WSR 12-19-071

PERMANENT RULES

DEPARTMENT OF REVENUE

[Filed September 17, 2012, 4:43 p.m., effective October 18, 2012]

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

Purpose: Chapter 23, Laws of 2010 1st sp. sess. changed the apportionment requirements for apportionable activities, effective June 1, 2010. The department had previously adopted emergency rules while it worked with stakeholders to develop permanent rules explaining the implications of this legislation.

The department is at this time adopting a new permanent rule WAC 458-20-19402 (Rule 19402) Single factor receipts apportionment—Generally. This rule provides general guidance on single factor receipts apportionment, how to attribute receipts, how to determine the receipts factor, and computing Washington taxable income.

Statutory Authority for Adoption: RCW 82.32.300 and 82.01.060(2).

Adopted under notice filed as WSR 12-06-080 on March 7, 2012.

Changes Other than Editing from Proposed to Adopted Version:

- Subsection (106), which provided an explanation of the use of examples, was moved to subsection (302) to be closer to the examples and further explanation was added to clarify that more than one reasonable method of proportionally attributing the benefit of a service may exist.
- Subsection (304)(c), example 22 was modified to state that the use of population in the customer's market may be a reasonable method of proportionally attributing the benefit of a service.
- Subsection (304)(c), example 24. This example was changed from general business services to human resources services to avoid confusion.
- Subsection (304)(c), example 29. This example was removed from the rule. The remaining examples were renumbered.
- Subsection (306), example 35 (formerly example 36) was modified to more accurately explain what is commercially reasonable.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 1, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 1, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.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: September 17, 2012.

Alan R. Lynn
Rules Coordinator

NEW SECTION

WAC 458-20-19402 Single factor receipts apportionment—Generally.

PART 1. INTRODUCTION.

(101) **General.** RCW 82.04.462 establishes the apportionment method for businesses engaged in apportionable activities and that have nexus with Washington for business and occupation (B&O) tax liability incurred after May 31, 2010. The express purpose of the change in the law was to require businesses "earn(ing) significant income from Washington residents from providing services" to "pay their fair share of the cost of services that this state renders and the infrastructure it provides." Section 101, chapter 23, 1st special session, 2010.

(102) **Guide to this rule.** This rule is divided into six parts, as follows:

1. Introduction.
2. Overview of single factor receipts apportionment.
3. How to attribute receipts.
4. Receipts factor.
5. How to determine Washington taxable income.
6. Reporting instructions.

(103) **Scope of rule.** This rule applies to the apportionment of income from engaging in apportionable activities as defined in WAC 458-20-19401, except:

(a) To the apportionment of income received by financial institutions and taxable under RCW 82.04.290, which is governed by WAC 458-20-19404; and

(b) To the attribution of royalty income from granting the right to use intangible property, which is governed by WAC 458-20-19403.

(104) **Separate accounting and cost apportionment.** The apportionment method explained in this rule replaces the previously allowed separate accounting and cost apportionment methods. Separate accounting and cost apportionment are not authorized for periods after May 31, 2010.

(105) **Other rules.** Taxpayers may also find helpful information in the following rules:

(a) WAC 458-20-19401 **Minimum nexus thresholds for apportionable activities.** This rule describes minimum nexus thresholds applicable to apportionable activities that are effective after May 31, 2010.

(b) WAC 458-20-19403 **Royalty receipts attribution.** This rule describes the attribution of royalty income for the purposes of single factor receipts apportionment and applies only to tax liability incurred after May 31, 2010.

(c) WAC 458-20-19404 **Single factor receipts apportionment—Financial institutions.** This rule describes the application of single factor receipts apportionment to certain income of financial institutions and applies only to tax liability incurred after May 31, 2010.

(d) WAC 458-20-194 **Doing business inside and outside the state.** This rule describes separate accounting and

cost apportionment and applies only to tax liability incurred from January 1, 2006, through May 31, 2010.

(e) WAC 458-20-14601 **Financial institutions—Income apportionment.** This rule describes the apportionment of income for financial institutions for tax liability incurred prior to June 1, 2010.

(106) **Definitions.** The following definitions apply to this rule:

(a) **"Apportionable activities"** has the same meaning as used in WAC 458-20-19401 Minimum nexus thresholds for apportionable activities.

(b) **"Apportionable income"** means apportionable receipts less the deductions allowable under chapter 82.04 RCW.

(c) **"Apportionable receipts"** means gross income of the business from engaging in apportionable activities, including income received from apportionable activities attributed to locations outside this state.

(d) **"Business activities tax"** means a tax measured by the amount of, or economic results of, business activity conducted in a state. The term includes taxes measured in whole or in part on net income or gross income or receipts. In the case of sole proprietorships and pass-through entities, the term includes personal income taxes if the gross income from apportionable activities is included in the gross income subject to the personal income tax. The term "business activities tax" does not include retail sales, use, or similar transaction taxes, imposed on the sale or acquisition of goods or services, whether or not named a gross receipts tax or a tax imposed on the privilege of doing business.

(e) **"Customer"** means a person or entity to whom the taxpayer makes a sale, grants the right to use intangible property, or renders services or from whom the taxpayer otherwise directly or indirectly receives gross income of the business. If the taxpayer performs apportionable services for the benefit of a third party, the term "customer" means the third party beneficiary.

Example 1. Assume a parent purchases apportionable services for their child. The child is the customer for the purpose of determining where the benefit is received.

(f) **"Reasonable method of proportionally attributing"** means a method of determining where the benefit of an activity is received and where the receipts are attributed that is uniform, consistent, and accurately reflects the market, and does not distort the taxpayer's market.

(g) **"State"** means a state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, any territory or possession of the United States, or any foreign country or political subdivision of a foreign country.

(h)(i) **"Taxable in another state"** means either:

(A) The taxpayer is subject to a business activities tax by another state on the taxpayer's income received from engaging in apportionable activity; or

(B) The taxpayer is not subject to a business activities tax by another state on the taxpayer's income received from engaging in apportionable activity, but the taxpayer meets the substantial nexus thresholds described in WAC 458-20-19401 for that state.

(ii) The determination of whether a taxpayer is taxable in a foreign country or political subdivision of a foreign country is made at the country or political subdivision level.

Example 2. Assume Taxpayer A is subject to a business activity tax in State X of Mexico (e.g., Taxpayer pays tax to State X), but nowhere else in Mexico. Also, assume that Taxpayer A is not subject to any national business activity tax in Mexico and does not meet the substantial nexus thresholds described in WAC 458-20-19401 for Mexico as a whole. In this case, Taxpayer is taxable in State X, but not taxable in any other portion or any other State of Mexico.

Example 3. Assume Taxpayer B is not subject to any business activity taxes in Mexico, but satisfies the substantial nexus thresholds described in WAC 458-20-19401 for Mexico as a whole. Taxpayer B is taxable in all of Mexico.

PART 2. OVERVIEW OF SINGLE FACTOR RECEIPTS APPORTIONMENT.

(201) **Single factor receipts apportionment generally.** Except as provided in WAC 458-20-19404 persons earning apportionable income who have substantial nexus with Washington as specified in WAC 458-20-19401 and who are also taxable in another state must use the apportionment method provided in this rule to determine their taxable income from apportionable activities for B&O tax purposes. Taxable income is determined by multiplying apportionable income from each apportionable activity by the receipts factor for that apportionable activity.

