 1/1/11)

WAC 182-12-250 Insurance coverage eligibility for survivors of emergency service personnel killed in the line of duty. Surviving spouses, Washington state registered domestic partners, and dependent children of emergency service personnel who are killed in the line of duty are eligible to enroll in health plans administered by the PEBB program within HCA.

(1) This section applies to the surviving spouse, the surviving Washington state registered domestic partner, and dependent children of emergency service personnel "killed in the line of duty" as determined by the Washington state department of labor and industries.

(2) "Emergency service personnel" means law enforcement officers and firefighters as defined in RCW 41.26.030, members of the Washington state patrol retirement fund as defined in RCW 43.43.120, and reserve officers and firefighters as defined in RCW 41.24.010.

(3) "Surviving spouse, Washington state registered domestic partner, and dependent children" means:

(a) A lawful spouse;

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

(c) A Washington state registered domestic partner as defined in RCW 26.60.020; and

(d) Children. The term "children" includes children of the emergency service worker up to age twenty-six. Children with disabilities as defined in RCW 41.26.030(7) are eligible at any age. "Children" is defined as:

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

(ii) Stepchildren or children of a Washington state registered domestic partner; and

(iii) Legally adopted children.

(4) Surviving spouses, Washington state registered domestic partners, and children who are entitled to medicare must enroll in both parts A and B of medicare.

(5) The survivor (or agent acting on their behalf) must submit the appropriate forms (to either enroll or defer enrollment in a PEBB health plan) to PEBB program no later than one hundred eighty days after the latter of:

(a) The death of the emergency service worker;

(b) The date on the letter from the department of retirement systems or the board for volunteer firefighters and reserve officers that informs the survivor that he or she is determined to be an eligible survivor;

(c) The last day the surviving spouse, Washington state registered domestic partner, or child was covered under any health plan through the emergency service worker's employer; or

(d) The last day the surviving spouse, Washington state registered domestic partner, or child was covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage from the emergency service worker's employer.

(6) Survivors who do not choose to defer enrollment in a PEBB health plan may choose among the following options for when their enrollment in a PEBB health plan will begin:

(a) June 1, 2006, for survivors whose appropriate forms are received by the PEBB program no later than September 1, 2006;

(b) The first of the month that is not earlier than sixty days before the date that the PEBB program receives the appropriate forms (for example, if the PEBB program receives the appropriate forms on August 29, the survivor may request health plan enrollment to begin on July 1); or

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

For surviving spouses, Washington state registered domestic partners, and children who enroll, monthly health plan premiums must be paid by the survivor except as provided in RCW 41.26.510(5) and 43.43.285 (2)(b).

(7) Survivors must choose one of the following two options to maintain eligibility for PEBB insurance coverage:

(a) Enroll in a PEBB health plan:

(i) Enroll in medical; or

(ii) Enroll in medical and dental.

(iii) Survivors enrolling in dental must stay enrolled in dental for at least two years before dental can be dropped.

(iv) Dental only is not an option.

(b) Defer enrollment:

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

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

(iii) PEBB health plan enrollment and premiums will begin the first day of the month following the day that the other coverage ended for eligible spouses and children who enroll.

(8) Survivors may change their health plan during annual open enrollment. In addition to annual open enrollment, survivors may change health plans as described in WAC 182-08-198.

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

~~(10)~~)) Survivors will lose their right to enroll in a PEBB health plan if they:

(a) Do not apply to enroll or defer PEBB health plan enrollment within the timelines stated in subsection (5) of this section; or

(b) Do not maintain continuous enrollment in comprehensive employer sponsored medical through an employer during the deferral period, as provided in subsection (7)(b)(i) of this section.

AMENDATORY SECTION (Amending Order 10-02, filed 10/6/10, effective 1/1/11)

WAC 182-12-260 Who are eligible dependents? To be enrolled in a health plan, a dependent must be eligible under this section and the subscriber must comply with enrollment procedures outlined in WAC 182-12-262.

The PEBB program verifies the eligibility of all dependents and reserves the right to request documents from subscribers that provide evidence of a dependent's eligibility. The PEBB program will remove a subscriber's enrolled dependents from health plan enrollment if the PEBB program is unable to verify a dependent's eligibility ((~~within a specified time~~)). The PEBB program will not enroll or reenroll dependents into a health plan if the PEBB program is unable to verify a dependent's eligibility.

The subscriber ((~~or dependent~~)) must notify the PEBB program, in writing, no later than sixty days after the date ((~~he or she~~)) his or her dependent is no longer eligible under this section. See WAC 182-12-262 for the consequences of not removing an ineligible dependent from coverage.

The following are eligible as dependents under the PEBB eligibility rules:

(1) Lawful spouse. Former spouses are not eligible dependents upon finalization of a divorce or annulment, even if a court order requires the subscriber to provide health insurance for the former spouse.

(2) Effective January 1, 2010, Washington state registered domestic partners, as defined in RCW 26.60.020(1). Former Washington state registered domestic partners are not eligible dependents upon dissolution or termination of a partnership, even if a court order requires the subscriber to provide health insurance for the former partner.

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

Eligible children include:

(a) Children up to age twenty-six.

(b) Effective January 1, 2011, children of any age with disabilities, mental illness, or intellectual or other developmental disabilities who are incapable of self-support, provided such condition occurs before age twenty-six.

(i) The subscriber must provide evidence of the disability and evidence that the condition occurred before age twenty-six:

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

For example, children who become self-supporting are not eligible under this ((~~rule~~)) subsection as of the last day of the month in which they become capable of self-support.

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

(iv) The PEBB program will certify the eligibility of children with disabilities periodically.

(4) Parents.

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

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

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

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

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

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

AMENDATORY SECTION (Amending Order 10-02, filed 10/6/10, effective 1/1/11)

WAC 182-12-262 When may subscribers enroll or remove eligible dependents? (1) **Enrolling dependents in health plan coverage.** A dependent must be enrolled in the same health plan coverage as the subscriber, and the subscriber must be enrolled to enroll his or her dependent except as provided in WAC 182-12-205 (1)(c). Subscribers may enroll eligible dependents at the following times:

(a) **When the subscriber becomes eligible** and enrolls in PEBB insurance coverage. If eligibility is verified and the dependent is enrolled, the dependent's effective date will be the same as the subscriber's effective date. ((~~Except as pro-~~

~~vided in WAC 182-12-205 (1)(c), a dependent must be enrolled in the same health plan coverage as the subscriber, and the subscriber must be enrolled to enroll his or her dependent.~~))

(b) **During the annual open enrollment.** PEBB health plan coverage begins January 1st of the following year.

(c) **During special open enrollment.** Subscribers may enroll dependents ((~~when the dependent becomes eligible or~~)) during ((~~another~~)) a special open enrollment as described in subsection((~~s~~)) (3) ((~~and~~)) of this section. The subscriber must satisfy the enrollment requirements as described in subsection (4) of this section.

(2) **Removing dependents from a subscriber's health plan coverage.**

(a) **Subscribers are required to remove a dependent((~~s~~))** within sixty days of the date the dependent no longer meets the eligibility criteria in WAC 182-12-250 or 182-12-260. Employees must notify their employing agency. All other subscribers must notify the PEBB program. The PEBB program will remove a subscriber's enrolled dependent the last day of the month in which the dependent ceases to meet the eligibility criteria. Consequences for not submitting notice within sixty days of any dependent ceasing to be eligible may include, but are not limited to:

(i) The dependent may lose eligibility to continue health plan coverage under one of the continuation coverage options described in WAC 182-12-270;

(ii) The subscriber may be billed for claims paid by the health plan for services that were rendered after the dependent lost eligibility;

(iii) The subscriber may not be able to recover subscriber-paid insurance premiums for dependents that lost their eligibility; and

(iv) The subscriber may be responsible for premiums paid by the state for the dependent's health plan coverage after the dependent lost eligibility.

(b) **Employees have the opportunity to remove dependents:**

(i) During the annual open enrollment. The dependent will be removed the last day of December; or

(ii) During a special open enrollment as described in subsection((~~s~~)) (3) ((~~and (4)~~)) of this section. ((~~The dependent will be removed the last day of the month in which the event that creates the special open enrollment occurs.~~))

(c) **Retirees, survivors, and enrollees with PEBB continuation coverage under WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, or 182-12-148 may remove dependents** from their coverage outside of the annual open enrollment or a special open enrollment by providing written notice to the PEBB program. Unless otherwise approved by the PEBB program, the dependent will be removed from the subscriber's coverage prospectively.

(3) **Special open enrollment.** Subscribers may enroll or remove their dependents outside of the annual open enrollment if a special open enrollment event occurs. The change in enrollment must correspond to the event that creates the special open enrollment for either the subscriber or the subscriber's dependents or both.

• Health plan coverage will begin the first of the month following the ((~~event that created the special open enrollment; or in cases where the event occurs on the first day of a month, health plan coverage will begin on that date~~)) later of the event date or the date the form is received.

• Enrollment of extended dependents or dependents with a disability will be the first day of the month following eligibility certification.

• Dependents will be removed from the subscriber's health plan coverage the last day of the month following the event.

• If the special open enrollment is due to the birth or adoption of a child, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of a child, health plan coverage will begin or end the month in which the event occurs.

Any one of the following ((~~changes are~~)) events ((~~that~~)) may create a special open enrollment ((~~for medical and dental~~)):

(a) ((~~Subscriber's~~)) Subscriber acquires a new dependent ((~~becomes eligible under PEBB rules~~)) due to:

(i) ((~~Through~~)) Marriage or registering a domestic partnership with Washington's secretary of state;

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

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

(iv) ((~~When~~)) A child ((~~becomes~~)) becoming eligible as ((~~an extended~~)) a dependent with a disability;

(b) ((~~Subscriber's dependent no longer meets PEBB eligibility criteria because:~~

~~(i) Subscriber has a change in marital status or Washington state registered domestic partnership status, including legal separation documented by a court order;~~

~~(ii) A child dependent turns age twenty-six;~~

~~(iii) A child dependent ceases to be eligible as an extended dependent or as a dependent with disabilities; or~~

~~(iv) A dependent dies;~~

~~(c)~~)) 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);

(((~~(d)~~))) (c) Subscriber or a subscriber's dependent has a change in employment status that affects the subscriber's or ((~~a~~)) the subscriber's dependent's eligibility for the employer contribution toward group health coverage ((~~or the employer contribution toward insurance coverage~~));

(((~~(e) Subscriber or a dependent has a change in residence that affects health plan availability;~~

~~(f)~~)) (d) Subscriber receives a court order or medical support order requiring the subscriber, the subscriber's spouse, or the subscriber's Washington state registered domestic partner to provide insurance coverage for an eligible dependent((~~,~~)) (a former spouse or former registered domestic partner is not an eligible dependent((~~,~~))); ((~~or~~

~~(g)~~)) (e) Subscriber or a subscriber's dependent becomes eligible for ((~~a medical~~)) state premium assistance ((~~program under the department of social and health services, including~~)) through medicaid or ((~~the~~)) a state children's health insurance program (CHIP), or the subscriber or dependent

loses eligibility ((~~in a medical assistance program~~)) for coverage under medicaid or CHIP.