This formula is:

(Taxable income) = (Apportionable income) x (Receipts factor)

See Part 4 of this rule for a discussion of the receipts factor.

(202) **Tax year.** The receipts factor applies to each tax year. A tax year is the calendar year, unless the taxpayer has specific permission from the department to use another period. (RCW 82.32.270.) For the purposes of this rule, "tax year" and "calendar year" have the same meaning.

PART 3. HOW TO ATTRIBUTE RECEIPTS.

(301) **Attribution of receipts generally.** Except as specifically provided for in WAC 458-20-19403 for the attribution of apportionable royalty receipts, this Part 3 explains how to attribute apportionable receipts. Receipts are attributed to states based on a cascading method or series of steps. The department expects that most taxpayers will attribute apportionable receipts based on (a)(i) of this subsection because the department believes that either the taxpayer will know where the benefit is actually received or a "reasonable method of proportionally attributing receipts" will generally be available. These steps are:

(a) Where the customer received the benefit of the taxpayer's service (see subsection (302) of this rule for an explanation and examples of the benefit of the service);

(i) If a taxpayer can reasonably determine the amount of a specific apportionable receipt that relates to a specific benefit of the services received in a state, that apportionable receipt is attributable to the state in which the benefit is

received. This may be shown by application of a reasonable method of proportionally attributing the benefit among states. The result determines the receipts attributed to each state. Under certain situations, the use of data based on an attribution method specified in (b) through (f) of this subsection may also be a reasonable method of proportionally attributing receipts among states (see Examples 4 and 5 below).

(ii) If a taxpayer is unable to separately determine or use a reasonable method of proportionally attributing the benefit of the services in specific states under (a)(i) of this subsection, and the customer received the benefit of the service in multiple states, the apportionable receipt is attributed to the state in which the benefit of the service was primarily received. Primarily means, in this case, more than fifty percent.

(b) If the taxpayer is unable to attribute an apportionable receipt under (a) of this subsection, the apportionable receipt must be attributed to the state from which the customer ordered the service.

(c) If the taxpayer is unable to attribute an apportionable receipt under (a) or (b) of this subsection, the apportionable receipt must be attributed to the state to which the billing statements or invoices are sent to the customer by the taxpayer.

(d) If the taxpayer is unable to attribute an apportionable receipt under (a), (b), or (c) of this subsection, the apportionable receipt must be attributed to the state from which the customer sends payment to the taxpayer.

(e) If the taxpayer is unable to attribute an apportionable receipt under (a), (b), (c), or (d) of this subsection, the apportionable receipt must be attributed to the state where the customer is located as indicated by the customer's address:

(i) Shown in the taxpayer's business records maintained in the regular course of business; or

(ii) Obtained during consummation of the sale or the negotiation of the contract, including any address of a customer's payment instrument when readily available to the taxpayer and no other address is available.

(f) If the taxpayer is unable to attribute an apportionable receipt under (a), (b), (c), (d), or (e) of this subsection, the apportionable receipt must be attributed to the commercial domicile of the taxpayer.

(g) The taxpayer may not use an attribution method that distorts the apportionment of the taxpayer's apportionable receipts.

(302) **Examples.** Examples included in this rule identify a number of facts and then state a conclusion; they should be used only as a general guide. The tax results of all situations must be determined after a review of all the facts and circumstances. The examples in this rule assume all gross income received by the taxpayer is from engaging in apportionable activities. Unless otherwise stated, the examples do not apply to tax liability prior to June 1, 2010.

When an example states that a particular attribution method is a reasonable method of proportionally attributing the benefit of a service, this does not preclude the existence of other reasonable methods of proportionally attributing the benefit depending on the specific facts and circumstances of a taxpayer's situation.

Example 4. Assume Law Firm has thousands of charges to clients. It is not commercially reasonable for Law Firm to track each charge to each client to determine where the benefit related to each service is received. Assume the scope of Law Firm's practice is such that it is reasonable to assume that the benefits of Law Firm's services are received at the location of the customer as reflected by the customer's billing address. Under these circumstances, Law Firm can use the billing addresses of each client as a reasonable method of proportionally attributing the benefit of its services.

Example 5. Same facts as Example 4 except, Law Firm has a single client that represents a statistically significant portion of its revenue and whose billing address is unrelated to any of the services provided. In this case, using the billing address of this client would not relate to the benefit of the services. Using the billing address for this client to determine where the benefit is received would significantly distort the apportionment of Law Firm's receipts. Therefore, Law Firm would need to evaluate the specific services provided to that client to determine where the benefits of those services are received and may use billing address to attribute the income received from other clients.

Example 6. Assume Taxpayer R attributes an apportionable receipt based on its customer's billing address, using (c) of this subsection, and the billing address is a P.O. Box located in another state. Taxpayer R also knows that mail delivered to this P.O. Box is automatically forwarded to the customer's actual location. In this case, use of the billing address is not allowed because it would distort the apportionment of Taxpayer R's receipts.

(303) **Benefit of the service explained.** The first two steps (subsection (301)(a)(i) and (ii) of this rule) used to attribute apportionable receipts to a state are based on where the taxpayer's customer receives the benefit of the service. This subsection explains the framework for determining where the benefit of a service is received.

(a) **If the taxpayer's service relates to real property, then the benefit is received where the real property is located.** The following is a nonexclusive list of services that relate to real property:

(i) Architectural;

(ii) Surveying;

(iii) Janitorial;

(iv) Security;

(v) Appraisals; and

(vi) Real estate brokerage.

(b) **If the taxpayer's service relates to tangible personal property, then the benefit is received where the tangible personal property is located or intended/expected to be located.**

(i) Tangible personal property is generally treated as located where the place of principal use occurs. If the tangible personal property is subject to state licensing (e.g., motor vehicles), the principal place of use is presumed to be where the property is licensed; or

(ii) If the tangible personal property will be created or delivered in the future, the principal place of use is where it is expected to be used or delivered.

(iii) The following is a nonexclusive list of services that relate to tangible personal property:

(A) Designing specific/unique tangible personal property;

(B) Appraisals;

(C) Inspections of the tangible personal property;

(D) Testing of the tangible personal property;

(E) Veterinary services; and

(F) Commission sales of tangible personal property.

(c) **If the taxpayer's service does not relate to real or tangible personal property, the service is provided to a customer engaged in business, and the service relates to the customer's business activities, then the benefit is received where the customer's related business activities occur.** The following is a nonexclusive list of business related services:

(i) Developing a business management plan;

(ii) Commission sales (other than sales of real or tangible personal property);

(iii) Debt collection services;

(iv) Legal and accounting services not specific to real or tangible personal property;

(v) Advertising services; and

(vi) Theatre presentations.

(d) **If the taxpayer's service does not relate to real or tangible personal property, is either provided to a customer not engaged in business or unrelated to the customer's business activities, and:**

(i) The service requires the customer to be physically present, then the benefit is received where the customer is located when the service is performed. The following is a nonexclusive list of services that require the customer to be physically present:

(A) Medical examinations;

(B) Hospital stays;

(C) Haircuts; and

(D) Massage services.

(ii) The taxpayer's service relates to a specific, known location(s), then the benefit is received at those location(s). The following is a nonexclusive list of services related to specific, known location(s):

(A) Wedding planning;

(B) Receptions;

(C) Party planning;

(D) Travel agent and tour operator services; and

(E) Preparing and/or filing state and local tax returns.

(iii) If (d)(i) and (ii) of this subsection do not apply, the benefit of the service is received where the customer resides. The following is a nonexclusive list of services whose benefit is received at the customer's residence:

(A) Drafting a will;

(B) Preparing and/or filing federal tax returns;

(C) Selling investments; and

(D) Blood tests (not blood drawing).

(e) **Special rule for extension of credit.** See subsection (304) of this rule for special rules attributing income related to loans (secured and unsecured) and credit cards that is received by persons who are not financial institutions as defined in WAC 458-20-19404.

(304) **Examples of the application of the benefit of service analysis and reasonable methods of proportionally attributing receipts.**

(a) **Services related to real property:**

Example 7. Architect drafts plans for a building to be built in Washington. Architect's services relate to real property which is located in Washington, therefore the customer receives the benefit of that service in Washington at the location of the real property. Architect's receipts for this service are solely attributed to Washington because the entire benefit is received in Washington.

Example 8. Franchisor hires Taxpayer, an architect, to create a design of a standardized building that will be used at four locations in Washington and two locations in Oregon. Taxpayer's services relate to real property at those six locations, therefore the customer receives the benefit of the service at the four Washington locations and the two Oregon locations. Taxpayer will attribute 2/3 (4 of 6 sites) of the receipts for this service to Washington and 1/3 (2 of 6 sites) of the receipts to Oregon.

Example 9. Assume the same facts as Example 8 except Franchisor will use the same design in all 50 states for all its franchisee's locations. Taxpayer and Franchisor do not know at the time the service is provided (and cannot reasonably estimate) how many franchise locations will exist in each state. Therefore, there is no reasonable means of proportionally attributing receipts at the time the services are performed and it is clear that no state will have a majority of the franchise locations. Accordingly, the apportionable receipts must be attributed following the steps in subsection (301)(b) through (f) of this rule.

Example 10. Real estate broker located in Florida receives a commission for arranging the sale of real property located in Washington. The real estate broker's service is related to the real property, therefore the benefit is received in Washington, where the real property is located, and the commission income is attributed to Washington.

(b) **Services related to tangible personal property.**

Example 11. Big Manufacturing hires an engineer to design a tool that will only be used in a factory located in Brewster, Washington. Big Manufacturing receives the benefit of the engineer's services at a single location in Washington where the tool is intended to be used. Therefore, 100% of engineer's receipts from this service must be attributed to Washington.

Example 12. The same facts as in Example 11, except Big Manufacturing will use the tool equally in factories located in Brewster and in Kapa'a, Hawai'i. Therefore, Big Manufacturer receives the benefit of the service equally in two states. Because the benefit of the service is received equally in both states, a reasonable method of proportionally attributing receipts would be to attribute 1/2 of the receipts to each state.

Example 13. Taxpayer, a commissioned salesperson, sells tangible personal property (100 widgets) for Distributor to XYZ Company for delivery to Spokane. Distributor receives the benefit of Taxpayer's service where the tangible personal property will be delivered. Therefore, Taxpayer will attribute the commission from this sale to Washington.

Example 14. Same facts as in Example 13, but the widgets are to be delivered 50 to Spokane, 25 to Idaho, and 25 to Oregon. In this case, the benefit is received in all three states. Taxpayer shall attribute the receipts (commission) from this

sale 50% to Washington, 25% to Idaho, and 25% to Oregon where the tangible personal property is delivered to the buyer.

Example 15. Training Company provides training to Customer's employees on how to operate a specific piece of equipment used solely in Washington. Customer receives the benefit of the service where the equipment is used, which is in Washington. Therefore, Training Company will attribute 100% of its receipts received from Customer to Washington.

(c) **Services related to customer's business activities.** The examples in this subsection assume that the customer is engaged in business and the services relate to the customer's business activities.

Example 16. Manufacturer hires Law Firm to defend Manufacturer in a class action product liability lawsuit involving Manufacturer's Widgets. The benefit of Law Firm's services relates to Manufacturer's widget selling activity in various states. A reasonable method of proportionally attributing receipts in this case would be to attribute the receipts to the locations where the Manufacturer's Widgets were delivered, which relates to Manufacturer's business activities.

Example 17. Debt Collector provides debt collection services to ABC. The benefit of Debt Collector's services relates to ABC's selling activity in various states. It is reasonable to assume that where the debtors are located is the same as where ABC's business activity occurred. If Debt Collector is able to attribute specific receipts to a specific debtor, then the receipt is attributed to where the debtor is located.

Example 18. Same facts as Example 17, except Debt Collector is unable to attribute specific benefits with specific debtors. In this case, a reasonable method of proportionally attributing benefits/receipts should be employed. Depending on Debt Collector's specific facts and circumstances, a reasonable method of proportionally attributing benefits/receipts could be: Relative number of debtors in each state; relative debt actually collected from debtors in each state; the relative amount of debt owed by debtors in each state; or another method that does not distort the apportionment of Debt Collector's receipts.

Example 19. Training Company provides training to Customer's employees who are all located in State A. The training is provided in State B. The training relates to the employees' ethical behavior within Customer's organization. Customer receives the benefit of Training Company's service in State A, where Customer's office is located and the employees presumably practice their ethical behavior. Training Company must attribute the apportionable receipts to State A where the benefit is solely received.

Example 20. Same facts as Example 19, except the training is provided for employees from several states and Training Company knows where each employee works. The benefit of the Training Company's services is received in those several states. Attributing receipts from the training based on where the employees work is a reasonable method of proportionally attributing the receipts income.

Example 21. Call Center provides "customer service" services to Retailer who has customers in all 50 states. Call Center's services relate to Retailer's selling activity in all 50 states, therefore Retailer receives the benefit of Call Center's services in all 50 states. Call Center has offices in Iowa and Alabama that answer questions about Retailer's products. Call Center records Retailer's customer's calls by area code. Call Center may attribute receipts received from Retailer based on the number of calls from area codes assigned to each state. This would be a reasonable method of proportionally attributing receipts notwithstanding the fact that mobile phone numbers and related area codes may not exactly reflect the physical location of the customer in all cases.

Example 22. Taxpayer provides internet advertising services to national retail chains, regional businesses, businesses with a single location, and businesses that operate solely over the Internet. Generally, the benefit of the advertising services is received where the customer's related business activities occur. Depending on what products or services are being provided by Taxpayer's customers, the use of relative population in the customer's market may be a reasonable method of proportionally attributing the benefit of Taxpayer's services.

Example 23. Oregon Newspaper sells newspaper advertising to Merlin's Potion Shop. Merlin's only makes over-the-counter sales from its single location in Vancouver, Washington. Merlin's Potion Shop receives the benefit of the Oregon Newspaper's advertising services in Washington where it makes sales to its customers. In this case Oregon Newspaper will report 100% of its receipts received from Merlin's to Washington.