(4) **Enrollment requirements. Subscribers must submit the appropriate forms within the time frames described in this subsection.** Employees submit the appropriate forms to their employing agency. All other subscribers submit the appropriate forms to the PEBB program. In addition to the appropriate forms indicating dependent enrollment, the ((~~PEBB program may require the subscriber to~~)) subscriber must provide ((~~documentation or~~)) the required documents as evidence of the dependent's eligibility; or as evidence of the event that created the special open enrollment.

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

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

(c) If a subscriber wants to enroll newly eligible dependents, the subscriber must submit the appropriate enrollment forms no later than sixty days after the dependent becomes eligible except as provided in (d) of this subsection.

(d) If a subscriber wants to enroll a newborn or child whom the subscriber has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption, the subscriber should notify the PEBB program by submitting an enrollment form as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the subscriber **must** submit the appropriate enrollment form no later than twelve months after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption.

(e) If the subscriber wants to enroll a child age twenty-six or older as a child with disabilities, the subscriber must submit the appropriate form(s) no later than sixty days after the last day of the month in which the child reaches age twenty-six or within the relevant time frame described in WAC 182-12-262 (4)(a), (b), and (f).

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

(((~~(g) If the subscriber wants to remove a dependent from enrollment during an open enrollment, the subscriber must submit the appropriate forms. Unless otherwise approved by the PEBB program, enrollment will be removed prospectively.~~)))

AMENDATORY SECTION (Amending Order 09-02, filed 11/17/09, effective 1/1/10)

WAC 182-12-265 What options for continuing health plan enrollment are available to widows, widowers and dependent children if the employee or retiree dies? The surviving dependent of an eligible employee or retiree who meets the eligibility criteria in subsection (1), (2), or (3) of this section is eligible to enroll in PEBB retiree insurance coverage as a surviving dependent. An eligible surviving spouse, Washington state registered domestic partner, or child must enroll in or defer enrollment in a PEBB medical plan no later than sixty days after the date of the employee's or retiree's death.

(1) Dependents who lose eligibility due to the death of an eligible employee may continue enrollment in a PEBB health plan enrollment as a survivor under retiree insurance coverage provided they immediately begin receiving a monthly retirement benefit from any state of Washington sponsored retirement system.

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

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

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

(d) The two federal retirement systems, Civil Service Retirement System and Federal Employees Retirement System, shall be considered a Washington sponsored retirement system for Washington State University extension service employees who were covered under PEBB insurance coverage at the time of death.

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

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

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

(c) Dependents, who are not enrolled in a PEBB health plan at the time of the retiree's death, are eligible to enroll or defer enrollment in PEBB retiree insurance. A form to enroll or defer PEBB health plan enrollment must be hand-delivered or mailed to the PEBB program no later than sixty days after the retiree's death. To enroll in a PEBB health plan, the dependent must provide satisfactory evidence of continuous enrollment in other medical coverage from the most recent open enrollment for which enrollment in PEBB was deferred.

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

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

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

(4) Surviving dependents must notify the PEBB program of their decision to enroll or defer enrollment in a PEBB health plan no later than sixty days after the date of death of the employee or retiree.

Note: If premium payment sufficient to maintain health plan enrollment continues after the employee's or retiree's death, the PEBB program will consider the payment as notice of the survivor's intent to continue enrollment.

If PEBB health plan enrollment ended due to the death of the employee or retiree, PEBB will reinstate health plan enrollment without a gap subject to payment of premium. In order to avoid duplication of group medical coverage, surviving dependents may defer enrollment in a PEBB health plan under WAC 182-12-200 and 182-12-205. To notify the PEBB program of their intent to enroll or defer enrollment in a PEBB health plan, the surviving dependent must submit the appropriate forms to the PEBB program no later than sixty days after the date of death of the employee or retiree.

AMENDATORY SECTION (Amending Order 09-02, filed 11/17/09, effective 1/1/10)

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

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

"Agency" means the health care authority;

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

"Director" means the director of the health care authority (HCA) or designee;

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

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

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

"Health plan" or "plan" means a medical or dental plan developed by the public employees benefits board and provided by a contracted vendor or self-insured plans administered by the HCA.

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

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

"PEBB" means the public employees benefits board.

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

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

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

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

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

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

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

AMENDATORY SECTION (Amending Order 10-02, filed 10/6/10, effective 1/1/11)

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

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

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

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

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

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

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

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

AMENDATORY SECTION (Amending Order 10-02, filed 10/6/10, effective 1/1/11)

WAC 182-16-032 How can ((~~an employee, retiree, self-pay enrollee, or dependent appeal~~)) a decision made by the PEBB program regarding eligibility, enrollment, or premium payments; or a decision made by an employer group regarding life insurance or long-term disability insurance be appealed? (1) An eligibility, enrollment, or premium payment decision made by the PEBB program may be appealed by submitting a notice of appeal to the PEBB appeals committee.

(2) An eligibility or enrollment decision made by an employer group regarding life insurance or long-term disability insurance may be appealed by submitting a notice of appeal to the PEBB appeals committee.

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

(((~~1~~))) (4) The notice of appeal from an employee or employee's dependent must be received by the PEBB appeals manager within thirty days of the date of the denial notice ((~~by the PEBB program~~)).

(((~~2~~))) (5) The notice of appeal from a retiree, self-pay enrollee, or dependent of a retiree or self-pay enrollee must be received by the PEBB appeals manager within sixty days of the date of the denial notice ((~~by the PEBB program~~)).

(((~~3~~))) (6) The PEBB appeals manager shall notify the appellant in writing when the notice of appeal has been received.

(((~~4~~))) (7) The PEBB appeals committee shall render a written decision within thirty days of receiving the notice of appeal. The written decision shall be sent to the appellant.

(((~~5~~))) (8) Any appellant who disagrees with the decisions of the PEBB appeals committee may request an administrative hearing, as described in WAC 182-16-050.

AMENDATORY SECTION (Amending Order 10-02, filed 10/6/10, effective 1/1/11)

WAC 182-16-050 How can an enrollee or entity request a hearing if aggrieved by a decision made by the PEBB appeals committee? (1) Any party aggrieved by a decision of the PEBB appeals committee, may request an administrative hearing.

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

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

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

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

(6) Within ninety days after the hearing record is closed, the ((~~administrator~~)) director or his or her designee shall render a decision which shall be the final decision of the agency. A copy of that decision shall be mailed to all parties.

WSR 11-22-042
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Economic Services Administration)

[Filed October 27, 2011, 10:51 a.m., effective December 1, 2011]

Effective Date of Rule: December 1, 2011.

Purpose: This amendment will permanently disqualify adults from receiving TANF/SFA benefits if they have been terminated due to noncompliance sanction at least three times since March 1, 2007. These amendments are necessary to conform to ESSB 5921, Laws of 2011.

Citation of Existing Rules Affected by this Order: Amending WAC 388-310-1600 and 388-400-0005.

Statutory Authority for Adoption: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.025, 74.08.090, and chapters 74.08A and 74.12 RCW.

Other Authority: ESSB 5921, Laws of 2011.

Adopted under notice filed as WSR 11-18-097 on September 7, 2011.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 2, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 2, Repealed 0.

Date Adopted: October 24, 2011.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 10-24-069, filed 11/30/10, effective 12/31/10)

WAC 388-310-1600 WorkFirst—Sanctions. Effective July 1, 2010.

(1) **What WorkFirst requirements do I have to meet?**

You must do the following when you are a mandatory WorkFirst participant:

(a) Give the department the information we need to develop your individual responsibility plan (IRP) (see WAC 388-310-0500);

(b) Show that you are participating fully to meet all of the requirements listed on your individual responsibility plan;

(c) Go to scheduled appointments listed in your individual responsibility plan;

(d) Follow the participation and attendance rules of the people who provide your assigned WorkFirst services or activities; and

(e) Accept available paid employment when it meets the criteria in WAC 388-310-1500.

(2) **What happens if I don't meet WorkFirst requirements?**

(a) If you do not meet WorkFirst requirements, we will send you a letter telling you what you did not do, and inviting you to a noncompliance sanction case staffing.

(i) A noncompliance case staffing is a meeting with you, your case manager, and other people who are working with your family, such as representatives from tribes, community or technical colleges, employment security, the children's administration, family violence advocacy providers or limited-English proficient (LEP) pathway providers to review your situation and compliance with your participation requirements.

(ii) You will be notified when your noncompliance sanction case staffing is scheduled so you can attend.

(iii) You may invite anyone you want to come with you to your case staffing.

(b) You will have ten days to contact us so we can talk with you about your situation. You can contact us in writing, by phone, by going to the noncompliance sanction case staffing appointment described in the letter, or by asking for an individual appointment.

(c) If you do not contact us within ten days, we will make sure you have been screened for family violence and other barriers to participation. We will use existing information to decide whether:

(i) You were unable to do what was required; or

(ii) You were able, but refused, to do what was required.

(d) If you had a good reason not to do a required activity we will work with you and may change the requirements in your individual responsibility plan if a different WorkFirst activity would help you move towards independence and employment sooner. If you have been unable to meet your WorkFirst requirements because of family violence, you and your case manager will develop an IRP to help you with your situation, including referrals to appropriate services.

(3) **What is considered a good reason for not doing what WorkFirst requires?**

You have a good reason if you were not able to do what WorkFirst requires (or get an excused absence, described in WAC 388-310-0500(5)) due to a significant problem or event outside your control. Some examples of good reasons include, but are not limited to:

(a) You had an emergent or severe physical, mental or emotional condition, confirmed by a licensed health care professional that interfered with your ability to participate;

(b) You were threatened with or subjected to family violence;

(c) You could not locate child care for your children under thirteen years that was:

(i) Affordable (did not cost you more than your copayment would under the working connections child care program in chapter 170-290 WAC);

(ii) Appropriate (licensed, certified or approved under federal, state or tribal law and regulations for the type of care you use and you were able to choose, within locally available options, who would provide it); and

(iii) Within a reasonable distance (within reach without traveling farther than is normally expected in your community).