Example 24. Company A provides human resources services to Racko, Inc. which has three offices that use those services in Washington, Oregon, and Idaho. Racko sells widgets and has customers for its widgets in all 50 states. The benefit of the service performed by Company A is received at Racko's locations in Washington, Oregon, and Idaho. Assuming that each office is approximately the same size and uses the services to approximately the same extent, then attributing 1/3 of the receipts to each of the states in which Racko has locations using the services is a reasonable method of proportionally attributing Company A's receipts from Racko.

Example 25. Director serves on the board of directors for DEF, Inc. Director's services relate to the general management of DEF, Inc. DEF, Inc. is Director's customer and receives the benefit of Director's services at its corporate domicile. Therefore, Director must attribute the receipts earned from Director's services to DEF to DEF's corporate domicile.

(d) **Services not related to real or tangible personal property and either provided to customers not engaged in business or unrelated to the customer's business activities.**

Example 26. A Washington resident travels to California for a medical procedure. Because the Washington resident must be physically in California, the Washington resident receives the benefit of the service in California. Therefore, the service provider must attribute its income from the procedure to California.

Example 27. Washington accountant prepares a Nevada couple's Arizona and Oregon state income tax returns as well as their federal income tax return. The benefit of the accountant's service associated with the state income tax returns is

attributed to Arizona and Oregon because these returns relate to specific locations (states). The benefit associated with the federal income tax return is attributed to the couple's residence. The fees for the state tax returns are attributed to Arizona and Oregon, respectively, and the fee for the federal income tax return is attributed to Nevada.

Example 28. Tour Operator provides cruises through Washington's San Juan Islands for four days and Victoria, British Columbia for one day. The benefit of the tour is received where the tour occurs. Tour Operator may use a reasonable method of proportionally attributing the benefit to determine that its customers receive 80% of the benefit in Washington and 20% outside of Washington. Therefore, Tour Operator must attribute 80% of apportionable receipts to Washington and 20% to British Columbia.

Example 29. A Washington couple hires a Washington attorney to prepare a last will and testament for Daughter who lives in California. Daughter is a third-party beneficiary and receives the benefit of the attorney's services in California because that is where Daughter lives. Washington Attorney must attribute the fee to California.

Example 30. A Washington couple hires a California accountant to prepare their joint federal income tax return. Because the couple does not have to be physically present for the accountant to perform services and services are not related to a specific location, the Washington couple receives the benefit of the accountant's services at their residence in Washington. California accountant must attribute its fee for this service to Washington.

Example 31. An Arizona resident retains a Washington stock broker to handle its investments. The stock broker receives orders from the client and executes trades of securities on the New York Stock Exchange. Because (a) the Arizona resident is not investing as part of a business; (b) the activity does not relate to real or tangible personal property; (c) and the client does not need to be physically present for the stock broker to perform its services; and (d) the services are not related to a specific location, the client receives the benefit of the services at client's place of residence. Washington stockbroker must attribute the fee to Arizona.

Example 32. Investment Manager manages a mutual fund. Investment Manager receives a fee for managing the fund based on the value of the assets in the fund on particular days. Investment Manager knows or should know the identity of the investors in the fund and their mailing addresses. The fees received by Investment Manager (whether from the mutual fund or from individual investor's accounts) are for the services provided to the investors. Investment Manager's services do not relate to real or tangible personal property and do not require that the client be physically present, therefore, the benefit of Investment Manager's services is received where the investors are located and Investment Manager's apportionable receipts must be attributed to those locations.

(305) **Special rules related to extending credit performed by nonfinancial institutions.** Businesses not included in the definition of a financial institution under WAC 458-20-19404 that provide services related to the extension of credit must attribute their income from such activities as follows:

(a) **Activities related to extending credit where real property secures the debt.** Such activities include, but are not limited to, servicing loans, making loans subject to deeds of trust or mortgages (including any fees in the nature of interest related to the loan), and buying and selling loans. Apportionable receipts from these activities are attributed in the same manner as a financial institution attributes these apportionable receipts under WAC 458-20-19404.

(b) **Activities related to credit cards.** Such activities include, but are not limited to, issuing credit cards, servicing, and billing. Apportionable receipts from these activities are attributed to the billing address of the card holder.

(c) **Other activities related to extending credit where real property does not secure the debt.** Such activities include, but are not limited to, servicing loans, making loans (including any fees related to such loans), and buying and selling loans. Apportionable receipts from these activities are attributed in the same manner a financial institution attributes income under WAC 458-20-19404.

(d) **All other apportionable receipts from such businesses are attributed using subsections (301) through (304) of this rule or WAC 458-20-19403.**

(306) **What does "unable to attribute" mean?** A taxpayer is "unable to attribute" apportionable receipts when the taxpayer has no commercially reasonable means to acquire the information necessary to attribute the apportionable receipts. Cost and time may be considered to determine whether a taxpayer has no commercially reasonable means to acquire the information necessary to attribute apportionable receipts.

Example 33. One office of ZYX LLC has information that can easily be used to determine a reasonable proportional attribution of receipts, but does not provide this information to the office preparing the tax returns. ZYX LLC must use the information maintained by the marketing office to attribute its receipts.

Example 34. CBA, Inc. is entitled to receive information from an affiliate or unrelated third party which it could use to determine where the benefit of its services is received but chooses not to obtain that information. CBA, Inc. must use the information maintained by the affiliate or unrelated third party to attribute its apportionable receipts.

Example 35. Same facts as Example 34, except that the information is raw data that must be formatted and otherwise processed at a cost that exceeds a reasonable estimate of the possible difference in the amount of tax CBA, Inc. would owe if used another attribution method authorized in subsection 301(b) through (f). In this case, it is not commercially reasonable for CBA, Inc. to use this data to determine where to attribute its income.

PART 4. RECEIPTS FACTOR.

(401) **General.** The receipts factor is a fraction that applies to apportionable income for each calendar year. Taxpayers must calculate a separate receipts factor for each apportionable activity (business and occupation tax classification) engaged in.

(402) **Receipts factor calculation.** The receipts factor is: Washington attributed apportionable receipts divided by world-wide apportionable receipts less throw-out income

(see subsection (403) of this section). The receipts factor expressed algebraically is:

$$\text{(Receipts factor)} = \frac{\text{(Washington apportionable receipts)}}{\text{((World-wide apportionable receipts) - (Throw-out income))}}$$

(a) The numerator of the receipts factor is: The total apportionable receipts attributable to Washington during the calendar year from engaging in the apportionable activity.

(b) The denominator of the receipts factor is: The total (world-wide, including Washington) apportionable receipts from engaging in the apportionable activity during the calendar year, less throw-out income.

Example 36. NOP, Inc. has $400,000 of receipts attributed to Washington and $1,000,000 of world-wide receipts. Assuming that there is no throw-out income, NOP's receipts factor is 40% (400,000/1,000,000).

(c) In the very rare situation where the receipts factor (after reducing the denominator by the throw-out income) is zero divided by zero, the receipts factor is deemed to be zero.

(403) **Throw-out income.** Throw-out income includes all apportionable receipts attributed to states where the taxpayer:

(a) Is not taxable (see subsection (107) of this rule); and

(b) At least part of the activity of the taxpayer related to the throw-out income is performed in Washington.

Example 37. XYZ Corp. performs all services in Washington and has apportionable receipts attributed using the criteria listed in subsections (301) through (305) of this rule or WAC 458-20-19403 as follows: Washington $500,000; Idaho $200,000; Oregon $100,000; and California $300,000. XYZ Corp. is subject to Oregon and Idaho corporate income tax, but does not owe any California business activities taxes. XYZ does not have any throw-out income because Oregon and Idaho impose a business activities tax on its activities and it is deemed to be taxable in California because it satisfies the minimum nexus standards explained in WAC 458-20-19401 (more than $250,000 in receipts). XYZ's receipts factor is: 500,000/1,100,000 or 45.45%.

Example 38. Same facts as Example 37 except Idaho does not impose any tax on XYZ Corp. The $200,000 attributed to Idaho is throw-out income that is excluded from the denominator because: XYZ Corp. is not subject to Idaho business activities taxes; does not have substantial nexus with Idaho under Washington standards; and performs in Washington at least part of the activities related to the receipts attributed to Idaho. The receipts factor is 500,000/900,000 or 55.56%.

Example 39. The same facts as Example 38 except XYZ Corp. performs no activities in Washington related to the $200,000 attributed to Idaho. In this situation, the $200,000 is not throw-out income and remains in the denominator. The receipts factor is: 500,000/1,100,000 or 45.45%.

PART 5. HOW TO DETERMINE WASHINGTON TAXABLE INCOME.

(501) **General.** Washington taxable income is determined by multiplying apportionable income by the receipts factor for each apportionable activity the taxpayer engages in. While the receipts factor is calculated without regard to deductions authorized under chapter 82.04 RCW, apportionable income is determined by reducing the apportionable receipts by amounts that are deductible under chapter 82.04 RCW regardless of where the deduction may be attributed. This formula can be expressed algebraically as:

$$\text{(Taxable Income)} = \text{(Receipts Factor)} \times \text{(Apportionable receipts - deductions)}$$

Example 40. Calculating apportionable income. Corporation A received $2,000,000 in apportionable receipts from its world-wide apportionable activities, which included $500,000 of receipts that are deductible under Washington law. Corporation A's total apportionable income is $1,500,000 ($2,000,000 minus $500,000 of deductions). If Corporation A's receipts factor is 31.25%, then its taxable income is $468,750 ($1,500,000 multiplied by 0.3125).

PART 6. REPORTING INSTRUCTIONS.

(601) **General.**

(a) Taxpayers required to use this rule's apportionment method may report their taxable income based on their apportionable income for the reporting period multiplied by the receipts factor for the most recent calendar year the taxpayer has available.

(b) If a taxpayer does not calculate its taxable income using (a) of this subsection, the taxpayer must use actual current calendar year information.

(602) **Reconciliation.** Regardless of how a taxpayer reports its taxable income under subsection (601)(a) or (b) of this rule, when the taxpayer has the information to determine the receipts factor for an entire calendar year, it must file a reconciliation and either obtain a refund or pay any additional tax due. The reconciliation must be filed on a form approved by the department. In either event (refund or additional taxes due), interest will apply in a manner consistent with tax assessments. If the reconciliation is completed prior to October 31st of the following year, no penalties will apply to any additional tax that may be due.

WSR 12-20-001

PERMANENT RULES

HEALTH CARE AUTHORITY

(Medicaid Program)

[Filed September 19, 2012, 2:51 p.m., effective October 20, 2012]

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

Purpose: The web link cited in WAC 182-519-0050 which connects the reader to the medically needy income level (MNIL) standards is obsolete. The agency has replaced the web link with a chart of the MNIL and reference to the annually updated federal benefit rate.

Citation of Existing Rules Affected by this Order: Repealing WAC 388-512-1210; amending WAC 182-512-0150, 182-512-0700, 182-512-0900, 182-512-0920, 182-512-0940, 182-519-0050, 388-519-0100, and 388-519-0110.

Statutory Authority for Adoption: RCW 41.05.021.

Adopted under notice filed as WSR 12-16-049 on July 27, 2012.

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 8, Repealed 1.

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 1.

Date Adopted: September 19, 2012.

Kevin M. Sullivan
Rules Coordinator

AMENDATORY SECTION (Amending WSR 11-24-018, filed 11/29/11, effective 12/1/11)

WAC 182-512-0150 SSI-related medical—Medically needy (MN) medical eligibility. (1) Medically needy (MN) medical coverage is available for any of the following:

(a) ((~~A person~~)) An individual who is SSI-related and not eligible for CN medical coverage because ((~~they have~~)) the individual has countable income that is above the CN income standard (or for long-term care (LTC) clients, above the special income limit (SIL)):

(i) ((~~Their~~)) The individual's countable income is at or below MN standards, leaving ((~~them with~~)) no spenddown requirement; or

(ii) ((~~Their~~)) The individual's countable income is above MN standards requiring ((~~them~~)) the individual to spenddown their excess income (see subsection (4) ((~~below~~)) of this section). See WAC ((~~388-475-0500~~)) 182-512-0500 through ((~~388-475-0800~~)) 182-512-0800 for rules on determining countable income, and WAC ((~~388-478-0080~~)) 182-519-0050 for program standards or chapter 388-513 WAC for institutional standards.

(b) An SSI-related ineligible spouse of an SSI recipient;

(c) An ((~~adult~~)) individual who meets SSI program criteria but is not eligible for the SSI cash grant due to immigration status or sponsor deeming. See WAC 388-424-0010 for limits on eligibility for aliens;

(d) ((~~A person~~)) An individual who meets the MN LTC services requirements of chapter 388-513 WAC ((~~and WAC 388-515-1540~~));

(e) ((~~A person~~)) An individual who lives in an alternate living facility and meets the requirements of WAC 388-513-1305; or

(f) ((~~A person~~)) An individual who meets resource requirements as described in chapter ((~~388-475~~)) 182-512 WAC, elects and is certified for hospice services per chapter ((~~388-551~~)) 182-551 WAC.

(2) ((~~Clients~~)) Individuals whose countable resources are above the SSI resource standards are not eligible for MN non-institutional medical benefits. See WAC ((~~388-475-0200~~)) 182-512-0200 through ((~~388-475-0550~~)) 182-512-0550 to determine countable resources.

(3) ((~~Clients~~)) Individuals who qualify for services under long term care have different criteria and may spend down excess resources to become eligible for LTC institutional or waiver medical benefits. Refer to WAC 388-513-1315 and 388-513-1395.

(4) ((~~A client~~)) An individual with income over the effective medically needy income limit (MNIL) described in WAC 182-519-0050 may become eligible for MN coverage when ((~~they have~~)) the individual has incurred medical expenses that are equal to the excess income. This is the process of meeting spenddown. Refer to chapter ((~~388-519~~)) 182-519 WAC for spenddown information.

(5) ((~~A client~~)) An individual may be eligible for medical coverage for up to three months immediately prior to the month of application, if the ((~~client~~)) individual:

(a) Met all eligibility requirements for the months being considered; and

(b) Received medical services covered by medicaid during that time.