(iv) You could not locate other care services for an incapacitated person who lives with you and your children.

(d) You had an immediate legal problem, such as an eviction notice; or

(e) You are a person who gets necessary supplemental accommodation (NSA) services under chapter 388-472 WAC and your limitation kept you from participating. If you have a good reason because you need NSA services, we will review your accommodation plan.

(4) **What happens in my noncompliance sanction case staffing?**

(a) At your noncompliance case staffing we will ensure you were offered the opportunity to participate and discuss with you:

(i) What happens if you are sanctioned and stay in sanction;

(ii) How you can participate and get out of sanction;

(iii) How you and your family benefit when you participate in WorkFirst activities;

(iv) That if you continue to refuse to participate, without good cause, your case may be closed after you have been in sanction status for four months in a row;

(v) How you plan to care for and support your children if your case is closed. We will also discuss the safety of your

family, as needed, using the guidelines under RCW 26.44.030; ((~~and~~))

(vi) How to reapply if your case is closed; and

(vii) That upon your third noncompliance sanction case closure after March 1, 2007, you may be permanently disqualified from receiving TANF/SFA. If you are permanently disqualified, your entire household is ineligible for TANF/SFA.

(b) If you do not come to your noncompliance sanction case staffing, we will make a decision based on the information we have.

(5) **What if we decide that you did not have a good reason for not meeting WorkFirst requirements?**

(a) Before you are placed in sanction, a supervisor will review your case to make sure:

(i) You knew what was required;

(ii) You were told how to end your sanction;

(iii) We tried to talk to you and encourage you to participate; and

(iv) You were given a chance to tell us if you were unable to do what we required.

(b) If we decide that you did not have a good reason for not meeting WorkFirst requirements, and a supervisor approves the sanction, we will send you a letter that tells you:

(i) What you failed to do;

(ii) That you are in sanction status;

(iii) Penalties that will be applied to your grant;

(iv) When the penalties will be applied;

(v) How to request a fair hearing if you disagree with this decision; and

(vi) How to end the penalties and get out of sanction status.

(c) We will also provide you with information about resources you may need if your case is closed. If you are sanctioned, then we will actively attempt to contact you another way so we can talk to you about the benefits of participation and how to end your sanction.

(6) **What is sanction status?**

When you are a mandatory WorkFirst participant, you must follow WorkFirst requirements to qualify for your full grant. If you or someone else on your grant doesn't do what is required and you can't prove that you had a good reason, you do not qualify for your full grant. This is called being in WorkFirst sanction status.

(7) **Are there penalties when you or someone in your household goes into sanction status?**

(a) When someone in your household is in sanction status, we impose penalties. The penalties last until you or the household member meet WorkFirst requirements.

(b) Your grant is reduced by one person's share or forty percent, whichever is more.

(8) **How do I end the penalties and get out of sanction status?**

To stop the penalties and get out of sanction status:

(a) You must provide the information we requested to develop your individual responsibility plan; and/or

(b) Start and continue to do your required WorkFirst activities for four weeks in a row (that is, twenty-eight calendar days).

(c) When you leave sanction status, your grant will be restored to the level you are eligible for beginning the first of the month following your four weeks of participation. For example, if you finished your four weeks of participation on June 15, your grant would be restored on July 1.

(9) **What if I reapply for TANF or SFA and I was in sanction status when my case closed?**

If your case closes while you are in sanction status and is reopened, you will start out where you left off in sanction.

That is, if you were in month two of sanction when your case closed, you will be in month three of sanction when you are approved for TANF or SFA.

(10) **What happens if I stay in sanction status?**

(a) We will send information to a supervisor or designee with a recommendation to close your case.

(b) A supervisor or designee will make the final decision.

(c) If the supervisor or designee approves case closure, your case will be closed after you have been in sanction for four months in a row.

(11) **What happens when a supervisor or designee approves closure of my case?**

When a supervisor or designee approves closure of your case, we will send you a letter to tell you:

(a) What you failed to do;

(b) When your case will be closed;

(c) How to request a fair hearing if you disagree with this decision;

(d) How to end your penalties and keep your case open (if you are able to participate for four weeks in a row before we close your case); and

(e) How your participation before your case is closed can be used to meet the participation requirement in subsection (12).

(12) **What if I reapply for TANF or SFA after a supervisor or designee approved case closure and my case was closed?**

If a supervisor or designee approves case closure and we close your case, you must participate for four weeks in a row before you can receive cash. Once you have met your four week participation requirement, your cash benefits will start, going back to the date we had all the other information we needed to make an eligibility decision.

(13) **What happens if a supervisor or designee approves case closure for the third time?**

If we close your case at least three times after March 1, 2007, you will be permanently disqualified from receiving TANF/SFA. If you are permanently disqualified, any household you are in will also be ineligible for TANF/SFA.

AMENDATORY SECTION (Amending WSR 06-13-043, filed 6/15/06, effective 7/17/06)

WAC 388-400-0005 Who is eligible for temporary assistance for needy families? (1) You can get temporary assistance for needy families (TANF), if you:

(a) Can be in a TANF/SFA assistance unit as allowed under WAC 388-408-0015 through 388-408-0030;

(b) Meet the citizenship/alien status requirements of WAC 388-424-0010;

(c) Live in the state of Washington. A child must live with a caretaker relative, guardian, or custodian who meets the state residency requirements of WAC 388-468-0005;

(d) Do not live in a public institution unless specifically allowed under RCW 74.08.025;

(e) Meet TANF/SFA:

(i) Income requirements under chapter 388-450 WAC;

(ii) Resource requirements under chapter 388-470 WAC; and

(iii) Transfer of property requirements under chapter 388-488 WAC.

(f) Assign your rights to child support as required under WAC 388-422-0005;

(g) Cooperate with the division of child support (DCS) as required under WAC 388-422-0010 by helping them:

(i) Prove who is the father of children applying for or getting TANF or SFA; and

(ii) Collect child support.

(h) Tell us your Social Security number as required under WAC 388-476-0005;

(i) Cooperate in a review of your eligibility as required under WAC 388-434-0005;

(j) Cooperate in a quality assurance review as required under WAC 388-464-0001;

(k) Participate in the WorkFirst program as required under chapter 388-310 WAC;

(l) Report changes of circumstances as required under WAC 388-418-0005; and

(m) Complete a mid-certification review and provide proof of any changes as required under WAC 388-418-0011.

(2) If you are an adult, you must have an eligible child living with you or you must be pregnant and meet the requirements of WAC 388-462-0010.

(3) If you are an unmarried pregnant teen or teen parent:

(a) Your living arrangements must meet the requirements of WAC 388-486-0005; and

(b) You must attend school as required under WAC 388-486-0010.

(4) In addition to rules listed in subsection (1) of this section, a child must meet the following rules to get TANF:

(a) Meet the age requirements under WAC 388-404-0005; and

(b) Live in the home of a relative, court-ordered guardian, court-ordered custodian, or other adult acting *in loco parentis* as required under WAC 388-454-0005; or

(c) If the child lives with a parent or other adult relative that provides care for the child, that adult cannot have used up their sixty-month lifetime limit of TANF or SFA cash benefits as defined in WAC 388-484-0005; or

(d) If the child lives with a parent who provides care for the child, that adult cannot have been permanently disqualified from receiving TANF/SFA due to noncompliance sanction as defined in WAC 388-310-1600.

(5) You cannot get TANF if you have been:

(a) Convicted of certain felonies and other crimes under WAC 388-442-0010; or

(b) Convicted of unlawful practices to get public assistance under WAC 388-446-0005 or 388-446-0010.

(6) If you are a client in a household which is eligible for a tribal TANF program, you cannot receive state and tribal TANF in the same month.

WSR 11-22-043
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Disability Services Administration)

[Filed October 27, 2011, 10:53 a.m., effective November 27, 2011]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The department is adopting new rules in chapter 388-106 WAC, Long-term care services, regarding addition of a new service to the state plan. This new service is called chronic care management (CCM). CCM provides chronic care management to high-cost and high-risk medicaid only clients who meet eligibility criteria and voluntarily agree to participate.

Citation of Existing Rules Affected by this Order: Amending WAC 388-106-0010.

Statutory Authority for Adoption: RCW 74.08.090, 74.09.520.

Adopted under notice filed as WSR 11-17-071 on August 16, 2011.

Number of Sections Adopted in Order to Comply with Federal Statute: New 8, Amended 1, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 8, Amended 1, Repealed 0.

Date Adopted: October 17, 2011.

Katherine I. Vasquez
Rules Coordinator

Reviser's note: The material contained in this filing exceeded the page-count limitations of WAC 1-21-040 for appearance in this issue of the Register. It will appear in the 11-23 issue of the Register.

WSR 11-22-044
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Economic Services Administration)

[Filed October 27, 2011, 10:55 a.m., effective November 27, 2011]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The department is amending WAC 388-460-0035 to assign a protective payee to a person receiving public assistance if the recipient illegally used a public assistance electronic benefit transfer (EBT) card or cash obtained with an EBT card two or more times. Illegal use includes infractions, felonies, or violations referenced in WAC 388-412-0046 or 388-446-0020. These changes are necessary to comply with ESSB 5921, section 14.

Citation of Existing Rules Affected by this Order: Amending WAC 388-460-0035.

Statutory Authority for Adoption: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 74.08.580.

Other Authority: ESSB 5921, chapter 42, Laws of 2011.

Adopted under notice filed as WSR 11-18-092 on September 7, 2011.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 1, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 1, Repealed 0.