(6) ((~~A client~~)) An individual eligible for MN without a spenddown is certified for up to twelve months. For an ((~~MN client with~~)) individual who must meet a spenddown, refer to WAC ((~~388-519-0110~~)) 182-519-0110. For a long-term care MN ((~~client~~)) individual, refer to WAC 388-513-1305 and 388-513-1315.

(7) ((~~A client~~)) An individual must reapply for each certification period. There is no continuous eligibility for MN. Although each additional certification period requires a new application, if the medical benefits have been closed less than thirty days, an eligibility review form may be used to reapply.

AMENDATORY SECTION (Amending WSR 11-24-018, filed 11/29/11, effective 12/1/11)

WAC 182-512-0700 SSI-related medical—Income eligibility. (1) In order to be eligible, ((~~a client~~)) an individual is required to do everything necessary to obtain any income to which ((~~they are~~)) he or she is entitled including (but not limited to):

(a) Annuities,

(b) Pensions,

(c) Unemployment compensation,

(d) Retirement, and

(e) Disability benefits; even if their receipt makes the ((~~client~~)) individual ineligible for ((~~department~~)) agency services, unless the ((~~client~~)) individual can provide evidence showing good reason for not obtaining the benefits.

((~~The department does not count this income until the client begins to receive it.~~))

(2) The agency or its authorized representative does not count this income until the individual begins to receive it. Income is budgeted prospectively for all medical programs.

(3) Anticipated nonrecurring lump sum payments other than retroactive SSI/SSDI payments are considered income in the month received, subject to reporting requirements in

WAC 388-418-0007(4). Any unspent portion is considered a resource the first of the following month.

(4) The ((~~department~~)) agency or its authorized representative follows income and resource methodologies of the supplemental security income (SSI) program defined in federal law when determining eligibility for SSI-related medical or medicare savings programs unless the ((~~department~~)) agency adopts rules that are less restrictive than those of the SSI program.

(5) Exceptions to the SSI income methodology:

(a) Lump sum payments from a retroactive SSDI benefit, when reduced by the amount of SSI received during the period covered by the payment, are not counted as income;

(b) Unspent retroactive lump sum money from SSI or SSDI is excluded as a resource for nine months following receipt of the lump sum; and

(c) Both the principal and interest portions of payments from a sales contract, that meet the definition in WAC ((~~388-475-0350~~)) 182-512-0350(10), are unearned income.

(6) To be eligible for categorically needy (CN) SSI-related medical coverage, ((~~a client's~~)) an individual's countable income cannot exceed the CN program standard described in:

(a) WAC ((~~388-478-0065 through 388-478-0085~~)) 182-512-0010 for noninstitutional medical unless living in an alternate living facility; or

(b) WAC 388-513-1305(2) for noninstitutional CN benefits while living in an alternate living facility; or

(c) WAC 388-513-1315 for institutional and waiver services medical benefits.

(7) To be eligible for SSI-related medical coverage provided under the medically needy (MN) program, ((~~a client~~)) an individual must:

(a) Have countable income at or below the effective MN program standard as described in WAC ((~~388-478-0070~~)) 182-519-0050; or

(b) Satisfy spenddown requirements described in WAC ((~~388-519-0110~~)) 182-519-0110;

(c) Meet the requirements for noninstitutional MN benefits while living in an alternate living facility (ALF). See WAC 388-513-1305(3); or

(d) Meet eligibility for ((~~the MN waiver program. See WAC 388-515-1540 and 388-515-1550~~)) institutional MN benefits described in WAC 388-513-1315.

AMENDATORY SECTION (Amending WSR 11-24-018, filed 11/29/11, effective 12/1/11)

WAC 182-512-0900 SSI-related medical—Deeming and allocation of income. The ((~~department~~)) agency or its authorized representative considers income of financially responsible persons to determine if a portion of that income must be regarded as available to other household members.

(1) Deeming is the process of determining how much of another person's income is counted when determining eligibility of an SSI-related applicant. When income is deemed to the SSI-related applicant from other household members, that income is considered the applicant's income. Income is deemed only:

(a) From a nonapplying spouse who lives with the SSI-related applicant; or

(b) From a parent(s) residing with an SSI-related applicant child.

(2) An allocation is an amount deducted from income counted in the eligibility determination and considered to be set aside for the support of a person other than the SSI-related applicant. When income is allocated to other household members from the SSI-related applicant(s) or from the applicant's spouse, that income is not counted as income of the SSI applicant.

(3) An SSI-related ((~~person~~)) individual applying for categorically needy (CN) medical coverage must have countable income at or below the SSI categorically needy income level (CNIL) described in WAC ((~~388-478-0080~~)) 182-512-0010 unless the ((~~person~~)) individual is working and meets all requirements for the healthcare for workers with disabilities (HWD) program described in WAC ((~~388-475-1000~~)) 182-511-1000 through ((~~388-475-1250~~)) 182-511-1250.

(4) For institutional or home and community based waiver programs, use rules described in WAC 388-513-1315.

(5) The ((~~department~~)) agency or its authorized representative follows rules described in WAC ((~~388-475-0600~~)) 182-512-0600 through ((~~388-475-0880~~)) 182-512-0880 to determine the countable income of an SSI-related applicant or SSI-related couple.

(6) If countable income of the applicant exceeds the one-person SSI CNIL prior to considering the income of a nonapplying spouse or children, the applicant is not eligible for CN medical coverage and the ((~~department~~)) agency or its authorized representative determines eligibility for the medically needy (MN) program. If the countable income does not exceed the SSI CNIL, see WAC ((~~388-475-0920~~)) 182-512-0920 to determine if income is to be deemed to the applicant from the nonapplying spouse.

(7) If countable income (after allowable deductions) of an SSI-related couple both applying for medical coverage exceeds the two-person SSI CNIL, the couple is not eligible for CN medical coverage and the ((~~department~~)) agency or its authorized representative determines eligibility for the medically needy (MN) program.

(8) For CN medical coverage, allocations to children are deducted from the nonapplying spouse's unearned income, then from their earned income before income is deemed to the SSI-related applicant. See WAC ((~~388-475-0820~~)) 182-512-0820.

(9) For MN medical coverage, allocations to children are deducted from the income of the SSI-related applicant or SSI-related applicant couple. See subsection (10) of this section to determine the amount of the allocation.

(10) An SSI-related individual or couple applying for MN medical coverage is allowed an allocation to a nonapplying spouse, their SSI recipient spouse or their dependent child(ren) to reduce countable income before comparing income to the effective medically needy income level (MNIL) described in WAC ((~~388-478-0070~~)) 182-519-0050. The ((~~department~~)) agency or its authorized representative allocates income:

(a) Up to the effective one-person MNIL to a nonapplying spouse or SSI recipient spouse minus the spouse's countable income; and

(b) Up to one-half of the federal benefit rate (FBR) to each dependent minus each dependent's countable income. See WAC ((~~388-475-0820~~)) 182-512-0820 for child exclusions.

(11) A portion of a nonapplying spouse's income may be deemed to the SSI-related applicant:

(a) See WAC ((~~388-475-0920~~)) 182-512-0920(5) to determine how much income is deemed from a nonapplying spouse to the SSI-related applicant when determining CN eligibility; and

(b) See WAC ((~~388-475-0920~~)) 182-512-0920(10) to determine how much income is deemed from a nonapplying spouse to the SSI-related applicant when determining MN eligibility.

(12) A portion of the income of an ineligible parent or parents is allocated to the needs of an SSI-related applicant child. See WAC ((~~388-475-0940~~)) 182-512-0940 (4) through (7) to determine how much income is allocated from ineligible parent(s).

(13) Only income and resources actually contributed to an alien applicant from their sponsor are counted as income. For allocation of income from an alien sponsor, refer to WAC 388-450-0155.

AMENDATORY SECTION (Amending WSR 11-24-018, filed 11/29/11, effective 12/1/11)

WAC 182-512-0920 SSI-related medical—Deeming/allocation of income from nonapplying spouse. The ((~~department~~)) agency or its authorized representative considers the income of financially responsible persons to determine if a portion of that income is available to other household members.

(1) A portion of the income of a nonapplying spouse is considered available to meet the needs of an SSI-related applicant. A nonapplying spouse is defined as someone who is:

(a) Financially responsible for the SSI-related applicant as described in WAC ((~~388-408-0055~~)) 182-506-0010 and ((~~388-475-0960~~)) 182-512-0960. For institutional and home and community based waiver programs, see WAC 388-513-1315;

(b) Living in the same household with the SSI-related applicant;

(c) Not receiving a needs based payment such as temporary assistance to needy families (TANF), state funded cash assistance (SFA); or

(d) Not related to SSI, or is not applying for medical assistance including spouses receiving SSI.

(2) An ineligible spouse is the spouse of an SSI cash recipient and is either not eligible for SSI for themselves or who has elected to not receive SSI cash so that their spouse may be eligible. An SSI-related applicant who is the ineligible spouse of an SSI cash recipient is not eligible for categorically needy (CN) medical coverage and must be considered for medical coverage under the medically needy (MN) program.

(3) When determining whether a nonapplying spouse's income is countable, the ((~~department~~)) agency or its authorized representative:

(a) Follows the income rules described in WAC ((~~388-475-0600~~)) 182-512-0600 through ((~~388-475-0750~~)) 182-512-0750;

(b) Excludes income described in WAC ((~~388-475-0800~~)) 182-512-0800 (2) through (((~~11~~))) (10), and all income excluded under federal statute or state law as described in WAC ((~~388-475-0860~~)) 182-512-0860.

(c) Excludes work-related expenses described in WAC ((~~388-475-0840~~)) 182-512-0840, with the exception that the sixty-five dollars plus one half earned income deduction described in WAC ((~~388-475-0840~~)) 182-512-0840(2) does not apply;

(d) Deducts any court ordered child support which the nonapplying spouse pays for a child outside of the home (current support or arrears); and

(e) Deducts any applicable child-related income exclusions described in WAC ((~~388-475-0820~~)) 182-512-0820.

(4) The ((~~department~~)) agency or its authorized representative allocates income of the nonapplying spouse to nonapplying children who reside in the home as described in WAC 388-475-0820. Allocations to children are deducted first from the nonapplying spouse's unearned income, then from their earned income.

(a) For CN medical determinations, allocations to children are not allowed out of the income of the SSI-related applicant, only from the income of the nonapplying spouse.

(b) For MN medical determinations, allocations to children are allowed from the income of the SSI-related applicant if the applicant is unmarried.

(5) For SSI-related CN medical determinations, a portion of the countable income of a nonapplying spouse remaining after the deductions and allocations described in subsections (3) and (4) of this section may be deemed to the SSI-related applicant. If the nonapplying spouse's countable income is:

(a) Less than or equal to one-half of the federal benefit rate (FBR), no income is deemed to the applicant. Compare the applicant's countable income to the one-person SSI categorically needy income level (CNIL) described in WAC ((~~388-470-0040~~)) 182-512-0010. For healthcare for workers with disabilities (HWD) applicants, compare to the one-person HWD standard described in WAC ((~~388-478-0075~~)) 182-505-0100 (1)(c).

(b) Greater than one-half of the FBR, then the entire nonapplying spouse's countable income is deemed to the applicant. Compare the applicant's income to the two-person SSI CNIL. For HWD applicants, compare to the two-person HWD standard described in WAC ((~~388-478-0075~~)) 182-505-0100 (1)(c).

(6) When income is not deemed to the SSI-related applicant from the nonapplying spouse per subsection (5)(a):

(a) Allow all allowable income deductions and exclusions as described in chapter ((~~388-475~~)) 182-512 WAC to the SSI-related applicant's income; and

(b) Compare the net remaining income to the one-person SSI CNIL or the one-person HWD standard.

(7) When income is deemed to the SSI-related applicant from the nonapplying spouse per subsection (5)(b) of this section:

(a) Combine the applicant's unearned income with any unearned income deemed from the nonapplying spouse and allow one twenty dollar general income exclusion to the combined amount.

(b) Combine the applicant's earned income with any earned income deemed from the nonapplying spouse and allow the sixty-five dollar plus one half of the remainder earned income deduction (described in WAC ((~~388-475-0840~~)) 182-512-0840(2)) to the combined amount.

(c) Add together the net unearned and net earned income amounts and compare the total to the two-person SSI CNIL described in WAC 182-512-0010 or the two-person HWD standard described in WAC ((~~388-478-0075~~)) 182-505-0100 (1)(c). If the income is equal to or below the applicable two-person standard, the applicant is eligible for CN medical coverage.

(8) An SSI-related applicant under the age of sixty-five who is working at or below the substantial gainful activity (SGA) level but who is not eligible for CN coverage under the regular SSI-related program, may be considered for eligibility under the MN program or under the HWD program. The SGA level is determined annually by the Social Security Administration and is posted at: https://secure.ssa.gov/apps10/poms.nsf/lnx/0410501015.

(9) If the SSI-related applicant's countable income is above the applicable SSI CNIL standard, the ((~~department~~)) agency or its authorized representative considers eligibility under the MN program or under the HWD program if the individual is under the age of sixty-five and working. An SSI-related applicant who meets the following criteria is not eligible for MN coverage and eligibility must be determined under HWD:

(a) A blind or disabled individual who is under the age of sixty-five;

(b) Who has earned income over the SGA level; and

(c) Is not receiving a Title II Social Security cash benefit based on blindness or disability.

(10) For SSI-related MN medical determinations, a portion of the countable income of a nonapplying spouse remaining after the deductions and allocations described in subsections (3) and (4) of this section may be deemed to the SSI-related applicant. If the nonapplying spouse's countable income is:

(a) Less than or equal to the effective one-person MNIL described in WAC ((~~388-478-0070~~)) 182-519-0050, no income is deemed to the applicant and a portion of the applicant's countable income is allocated to the nonapplying spouse's income to raise it to the effective MNIL standard.

(b) Greater than the effective MNIL, then the amount in excess of the effective one-person MNIL is deemed to the applicant. Compare the applicant's income to the effective one-person MNIL.

(11) When income is not deemed to the SSI-related applicant from the nonapplying spouse per subsection (10)(a) of this section:

(a) Allocate income from the applicant to bring the income of the nonapplying spouse up to the effective one-person MNIL standard;

(b) Allow all allowable income deductions and exclusions as described in chapter ((~~388-475~~)) 182-512 WAC to the SSI-related applicant's remaining income;

(c) Allow a deduction for medical insurance premium expenses (if applicable); and

(d) Compare the net countable income to the effective one-person MNIL.