Date Adopted: October 24, 2011.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 02-14-083, filed 6/28/02, effective 7/1/02)

WAC 388-460-0035 When is a protective payee assigned for mismanagement of funds? (1) The decision to assign a person to a protective payee because of mismanagement of funds must be based on law or with proof the client is unable to manage their cash benefits. The proof must be current and show how this threatens the well being of a child or client on ((~~TANF/SFA, GA or WCCC~~)) public assistance. Examples of proof are:

(a) Department employees or others observe that the client or client's children are hungry, ill, or not adequately clothed;

(b) Repeated requests from the client for extra money for basic essentials such as food, utilities, clothing, and housing;

(c) A series of evictions or utility shut off notices within the last twelve months;

(d) Medical or psychological evaluations showing an inability to handle money;

(e) Persons having had ((~~an ADATSA~~)) a chemical dependency assessment and who are participating in ((~~ADATSA-funded~~)) chemical dependency treatment;

(f) ((~~Not paying an in-home child care provider for services when payment has been issued to the client by the department for that purpose;~~

~~(g)~~)) A complaint from businesses showing a pattern of failure to pay bills or rent;

(((~~(h)~~))) (g) ((~~Using public assistance electronic benefits transfer (EBT) card or cash obtained through EBT to purchase or pay for lottery tickets, pari-mutuel wagering, or any of the activities authorized under chapter 9.46 RCW~~)) Notice from the office of fraud and accountability that a client illegally used a public assistance electronic benefits transfer (EBT) card or cash obtained with an EBT card two or more times. Illegal use includes infractions, felonies, or violations referenced in WAC 388-412-0046 or WAC 388-446-0020.

(2) A lack of money or a temporary shortage of money because of an emergency does not constitute mismanagement.

(3) When a client has a history of mismanaging money, benefits can be paid through a protective payee or directly to a vendor.

WSR 11-22-054
PERMANENT RULES
DEPARTMENT OF LABOR AND INDUSTRIES

[Filed October 31, 2011, 9:39 a.m., effective December 1, 2011]

Effective Date of Rule: Thirty-one days after filing.

Purpose: This rule making will update four rules under chapter 296-30 WAC and will add one rule to be consistent with SSB 5691 (chapter 346, Laws of 2011). The updates include removal of references to Title 51 RCW, addition or clarification of some definitions, an explanation of new medical cap, fee schedule changes, and fee schedule change notification methods.

Citation of Existing Rules Affected by this Order: Amending WAC 296-30-010, 296-30-085, 296-30-090, and 296-30-100.

Statutory Authority for Adoption: Chapter 7.68 RCW.

Adopted under notice filed as WSR 11-17-108 on August 23, 2011.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 1, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 1, Amended 4, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 1, Amended 4, Repealed 0.

Date Adopted: October 31, 2011.

Judy Schurke
Director

AMENDATORY SECTION (Amending WSR 01-22-105, filed 11/7/01, effective 12/8/01)

WAC 296-30-010 Definitions. The following definitions are used to administer the crime victims compensation program:

Acceptance, accepted condition: A determination by the department that the diagnosis of the claimant's medical or mental health condition is the result of the criminal act. The condition being accepted must be specified by one or more diagnostic codes from the current edition of the International Classification of Diseases, Clinically Modified (ICD-CM), or the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Authorization: Notification by a qualified representative of the department that specific treatment, services or equipment provided for the accepted condition is allowable under the claim. Providers must ((~~insure they~~)) maintain records ((~~indicating the name of the qualified representative~~)) naming the claim manager who authorizes treatment, services or equipment.

Bodily injury: Any harmful or offensive touching, including severe emotional distress where no touching takes place when:

(1) The victim **is not** the object of the criminal act and:

(a) The distress is intentionally or recklessly inflicted by extreme or outrageous conduct;

(b) Caused the victim to have a reasonable apprehension of imminent bodily harm; and

(c) The victim is in the immediate vicinity at the time of the criminal act.

(2) The victim **is** the object of the criminal act and:

(a) The distress is intentionally or recklessly inflicted by extreme or outrageous conduct; and

(b) Caused the victim to have a reasonable apprehension of imminent bodily harm.

Claimant: A victim who submits an application for benefits, or on whose behalf an application is submitted.

Consultation: The services rendered by a ((~~mental~~)) health care provider whose opinion or advice is requested by the ((~~attending (~~))treating((~~) mental health~~)) provider, ((~~or agency,~~)) or by the department, in the evaluation and/or treatment of a claimant. Case management or case staffing does not constitute a consultation.

Criminal act: An act defined in RCW 7.68.020, the occurrence of which can be verified by the department or which is reasonably credible. Physically impossible acts, highly improbable acts for which verification is not available, or unverified memories of acts occurring prior to the age of two will not be accepted as reasonably credible. In evaluating evidence to determine verification of claimed criminal acts, the department will give greater weight to the quality, than to the quantity, of evidence. Evidence that can be considered for verification of claimed criminal acts includes, but is not limited to, one or more of the following:

(1) Police or other investigation reports.

(2) Child protective services or other government agency reports.

(3) Diaries or journals kept by victims and others.

(4) Third party reports from school counselors, therapists and others.

(5) Current medical examinations.

(6) Medical or psychological forensic evaluations. In the absence of other adequate forensic evaluation reports, independent assessments per WAC 296-31-069 may be conducted when indicated.

(7) Legal and historical reports.

(8) Current and past medical and mental health records.

(9) Reports of interviews with the victim's family members, friends, acquaintances and others who may have knowledge of pertinent facts. When such interviews are necessary to determine eligibility, the victim will be given the choice of whether to allow the interviews to be conducted. The victim will also be given the understanding that eligibility may be denied if the interviews are not conducted. The department will act according to the victim's choice.

Crisis intervention: Therapy to alleviate the claimant's most pressing problems. The vital mental and safety functions of the claimant are stabilized by providing support, structure and, if necessary, restraint.

((~~**Disability awards for mental health conditions:** Direct monetary compensation that may be provided to an eligible claimant who is either temporarily totally disabled, permanently totally disabled, or permanently partially disabled resulting from an accepted condition.~~))

Evidence-based and curative treatment: Treatment practices, interventions and services that are supported by empirically based research and shown to produce consistent and effective outcomes.

Family therapy: Therapy involving one or more members of the claimant's family, excluding the perpetrator, which centers on issues resulting from the claimant's sexual assault pursuant to WAC 296-30-080.

Group therapy: Therapy involving the claimant, and one or more clients who are not related to the claimant, which includes issues related to the claimant's condition and pertinent to other group members.

Immediate family members: Any claimant's parents, spouse, child(ren), siblings, grandparents, and those members of the same household who have assumed the rights and duties commonly associated with a family unit.

Individual therapy: Therapy provided on a one-to-one basis between a ((~~therapist~~)) provider and client.

Lost wage certification: Documentation from a treating provider based on objective medical evidence stating the claimant is not able to work based on the effects of the crime injury.

Mental health provider: Any person, firm, corporation, partnership, association, agency, institution, or other entity providing any kind of mental health services related to the treatment of a claimant. This includes, but is not limited to, hospitals, psychiatrists, psychologists, advanced registered nurse practitioners with a specialty in psychiatric and mental health nursing, registered and/or licensed master level counselors, and other qualified service providers licensed, registered and/or certified with the department of health and

registered with the crime victims compensation program. (Refer to WAC 296-31-030 for specific details.)

((**Permanent partial disability:** Any anatomic or functional loss after maximum recovery has been achieved. When the attending provider has reason to believe a permanent functional loss exists, the department should be notified. Specified disabilities (amputation or loss of function of extremities, loss of hearing or vision) are to be rated utilizing a nationally recognized impairment rating guide. Unspecified disabilities (internal injuries, spinal injuries, mental health, etc.) are to be rated utilizing the category system detailed under WAC 296-20-200, et al. Under Washington law disability awards are based solely on physical or mental impairment due to the accepted injury or conditions without consideration of economic factors. Maximum benefit levels are established by statute.

Permanent total disability (pension): A condition permanently incapacitating a claimant from performing work at any gainful employment. Maximum benefit levels are established by statute.))

Payer of last resort: The crime victims compensation program pays after all other public or private insurance programs, up to our fee schedule.

Proper and necessary: (((1))) Proper and necessary services for the diagnosis or rehabilitative treatment of an accepted condition((;)):

(((2))) (1) Reflective of accepted standards of good practice within the scope of the provider's license, certification, or registration;

(((3))) (2) Not delivered primarily for the convenience of the claimant, the claimant's attending provider, or another provider;

(((4))) (3) Curative or rehabilitative care that produces long lasting changes which reduces the effects of the accepted condition;

(((5))) (4) Provided at the least cost and in the least intensive setting of care consistent with the other provisions of this definition; and

(((6))) (5) Concluded once a claimant has reached a state of maximum improvement. Maximum improvement occurs when no fundamental or marked change in an accepted condition can be expected with or without treatment. A claimant's condition may have reached maximum improvement though it might be expected to improve or deteriorate with the passage of time. Once a claimant's condition has reached maximum improvement, treatment that results only in temporary changes is not proper and necessary. Maximum improvement is equivalent to fixed and stable.

Reasonable cooperation: The victim is able to talk to the police and give information to help in the investigation and prosecution of the alleged offender. There may be circumstances in which the victim is not able to fully cooperate. In these instances, consideration is given to the needs of the victim. The department may consider the following issues. The list is not inclusive:

(1) There is fear of retribution from the offender;

(2) There is a mental or physical condition which inhibits cooperation;

(3) The victim is dependent upon the offender for support;

(4) The victim is a minor.

((**Temporary partial disability (loss of earning power):** Partial time loss compensation may be paid when the claimant can return to work on a limited basis, or return to a lesser paying job is necessitated by the accepted condition. The claimant must have a reduction in wages of at least five percent before consideration of partial time loss can be made. No partial time loss compensation can be paid after the claimant's condition is stationary. All time loss compensation must be certified by the attending provider based on objective findings.

Temporary total disability (time loss compensation): Time loss compensation may be paid when the claimant is temporarily unable to return to reasonable continuous gainful employment as a direct result of an accepted condition. Maximum benefit levels are established by statute.))

Termination of treatment: Treatment is concluded when ((treatment)) it is no longer ((required)) curative because the accepted condition for which the claim was allowed has become stable. The provider ((should)) shall submit a report indicating the date the condition became stable to the department. ((The claimant may require continued treatment for conditions not related to the crime injury condition; however, financial responsibility for such care must be the claimants.))

The result of: The test used to define "the result of" used in RCW ((7.68.070(3))) 7.68.060 (2)(a) is two-pronged. First, it must be determined that cause in fact exists, and second, it must then be determined that proximate cause exists.

(1) Cause in fact exists if "but for" the acts of the victim the crime that produced the injury would not have occurred.

(2) Proximate cause exists if, once cause in fact is found, it is determined that the acts of the victim:

(a) Resulted in a foreseeable injury to the victim;

(b) Played a substantial role in the injury; and

(c) Were the direct cause of the injury.

((**Time loss certification:** Documentation from a physician, or mental health professional qualified to treat under the Crime Victims Act, based upon objective findings which are specific symptoms that an accepted condition of a claimant either partially or totally incapacitates the claimant from returning to work.))

Treating provider: A person licensed to practice one or more of the following professions: Medicine and surgery, osteopathic medicine and surgery, chiropractic naturopathic physician, podiatry, dentistry, optometry, advanced registered nurse practitioner (ARNP), mental health therapists, and certified medical physician assistants or osteopathic physician assistants. A treating provider actively treats an injured or ill claimant.

Unjustly enriched: It would not be fair or equitable justice to allow a person to obtain, or have control of, or access to benefits or compensation paid to a victim of crime.

AMENDATORY SECTION (Amending WSR 00-03-056, filed 1/14/00, effective 2/14/00)

WAC 296-30-085 What is different about billing for a crime victim ((client)) claimant? (1) Providers must qualify as approved providers and register with the crime victims

compensation program before they are authorized to provide treatment and receive payment. To register with the crime victims compensation program, you must send us:

(a) A completed provider application and Form W-9.

(b) A legible copy of your professional license, certification and/or registration.

(c) Ph.D.s not licensed as psychologists and master level counselors must provide a legible copy of their degree.

(2) Providers must determine if any public or private insurance benefits are available before billing the department. ((~~Available~~)) Public or private insurance must be billed first and a copy of the insurance explanation of benefits must be attached to billings submitted to the department. All copayments, deductibles or out-of-pocket expenses not covered by primary insurance should be included in your billings to the department.

(3) ((~~A client must not be billed for treatment of his or her accepted condition. All copayments, deductibles or out of pocket expenses not covered by primary insurance should be included in your billings to the department.~~

EXCEPTION: ~~A provider may require the client to pay for treatment if the client's eligibility is in question (e.g., when an investigation or claim determination is pending). If the claim is subsequently allowed, the provider must refund the client in full and bill us at their usual and customary fees if such rates are in excess of the public or private insurance entitlements.~~

~~(4)~~)) On claims closed over ninety days, and the maximum benefit has not been reached, we will pay up to the maximum benefit for completion of a reopening application, an office visit, and diagnostic studies necessary to complete the application. No other benefits will be paid until the reopening decision is made. If the reopening application is approved, we can pay benefits for a period not to exceed sixty days prior to the date the reopening application was received by us.

NEW SECTION

WAC 296-30-087 Can a victim be billed for expenses related to their claim? (1) If claim costs are under fifty thousand dollars, the claimant should not pay any expenses relating to an allowed claim. Providers must bill the claimant's public or private insurance first, and then bill the department.

EXCEPTION: A provider may require the claimant to pay for treatment if the claimant's eligibility is pending. If benefits are authorized, and payable by the department, the provider must refund the claimant in full.

(2) If claim costs exceed fifty thousand dollars, the claimant is responsible for expenses.

AMENDATORY SECTION (Amending WSR 05-16-096, filed 8/2/05, effective 9/2/05)

WAC 296-30-090 What are the maximum allowable fees? (1) Maximum allowable fees for medical and mental health services ((~~are~~)), that are not hospital inpatient or outpatient services, are a percentage of those fees ((~~established by the department of labor and industries for the crime victims compensation program~~)) published in the medical aid rules and fee schedules, less any available benefits of public or private insurance.

EXCEPTION: If any of the percentage of the maximum allowable fees ((~~established by the department of labor and industries for the crime victims compensation program~~)) in the medical aid rules and fee schedules, are lower than the maximum allowable fees for those procedures established by the department of social and health services under Title 74 RCW, the Title 74 RCW fees are the maximum allowable fees for those procedures.

(2) The percent of allowed charges for authorized ((~~for~~)) hospital inpatient and outpatient services billed by revenue codes are those rates established by the department ((~~of social and health services under Title 74 RCW and WAC 388-550-4500 (1)(a) and 388-550-6000 (1)(a) less any available benefits of public or private insurance~~)). If the maximum allowable fees for hospital inpatient or outpatient services is lower than the maximum allowable fees for those procedures established under Title 74 RCW for the ratio of costs to charges (RCC) rate, the department will use the RCC rate as the percent of allowed charges for hospital inpatient and outpatient services, regardless of whether the hospital is diagnosis related group (DRG) exempt.

AMENDATORY SECTION (Amending WSR 00-03-056, filed 1/14/00, effective 2/14/00)

WAC 296-30-100 Will the department notify providers if a fee schedule is amended or established? ((~~We will give you~~)) Our web site will be updated at least thirty days in advance ((~~notice by mail~~)) when we amend or establish a fee schedule.

WSR 11-22-068
PERMANENT RULES
OFFICE OF INSURANCE COMMISSIONER

[Insurance Commissioner Matter No. R 2011-08—Filed October 31, 2011, 3:54 p.m., effective December 1, 2011]

Effective Date of Rule: Thirty-one days after filing.

Purpose: These new rules add sections to chapter 284-83 WAC so that partnership policies can be issued in Washington state. WAC 284-83-140 is amended for internal consistency and clarity.

Citation of Existing Rules Affected by this Order: Amending WAC 284-83-140.

Statutory Authority for Adoption: RCW 48.02.060 and 48.85.030.

Adopted under notice filed as WSR 11-18-085 on September 7, 2011.

Changes Other than Editing from Proposed to Adopted Version: 1. WAC 284-83-410 [(1)](c), the following words were added to the sentence for clarification "at least" the following "levels of."

2. WAC 284-83-410 [(1)](c)(ii) and (iii), deleted the word "simple" because it was not necessary.

3. WAC 284-83-410 [(1)](c)(iv), was deleted because the change in [(1)](c) made this subsection unnecessary.

A final cost-benefit analysis is available by contacting Kacy Scott, P.O. Box 40258, phone (360) 725-7041, fax (360) 586-3109, e-mail kacys@oic.wa.gov.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 6, Amended 1, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 6, Amended 1, Repealed 0.

Date Adopted: October 31, 2011.

Mike Kreidler
Insurance Commissioner

AMENDATORY SECTION (Amending Matter No. R 2008-09, filed 11/24/08, effective 12/25/08)

WAC 284-83-140 Qualified long-term care insurance policies—Additional standards for benefit triggers. (1) For purposes of this section the following definitions apply:

(a) "Qualified long-term care services" means services that meet the requirements of Section 7702B (c)(1) of the Internal Revenue Code of 1986, as amended, including: Necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(b)(i) "Chronically ill individual" has the meaning of Section 7702B (c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:

(A) Being unable to perform (without substantial assistance from another individual) at least two activities of daily living for a period of at least ninety days due to a loss of functional capacity; or

(B) Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

(ii) The term "chronically ill individual" does not include an individual otherwise meeting these requirements unless within the preceding twelve-month period a licensed health care practitioner certified that the individual meets these requirements.

(c) "Licensed health care practitioner" means a physician, as defined in Section 1861 (r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets requirements prescribed by the federal Secretary of the Treasury.

(d) "Maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

(2) A qualified long-term care insurance policy must pay only for qualified long-term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(3) A qualified long-term care insurance policy must condition the payment of benefits on a determination ((~~of~~)) that the ((~~insured's inability to perform activities of daily living for an expected period of at least ninety days due to a loss of functional capacity or to severe cognitive impairment~~)) insured is a chronically ill individual as defined in subsection (1)(b)(i) of this section.

(4) Certifications regarding activities of daily living and cognitive impairment required pursuant to subsection (3) of this section must be performed by a licensed or certified physician, registered professional nurse, licensed social worker, or other individual who meet requirements prescribed by the federal Secretary of the Treasury.

(5) Certifications required pursuant to subsection (3) of this section may be performed by a licensed health care professional at the direction of the issuer as is reasonably necessary with respect to a specific claim; except that when a licensed health care practitioner has certified that the insured is unable to perform activities of daily living for an expected period of at least ninety days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the ninety-day period.

(6) Qualified long-term care insurance policies must include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

LONG-TERM CARE PARTNERSHIP PROGRAM

NEW SECTION

WAC 284-83-400 Purpose and authority. WAC 284-83-400 through 284-83-420 is adopted pursuant to RCW 48.85.030 and 48.85.040. The purpose of these sections is to effectuate chapter 48.85 RCW, the Washington Long-Term Care Partnership Act. Pursuant to RCW 48.85.030, these sections establish minimum standards and disclosure requirements to be met by insurers, health care service contractors, health maintenance organizations, and fraternal benefit societies with respect to long-term care partnership insurance policies to include: Contracts, certificates, riders, and endorsements.

NEW SECTION

WAC 284-83-405 Applicability and scope. (1) WAC 284-83-400 through 284-83-420 applies to any qualified long-term care insurance partnership policy, as defined by federal law and this chapter.

(2) These sections do not apply to medicare supplement policies regulated under chapters 48.66 RCW and 284-55 or

284-66 WAC; policies or contracts between a continuing care retirement community and its residents; or to long-term care insurance policies that are not intended to provide asset protection under chapter 48.85 RCW.

(3) Policies that do not meet the requirements of the Washington Long-Term Care Partnership Act and the requirements of this chapter may not be advertised, issued or delivered in this state as partnership policies.

NEW SECTION

WAC 284-83-410 Minimum standards for long-term care partnership policies. Every long-term care partnership policy must meet the standards for long-term care policies or contracts in chapters 48.83 and 48.85 RCW and this chapter, unless specifically provided otherwise.

(1) As used in WAC 284-83-400 through 284-83-420, "qualified long-term care partnership policy" or "partnership policy" means a long-term care policy that meets all of the following additional requirements:

(a) The policy was issued on or after January 1, 2012, or exchanged as provided in WAC 284-83-415 on or after January 1, 2012, and covers an insured who was a resident of this state or of another state that has entered into a reciprocal agreement with this state when coverage first became effective under the policy.

(b) The policy is a tax qualified long-term care insurance policy as defined in Section 7702B(b) of the Internal Revenue Code of 1986 (26 U.S.C. 7702B(b)).

(c) The policy provides at least the following levels of inflation protection:

(i) If the policy is sold to an individual who has not attained age sixty-one as of the date of purchase, the policy must provide automatic annual compounded inflation increases at a rate not less than three percent or automatic annual compounded inflation increases at a rate based on changes in the consumer price index, not to be less than zero percent.

(ii) If the policy is sold to an individual who has attained age sixty-one but has not attained age seventy-six as of the date of purchase, the policy must provide automatic simple inflation increases at a rate not less than three percent or automatic inflation increases at a rate based on changes in the consumer price index, not to be less than zero percent.

(iii) If the policy is sold to an individual who has attained age seventy-six as of the date of purchase, the policy may, but is not required to, provide automatic inflation increases at a rate based on changes in the consumer price index, not to be less than zero percent.

(iv) For purposes of this section, "consumer price index" means the consumer price index for all urban consumers, U.S. city average, all items, as determined by the Bureau of Labor Statistics of the United States Department of Labor.

(2) Issuers must file a long-term care insurance policy for approval for use as a partnership policy. The long-term care Partnership Policy Certification Form must be completed and accompany the request for approval. The form is available on the commissioner's web site: www.insurance.wa.gov.

(3) Issuers requesting to make use of a previously approved policy form as a qualified state long-term care partnership policy must:

(a) Submit to the commissioner a Partnership Policy Certification Form signed by an officer of the company; and

(b) File for approval an amendatory rider or endorsement indicating the policy is partnership qualified.

(4) An issuer or its agent, soliciting or offering to sell a policy that is intended to qualify as a partnership policy, must provide to each prospective applicant a Partnership Program Notice found on the commissioner's web site: www.insurance.wa.gov, outlining the requirements and benefits of a partnership policy. The Partnership Program Notice must be provided with the required outline of coverage.

(5) A partnership policy issued for delivery in Washington must be accompanied by a Partnership Status Disclosure Notice found on the commissioner's web site: www.insurance.wa.gov, explaining the benefits associated with a partnership policy and indicating that at the time issued, the policy is a qualified Washington state long-term care insurance partnership policy. The Partnership Disclosure Notice must also include a statement indicating that by purchasing this partnership policy, the insured does not automatically qualify for medicaid.

NEW SECTION

WAC 284-83-415 Long-term care partnership policy exchange or replacement. (1) Within one year of the date that an issuer begins to advertise, market, offer, or sell policies that qualify under the Washington state long-term care partnership program, the issuer must offer to all of its current policyholders and certificate holders the opportunity to exchange their existing long-term policy for a policy that is intended to qualify under the state's long-term care partnership program provided that:

(a) The existing long-term care policy was issued on or after February 8, 2006; and

(b) The existing long-term care policy is the type certified by the issuer for purposes of the state long-term care partnership program.

(2) In making an offer to exchange, an issuer must comply with the following requirements:

(a) The offer must be made on a nondiscriminatory basis without regard to the age or health status of the insured; and

(b) The offer must remain open for a minimum of ninety days from the date of mailing by the issuer.

(3) An exchange occurs when an issuer offers a policyholder or certificate holder (hereinafter "insured") the option to replace an existing long-term care insurance policy with a policy that qualifies as a long-term care partnership policy, and the insured accepts the offer to terminate the existing policy and accepts the new policy.

(4) Notwithstanding subsections (1), (2), and (3) of this section:

(a) An offer to exchange may be deferred for any insured who is currently eligible for benefits under an existing policy or who is subject to an elimination period on a claim, but such deferral shall continue only as long as such eligibility or elimination period exists; and

(b) An offer to exchange does not have to be made if the insured would be required to purchase additional benefits to qualify for the state long-term care partnership program and the insured is not eligible to purchase the additional benefits under the issuer's long-term care underwriting guidelines.

(5) If the partnership policy has an actuarial value of benefits equal to or lesser than the actuarial value of benefits of the existing policy, then the following requirements apply:

(a) The partnership policy must not be underwritten; and

(b) The rate charged for the partnership policy shall be determined using the original issue age and risk class of the insured that was used to determine the rate of the existing policy.

(6) If the partnership policy has an actuarial value of benefits exceeding the actuarial value of the benefits of the existing policy, then the following requirements apply:

(a) The issuer must apply its long-term care underwriting guidelines to the increased benefits only; and

(b) The rate charged for the partnership policy must be determined using the method set forth in subsection (5)(b) of this section for the existing benefits, increased by the rate for the increased benefits using the then current attained age and risk class of the insured for the increased benefits only.

(7) The partnership policy offered in an exchange must be on a form that is currently offered for sale by the issuer in the general market.

(8) In the event of an exchange, the insured must not lose any rights, benefits, or built-up value that has accrued under the original policy with respect to the benefits provided under the original policy including, but not limited to, rights established because of the lapse of time related to preexisting condition exclusions, elimination periods, or incontestability clauses.

(9) Issuers may complete an exchange by either issuing a new policy or by amending an existing policy with an endorsement or rider. An issuer must file such endorsement or rider for approval prior to issue.

(10) For those insureds with long-term care policies issued before February 8, 2006, an issuer may offer an insured the option to exchange an existing policy for a policy that qualifies as a Washington state long-term partnership policy. The requirements set forth in subsections (2) through (9) of this section apply to any such exchange.

(11) Policies issued pursuant to this section shall be considered exchanges and not replacements and are not subject to WAC 284-83-060 through 284-83-070.

NEW SECTION

WAC 284-83-420 Reporting. All issuers of qualified long-term care partnership policies must provide regular reports to the United States Secretary of Health and Human Services in accordance with regulations of the secretary. These reports include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the secretary determines may be appropriate to the administration of partnership policies.

NEW SECTION

WAC 284-83-425 Producer education. Prior to selling, soliciting, or negotiating, or continuing to sell, solicit, or negotiate long-term care partnership policies in this state, all licensed producers must meet the education requirements in RCW 48.83.130(2).

WSR 11-22-077

PERMANENT RULES

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

(Aging and Disability Services Administration)

[Filed November 1, 2011, 9:26 a.m., effective December 2, 2011]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The department is amending these rules as a result of legislative activity during session and to be consistent with federal regulations and newly passed state laws: SSB 5042, vulnerable adults protection, ESHB 1277, oversight of licensed or certified long-term care settings for vulnerable adults and 2E2SHB 1738, changing the designation of medicaid state agency.

Citation of Existing Rules Affected by this Order: Amending WAC 388-97-0001, 388-97-0140, 388-97-0600, 388-97-1640, 388-97-4160, 388-97-4180, 388-97-4280, and 388-97-4460.

Statutory Authority for Adoption: Chapters 18.51 and 74.42 RCW.

Adopted under notice filed as WSR 11-17-070 on August 16, 2011.

Changes Other than Editing from Proposed to Adopted Version: See Reviser's note below.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 1, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 7, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 8, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 8, Repealed 0.

Date Adopted: October 31, 2011.

Katherine I. Vasquez

Rules Coordinator

Reviser's note: The material contained in this filing exceeded the page-count limitations of WAC 1-21-040 for appearance in this issue of the Register. It will appear in the 11-23 issue of the Register.

WSR 11-22-086
PERMANENT RULES
DEPARTMENT OF HEALTH
(Board of Pharmacy)
[Filed November 1, 2011, 3:03 p.m., effective December 2, 2011]

Effective Date of Rule: Thirty-one days after filing.

Purpose: WAC 246-887-100 adds synthetic cannabinoids and substituted cathinones to Schedule I of the Controlled Substances Act. Synthetic cannabinoids are sold as incense and are most commonly known as Spice. Substituted cathinones are sold as bath salts and are known by names like Ivory Wave and Zoom. The rule gives law enforcement clear authority to prosecute for the sale, possession, manufacture and delivery of these substances.

Citation of Existing Rules Affected by this Order: Amending WAC 246-887-100.

Statutory Authority for Adoption: RCW 18.64.005.

Other Authority: RCW 69.50.201 and 69.50.203.

Adopted under notice filed as WSR 11-16-040 on July 27, 2011.

A final cost-benefit analysis is available by contacting Kitty Slater-Einert, P.O. Box 47863, Olympia, WA 98504-7863, phone (360) 236-4861, fax (360) 236-2901, e-mail kitty.slater@doh.wa.gov.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 1, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 1, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 1, Repealed 0.

Date Adopted: September 8, 2011.

A. J. Linggi, Chair
Board of Pharmacy

AMENDATORY SECTION (Amending WSR 01-03-108, filed 1/22/01, effective 1/22/01)

WAC 246-887-100 Schedule I. The board finds that the following substances have high potential for abuse and have no accepted medical use in treatment in the United States or that they lack accepted safety for use in treatment under medical supervision. The board, therefore, places each of the following substances in Schedule I.

(a) The controlled substances listed in this section, by whatever official name, common or usual name, chemical name, or brand name, are included in Schedule I.

(b) Opiates. Unless specifically excepted or unless listed in another schedule, any of the following opiates, including their isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever the existence of these isomers, esters, ethers, and salts is possible within the specific chemical designation:

(1) Acetyl-alpha-methylfentanyl (N-[1-(1-methyl-2-phenethyl)-4-piperidinyl]-N-phenylacetamide);

(2) Acetylmethadol;

(3) Allylprodine;

(4) Alphacetylmethadol; ((~~[(except for levo-alphacetylmethadol - also known as levo-alpha-acetylmethadol, levo-methadyl acetate or LAAM);]~~)) (except for levo-alphacetylmethadol - Also known as levo-alpha-acetylmethadol, levo-methadyl acetate or LAAM);

(5) Alphameprodine;

(6) Alphamethadol;

(7) Alpha-methylfentanyl (N-[1-alpha-methyl-beta-phenyl) ethyl-4-piperidyl] propionanilide; 1-(1-methyl-2-phenylethyl)-4-(N-propanilido) piperidine);

(8) Benzethidine;

(9) Betacetylmethadol;

(10) Betameprodine;

(11) Betamethadol;

(12) Betaprodine;

(13) Clonitazene;

(14) Dextromoramide;

(15) Diampromide;

(16) Diethylthiambutene;

(17) Difenoxin;

(18) Dimenoxadol;

(19) Dimepheptanol;

(20) Dimethylthiambutene;

(21) Dioxaphetyl butyrate;

(22) Dipipanone;

(23) Ethylmethylthiambutene;

(24) Etonitazene;

(25) Etoxeridine;

(26) Furethidine;

(27) Gamma-hydroxybutyric Acid (other names include: GHB);

(28) Hydroxypethidine;

(29) Ketobemidone;

(30) Levomoramide;

(31) Levophenacylmorphan;

(32) 3-Methylfentanyl (N-[3-Methyl-1-(2-phenylethyl)-4-piperidyl)]-N-phenylpropanamide);

(33) Morpheridine;

(34) MPPP (1-Methyl-4-phenyl-4-propionoxypiperidine);

(35) Noracymethadol;

(36) Norlevorphanol;

(37) Normethadone;

(38) Norpipanone;

(39) PEPAP (1-(-2-phenethyl)-4-phenyl-4-acetoxypiperidine);

(40) Phenadoxone;

(41) Phenampromide;

(42) Phenomorphan;

(43) Phenoperidine;

(44) Piritramide;

(45) Proheptazine;

(46) Properidine;

(47) Propiram;

(48) Racemoramide;
(49) Tilidine;
(50) Trimeperidine.

(c) Opium derivatives. Unless specifically excepted or unless listed in another schedule, any of the following opium derivatives, their salts, isomers, and salts of isomers, whenever the existence of these salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) Acetorphine;
(2) Acetyldihydrocodeine;
(3) Benzylmorphine;
(4) Codeine methylbromide;
(5) Codeine-N-Oxide;
(6) Cyprenorphine;
(7) Desomorphine;
(8) Dihydromorphine;
(9) Drotebanol;
(10) Etorphine (except hydrochloride salt);
(11) Heroin;
(12) Hydromorphinol;
(13) Methyldesorphine;
(14) Methyldihydromorphine;
(15) Morphine methylbromide;
(16) Morphine methylsulfonate;
(17) Morphine-N-Oxide;
(18) Myrophine;
(19) Nicocodeine;
(20) Nicomorphine;
(21) Normorphine;
(22) Pholcodine;
(23) Thebacon.

(d) Hallucinogenic substances. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following hallucinogenic substances, or which contains any of its salts, isomers, and salts of isomers, whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation (for purposes of paragraph (d) of this section, only, the term "isomer" includes the optical, position, and geometric isomers):

(1) 4-bromo-2,5-dimethoxy-amphetamine: Some trade or other names: 4-bromo-2,5-dimethoxy-a-methylphenethylamine; 4-bromo-2,5-DMA;

(2) 2,5-dimethoxyamphetamine: Some trade or other names: 2,5-dimethoxy-a-methylphenethylamine; 2,5-DMA;

(3) 2,5-dimethoxy-4-ethylamphetamine (DOET)

(4) 4-methoxyamphetamine: Some trade or other names: 4-methoxy-a-methylphenethylamine; paramethoxyamphetamine, PMA;

(5) 5-methoxy-3,4-methylenedioxy-amphetamine;

(6) 4-methyl-2,5-dimethoxy-amphetamine: Some trade and other names: 4-methyl-2,5-dimethoxy-a-methylphenethylamine; "DOM"; and "STP";

(7) 3,4-methylenedioxy amphetamine;

(8) 3,4-methylenedioxymethamphetamine (MDMA);

(9) 3,4,5-trimethoxy amphetamine;

(10) Bufotenine: Some trade or other names: 3-(beta-Dimethylaminoethyl)-5-hydroxindole; 3-(2-dimethylaminoethyl)-5-indolol; N, N-dimethylserotonin; 5-hydroxy-N,N-dimethyltryptamine; mappine;

(11) Diethyltryptamine: Some trade or other names: N,N-Diethyltryptamine; DET;

(12) Dimethyltryptamine: Some trade or other names: DMT;

(13) Ibogaine: Some trade or other names: 7-Ethyl-6,6 beta,7,8,9,10,12,13,-octahydro-2-methoxy-6,9methano-5H-pyndo (1',2':1,2) azepino (5,4-b) indole; Tabernanthe iboga;

(14) Lysergic acid diethylamide;

(15) Marihuana;

(16) Mescaline;

(17) Parahexyl-7374; some trade or other names: 3-Hexyl-1-hydroxy-7, 8, 9, 10-tetrahydro-6, 6, 9-trimethyl-6H-dibenzo[b,d]pyran; synhexyl;

(18) Peyote, meaning all parts of the plant presently classified botanically as Lophophora Williamsii Lemaire, whether growing or not, the seeds thereof, any extract from any part of such plant, and every compound, manufacture, salts, derivative, mixture, or preparation of such plant, its seeds, or extracts; (interprets 21 USC § 812 (c), Schedule I (c)(12))

(19) N-ethyl-3-piperidyl benzilate;

(20) N-methyl-3-piperidyl benzilate;

(21) Psilocybin;

(22) Psilocyn;

(23) Any of the following synthetic cannabimimetics, their salts, isomers, and salts of isomers, unless specifically excepted, whenever the existence of these salts, isomers, and salts of isomers is possible within the specific chemical designation:

(i) Naphthoylindoles: Any compound containing a 3-(1-naphthoyl) indole structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl) methyl, or 2-(4-morpholinyl) ethyl group, whether or not further substituted in the indole ring to any extent and whether or not substituted in the naphthyl ring to any extent including, but not limited to, JWH-015, JWH-018, JWH-019, JWH-073, JWH-081, JWH-122, JWH-200, JWH-210, and AM-2201;

(ii) Naphthylmethylindoles: Any compound containing a1H-indol-3-yl-(1-naphthyl) methane structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl) methyl, or 2-(4-morpholinyl) ethyl group, whether or not further substituted in the indole ring to any extent and whether or not substituted in the naphthyl ring to any extent including, but not limited to, JWH-175, JWH-184, and JWH-199;

(iii) Naphthoylpyrroles: Any compound containing a 3-(1-naphthoyl) pyrrole structure with substitution at the nitrogen atom of the pyrrole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl) methyl, or 2-(4-morpholinyl) ethyl group, whether or not further substituted in the pyrrole ring to any extent and whether or not substituted in the naphthyl ring to any extent including, but not limited to, JWH-307;

(iv) Naphthylmethylindenes: Any compound containing a naphthylideneindene structure with substitution at the 3-

position of the indene ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl) methyl, or 2-(4-morpholinyl) ethyl group, whether or not further substituted in the indene ring to any extent and whether or not substituted in the naphthyl ring to any extent including, but not limited to, JWH-176;

(v) Phenylacetylindoles: Any compound containing a 3-phenylacetylindole structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl) methyl, or 2-(4-morpholinyl) ethyl group, whether or not further substituted in the indole ring to any extent and whether or not substituted in the phenyl ring to any extent including, but not limited to, JWH-203, JWH-250, JWH-251, and RCS-8;

(vi) Cyclohexylphenols: Any compound containing a 2-(3-hydroxycyclohexyl) phenol structure with substitution at the 5-position of the phenolic ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl) methyl, or 2-(4-morpholinyl) ethyl group, whether or not substituted in the cyclohexyl ring to any extent including, but not limited to, Cannabicyclohexanol, and CP 47,497;

(vii) Benzoylindoles: Any compound containing a 3-(benzoyl) indole structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl) methyl, or 2-(4-morpholinyl) ethyl group, whether or not further substituted in the indole ring to any extent and whether or not substituted in the phenyl ring to any extent including, but not limited to, AM-694, Pravadoline (WIN 48,098), RCS-4, and AM-1241;

(viii) 2,3-Dihydro-5-methyl-3-(4-morpholinylmethyl) pyrrolo [1,2,3-de]-[1,4-benzoxazin-6-yl]-1-napthalenylmethanone: Some trade or other names: WIN 55,212-2.

(24) Tetrahydrocannabinols, synthetic equivalents of the substances contained in the plant, or in the resinous extractives of Cannabis, sp., and/or synthetic substances, derivatives, and their isomers with similar chemical structure and pharmacological activity such as the following:

(i) Delta 1 - cis - or transtetrahydrocannabinol, and their optical isomers, excluding tetrahydrocannabinol in sesame oil and encapsulated in a soft gelatin capsule in a drug product approved by the United States Food and Drug Administration;

(ii) Delta 6 - cis - or transtetrahydrocannabinol, and their optical isomers;

(iii) Delta 3,4 - cis - or transtetrahydrocannabinol, and its optical isomers;

(iv) (6aR,10aR)-9-(hydroxymethyl)-6, 6-dimethyl-3-(2-methyloctan-2-yl)-6a,7,10, 10a-tetrahydrobenzo[c]chromen-1-ol: Some trade or other names: HU-210.

(Since nomenclature of these substances is not internationally standardized, compounds of these structures, regardless of numerical designation of atomic positions covered.)

(((~~(24)~~))) (25) Ethylamine analog of phencyclidine: Some trade or other names: N-ethyl-1-phenylcyclohexylamine, (1-phenylcyclohexyl) ethylamine, N-(1-phenylcyclohexyl)ethylamine, cyclohexamine, PCE;

(((~~(25)~~))) (26) Pyrrolidine analog of phencyclidine: Some trade or other names: 1-(1-phencyclohexyl)pyrrolidine; PCPy; PHP;

(((~~(26)~~))) (27) Thiophene analog of phencyclidine: Some trade or other names: 1-(1-[2-thenyl]-cyclohexly)-pipendine; 2-thienylanalog of phencyclidine; TPCP; TCP;

(e) Depressants. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

(i) Mecloqualone;

(ii) Methaqualone.

(f) Stimulants. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system, including its salts, isomers, and salts of isomers:

(((~~(i)~~))) (1) Cathinone (also known as 2-amino-1-phenyl-1-propanone, alpha-aminopropiophenone, 2-aminopropiophenone and norephedrone);

(((~~(ii)~~))) (2) 4-Fluoromethcathinone (Flephedrone);

(3) Beta-keto-N-Methylbenzodioxolylpropylamine (bk-MBDB, Butylone);

(4) 3,4-Methylenedioxymethcathinone (Methylone);

(5) 3,4-Methylenedioxypyrovalerone (MDPV);

(6) 4-Methylmethcathinone (Mephedrone);

(7) Fenethylline;

(((~~(iii)~~))) (8) N-ethylamphetamine;

(((~~(iv)~~))) (9) 4-methylaminorex;

(((~~(v)~~))) (10) N,N-dimethylamphetamine.

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency and appear in the Register pursuant to the requirements of RCW 34.08.040.

WSR 11-22-087
PERMANENT RULES
DEPARTMENT OF HEALTH

[Filed November 1, 2011, 3:20 p.m., effective December 2, 2011]

Effective Date of Rule: Thirty-one days after filing.

Purpose: WAC 246-810-010 Definitions and 246-810-016 Agencies, facilities, or counties that can employ agency affiliated counselors, adds federally recognized Indian tribes located within Washington state to the definitions of an agency. Agency affiliated counselor applicants who are employed by a federally recognized Indian tribe will be able to qualify for the agency affiliated counselor credential.

Citation of Existing Rules Affected by this Order: Amending WAC 246-810-010 and 246-810-016.

Statutory Authority for Adoption: RCW 18.19.050.

Other Authority: RCW 18.19.020.

Adopted under notice filed as WSR 11-17-106 on August 22, 2011.

A final cost-benefit analysis is available by contacting Leann Yount, Program Manager, Department of Health, P.O.

Box 47852, Olympia, WA 98504-7852, phone (360) 236-4856, fax (360) 236-2901, e-mail leann.yount@doh.wa.gov.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 2, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 2, Repealed 0.

Date Adopted: October 24, 2011.

Mary C. Selecky
Secretary

AMENDATORY SECTION (Amending WSR 10-22-111, filed 11/2/10, effective 12/3/10)

WAC 246-810-010 Definitions. The definitions in this section apply throughout this chapter unless the content clearly requires otherwise.

(1) "Agency" means:

(a) An agency or facility operated, licensed, or certified by the state of Washington to provide a specific counseling service or services; ((~~or~~))

(b) A federally recognized Indian tribe located within the state; or

(c) A county as listed in chapter 36.04 RCW.

(2) "Agency affiliated counselor" means a person registered under chapter 18.19 RCW, and this chapter, who is engaged in counseling and employed by an agency listed in WAC 246-810-016 or an agency recognized under WAC 246-810-017 to provide a specific counseling service or services.

(3) "Certified adviser" means a person certified under chapter 18.19 RCW, and this chapter, who is engaged in private practice counseling to the extent authorized in WAC 246-810-021.

(4) "Certified counselor" means a person certified under chapter 18.19 RCW, and this chapter, who is engaged in private practice counseling to the extent authorized in WAC 246-810-0201.

(5) "Client" means an individual who receives or participates in counseling or group counseling.

(6) "Consultation" means the professional assistance and practice guidance that a certified counselor receives from a counseling-related professional credentialed under chapter 18.130 RCW. This may include:

(a) Helping the certified counselor focus on counseling practice objectives;

(b) Refining counseling modalities;

(c) Providing support to progress in difficult or sensitive cases;

(d) Expanding the available decision-making resources; and

(e) Assisting in discovering alternative approaches.

(7) "Counseling" means employing any therapeutic techniques including, but not limited to, social work, mental health counseling, marriage and family therapy, and hypnotherapy, for a fee that offer, assist, or attempt to assist, an individual or individuals in the amelioration or adjustment of mental, emotional, or behavioral problems, and includes therapeutic techniques to achieve sensitivity and awareness of self and others and the development of human potential. For the purpose of this chapter, nothing may be construed to imply that the practice of hypnotherapy is necessarily limited to counseling.

(8) "Counselor" means an individual who engages in the practice of counseling to the public for a fee, including for the purposes of this chapter, agency affiliated counselors, certified counselors, certified advisers, hypnotherapists, and until July 1, 2010, registered counselors.

(9) "Department" means the Washington state department of health.

(10) "Fee" as referred to in RCW 18.19.030 means compensation received by the counselor for counseling services provided, regardless of the source.

(11) "Hypnotherapist" means a person registered under chapter 18.19 RCW, and this chapter, who is practicing hypnosis as a modality.

(12) "Licensed healthcare practitioner" means a licensed practitioner under the following chapters:

(a) Physician licensed under chapter 18.71 RCW.

(b) Osteopathic physician licensed under chapter 18.57 RCW.

(c) Psychiatric registered nurse practitioner licensed under chapter 18.79 RCW.

(d) Naturopathic physician licensed under chapter 18.36A RCW.

(e) Psychologist licensed under chapter 18.83 RCW.

(f) Independent clinical social worker, marriage and family therapist, or advanced social worker licensed under chapter 18.225 RCW.

(13) "Private practice counseling" means the practice of counseling by a certified counselor or certified adviser as specified in WAC 246-810-0201 or 246-810-021.

(14) "Psychotherapy" means the practice of counseling using diagnosis of mental disorders according to the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, and the development of treatment plans for counseling based on diagnosis of mental disorders in accordance with established practice standards.

(15) "Recognized" means acknowledged or formally accepted by the secretary.

(16) "Recognized agency or facility" means an agency or facility that has requested and been recognized under WAC 246-810-017 to employ agency affiliated counselors to perform a specific counseling service, or services for those purposes only.

(17) "Secretary" means the secretary of the department of health or the secretary's designee.

(18) "Supervision" means the oversight that a counseling-related professional credentialed under chapter 18.130 RCW provides.

(19) "Unprofessional conduct" means the conduct described in RCW 18.130.180.

AMENDATORY SECTION (Amending WSR 10-22-111, filed 11/2/10, effective 12/3/10)

WAC 246-810-016 Agencies, facilities, federally recognized Indian tribes located within the state, or counties that can employ agency affiliated counselors. Agencies or facilities that may employ an agency affiliated counselor are:

(1) Washington state departments and agencies listed in the Agency, Commission & Organization Directory available on the state of Washington web site.

(2) Federally recognized Indian tribes located within the state.

(3) Counties as listed in chapter 36.04 RCW.

(((~~3~~))) (4) Community and technical colleges governed by the Washington state board for community and technical colleges.

(((~~4~~))) (5) Colleges and universities governed by the Washington state higher education coordinating board.

(((~~5~~))) (6) Hospitals licensed under chapter 70.41 RCW.

(((~~6~~))) (7) Home health care agencies, home care agencies, and hospice care agencies licensed under chapter 70.127 RCW.

(((~~7~~))) (8) Agencies and facilities licensed or certified under chapters 71.05 or 71.24 RCW.

(((~~8~~))) (9) Psychiatric hospitals, residential treatment facilities, hospitals, and alcohol and chemical dependency entities licensed under chapter 71.12 RCW.

(((~~9~~))) (10) Other agencies or facilities recognized by the secretary as provided in WAC 246-810-017.

WSR 11-22-092
PERMANENT RULES
BENTON CLEAN AIR AGENCY

[Filed November 1, 2011, 3:58 p.m., effective December 2, 2011]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The changes are primarily housekeeping items such as:

- Updating outdated references to WACs and/or RCWs.
- Aligning language with the current RCWs and WACs.
- Making the document easier to read and clarifying language, including clarifying definitions.
- Updating Agricultural Burning rule and fees per changes already made to the WAC.
- Updating agency name change.

Statutory Authority for Adoption: Chapter 70.94 RCW.

Adopted under notice filed as WSR 11-17-117 on August 23, 2011.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: October 27, 2011.

Robin Priddy
Director/Control Officer

Reviser's note: The material contained in this filing exceeded the page-count limitations of WAC 1-21-040 for appearance in this issue of the Register. It will appear in the 11-23 issue of the Register.

WSR 11-22-116
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Economic Services Administration)

[Filed November 2, 2011, 11:54 a.m., effective December 3, 2011]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The DSHS division of child support (DCS) is adopting new rules and amending existing sections in chapter 388-14A WAC to implement changes in the federal regulations concerning establishing and enforcing intergovernmental child support obligations. The federal rules being implemented in this rule-making order are 45 C.F.R. Parts 301.1, 302.35, 302.36, 303.3, 303.7, 303.11, 303.20, 305.63, 307.13, and 308.2.

DCS filed emergency rules with an effective date of March 31, 2011, under WSR 11-08-020; DCS filed a second emergency rule package under WSR 11-16-006, effective July 30, 2011, in order to maintain the status quo until after this CR-103P, Rule-making order, is filed and the thirty-day period required under RCW 34.08.380(2) has run.

Citation of Existing Rules Affected by this Order: New sections WAC 388-14A-2081 Under what circumstances can DCS close a case when the application for services was made directly to DCS? and 388-14A-2083 Under what circumstances can DCS close an intergovernmental case, otherwise known as a case where the application for services was originally made to another state, tribe, territory or country?; and amending WAC 388-14A-2080 Once DCS opens a support enforcement case, under what circumstances can it be closed?, 388-14A-2085 Under what circumstances may DCS ((~~deny~~)) keep a support enforcement case open despite a request to close ((~~a support enforcement case~~)) it?, 388-14A-2090 Who ((~~is mailed~~)) receives notice ((~~of DCS' intent to close~~)) when DCS closes a case?, 388-14A-2097 What happens to payments that come in after a case is closed?, 388-14A-2160 ((~~If my information is confidential, can~~)) On what

authority does DCS ((~~report me to~~)) share my confidential information with a credit bureau?, 388-14A-3130 What happens if a ((~~parent~~)) party makes a timely request for hearing on a support establishment notice?, 388-14A-3302 How does the division of child support decide what notice to serve when there is already an existing order for child support?, 388-14A-3304 The division of child support may serve a notice of support debt and demand for payment when it is enforcing a support order issued in Washington state, a foreign court order or a foreign administrative order for support, 388-14A-3305 What can I do if I disagree with a notice of support debt and demand for payment?, 388-14A-3306 Does a notice of support debt and demand for payment result in a final determination of support arrears?, 388-14A-3307 How does the division of child support proceed when there are multiple child support orders for the same obligor and children?, 388-14A-3310 What notice does the division of child support serve to establish a fixed dollar amount under an existing child support order?, 388-14A-7100 The division of child support may register an order from another state for enforcement or modification, 388-14A-7110 The division of child support may ((~~assess and collect~~)) enforce interest on amounts owed under support orders entered or established in a jurisdiction other than Washington state, 388-14A-7115 Are there special rules for a hearing on a notice seeking to ((~~assess and collect~~)) enforce interest on a support order?, 388-14A-7120 When does DCS update the interest ((~~assessed~~)) on a case for enforcement?, 388-14A-7305 How ((~~do I~~)) does a party, IV-D agency or jurisdiction ask ((~~DCS to do~~)) for a determination of controlling order?, 388-14A-7325 How does DCS notify the parties ((~~of its~~)) that a determination of the controlling order ((~~has been~~)) is going to be made?, and 388-14A-7335 What happens if someone objects to ((~~DCS' proposed~~)) a notice of support debt and registration which contains a determination of the presumed controlling order?

Statutory Authority for Adoption: RCW 26.23.120, 43.20A.550, 74.04.055, 74.08.090, 74.20.040(9), 74.20A.-310.

Other Authority: 45 C.F.R. Parts 301.1, 302.35, 302.36, 303.3, 303.7, 303.11, 303.20, 305.63, 307.13, and 308.2.

Adopted under notice filed as WSR 11-18-098 on September 7, 2011.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 2, Amended 19, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 2, Amended 19, Repealed 0.

Date Adopted: October 31, 2011.

Katherine I. Vasquez
Rules Coordinator

Reviser's note: The material contained in this filing exceeded the page-count limitations of WAC 1-21-040 for appearance in this issue of the Register. It will appear in the 11-23 issue of the Register.