(12) When income is deemed to the SSI-related applicant from the nonapplying spouse per subsection (10)(b) of this section:

(a) Combine the applicant's unearned income with any unearned income deemed from the nonapplying spouse and allow one twenty dollar general income exclusion to the combined amount;

(b) Combine the applicant's earned income with any earned income deemed from the nonapplying spouse and allow the sixty-five dollar plus one half of the remainder earned income deduction (described in WAC ((~~388-475-0840~~)) 182-512-0840(2)) to the combined amount;

(c) Add together the net unearned and net earned income amounts;

(d) Allow a deduction for medical insurance premium expenses (if applicable) per WAC ((~~388-519-0100~~)) 182-519-0100(5); and

(e) Compare the net countable income to the effective one-person MNIL described in WAC ((~~388-478-0070~~)) 182-519-0050. If the income is:

(i) Equal to or below the effective one-person MNIL, the applicant is eligible for MN medical coverage with no spend-down.

(ii) Greater than the effective MNIL, the applicant is only eligible for MN medical coverage after meeting a spend-down liability as described in WAC ((~~388-519-0110~~)) 182-519-0110.

(13) The ineligible spouse of an SSI-cash recipient applying for MN coverage is eligible to receive the deductions and allocations described in subsection (10)(a) of this section.

AMENDATORY SECTION (Amending WSR 11-24-018, filed 11/29/11, effective 12/1/11)

WAC 182-512-0940 SSI-related medical—Deeming income from an ineligible parent(s) to a child applying for SSI-related medical. The ((~~department~~)) agency or its authorized representative considers income of financially responsible persons to determine if a portion of that income must be regarded as available to other household members.

(1) A portion of the income of a parent(s) is considered available to the SSI-related applicant child when the child is age seventeen or younger and the parent(s) is:

(a) Financially responsible for the SSI-related child as described in WAC ((~~388-408-0055~~)) 182-506-0010(2);

(b) The natural, adoptive, or step-parent of the child;

(c) Living in the same household with the child;

(d) Not receiving a needs-based payment such as TANF, SFA or SSI; and

(e) Not related to SSI or not applying for medical assistance.

(2) If an SSI-related applicant between the ages of eighteen to twenty-one lives with their parents, only consider the parent's income available to the applicant if it is actually contributed to the applicant. If income is not contributed, count only the applicant's own separate income.

(3) Income that is deemed to the child is considered as that child's income.

(4) When determining whether a parent's income is countable, the ((~~department~~)) agency or its authorized representative follows:

(a) The income rules described in WAC ((~~388-475-0600~~)) 182-512-0600 through ((~~388-475-0750~~)) 182-512-0750; and

(b) Excludes income described in WAC ((~~388-475-0800~~)) 182-512-0800 and ((~~388-475-0840~~)) 182-512-0840, and all income excluded under a federal statute or state law as described in WAC ((~~388-475-0860~~)) 182-512-0860.

(5) When determining the amount of income to be deemed from a parent(s) to an SSI-related minor child for categorically needy (CN) and medically needy (MN) coverage, the ((~~department~~)) agency or its authorized representative reduces the parent(s) countable income in the following order:

(a) Court ordered child support paid out for a child not in the home;

(b) An amount equal to one half of the federal benefit rate (FBR) for each SSI-eligible sibling living in the household, minus any countable income of that child. See WAC 388-478-0055 for FBR amount;

(c) A twenty dollar general income exclusion;

(d) A deduction equal to sixty-five dollars plus one-half of the remainder from any remaining earned income of the parent(s);

(e) An amount equal to the one-person SSI CNIL for a single parent or the two-person SSI CNIL for a two parent household;

(f) Any income remaining after these deductions is considered countable income to the SSI-related child and is added to the child's own income. If there is more than one child applying for SSI-related medical coverage, the deemed parental income is divided equally between the applicant children; and

(g) The deductions described in this section are deducted first from unearned income then from earned income unless they are specific to earned income.

(6) The SSI-related applicant child is also allowed all applicable income exclusions and disregards described in chapter ((~~388-475~~)) 182-475 WAC from their own income. After determining the child's nonexcluded income, the ((~~department~~)) agency or its authorized representative:

(a) Allows the twenty dollar general income exclusion from any unearned income;

(b) Deducts sixty-five dollars plus one half of the remainder from any earned income which has not already been excluded under the student earned income exclusion (see WAC ((~~388-475-0820~~)) 182-512-0820).

(c) Adds the child's countable income to the amount deemed from their parent(s). If the combination of the child's countable income plus deemed parental income is equal to or less than the SSI CNIL, the child is eligible for SSI-related CN medical coverage.

(7) If the combination of the child's countable income plus deemed parental income is greater than the SSI CNIL, the ((~~department~~)) agency or its authorized representative considers the child for SSI-related medically needy (MN) coverage. Any amount exceeding the effective medically needy income level (MNIL) is used to calculate the amount of the child's spenddown liability as described in WAC ((~~388-519-0110~~)) 182-519-0110. See WAC ((~~388-478-0070~~)) 182-519-0050 for the current MNIL standards.

REPEALER

The following chapter of the Washington Administrative Code is repealed:

WAC 388-512-1210	Program description.

AMENDATORY SECTION (Amending WSR 11-23-091, filed 11/17/11, effective 11/21/11)

WAC 182-519-0050 Monthly income and countable resource standards for medically needy (MN). (1) Changes to the medically needy income level (MNIL) occur on January 1st of each calendar year((~~. Current income standards can be found at http://www1.dshs.wa.gov/pdf/esa/manual/Standards_C_MedAsst_Chart.pdf~~)) when the Social Security Administration (SSA) issues a cost-of-living adjustment for that year.

(2) Medically needy (MN) standards for persons who meet institutional status requirements are in WAC 388-513-1395. The standard for a client who lives in an alternate living facility can be found in WAC 388-513-1305.

(3) ((~~Find~~)) The resource standards for institutional programs are found in WAC 388-513-1350. The institutional standard chart can be found at ((~~http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.

(4) Countable resource standards for the noninstitutional MN program are:

(a) One person	$2,000
(b) A legally married couple	$3,000
(c) For each additional family member add	$50

(5) For individuals who do not meet institutional status requirements, the income standard used to determine eligibility for the medically needy program is the "effective" MNIL. The "effective" MNIL is the one-person federal benefit rate (FBR) established by SSA each year, or the MNIL listed below, whichever amount is higher. The FBR is the supplemental security income (SSI) payment standard. For example, in 2012 the FBR is six hundred ninety-eight dollars.

1	2	3	4	5	6	7	8	9	10
467	592	667	742	858	975	1125	1242	1358	1483

AMENDATORY SECTION (Amending WSR 09-08-003, filed 3/19/09, effective 4/19/09)

WAC 388-519-0100 Eligibility for the medically needy program. (1) An individual who meets the following conditions may be eligible for medically needy (MN) coverage under the special rules in chapters 388-513 WAC and 388-515 WAC:

(a) Meets the institutional status requirements of WAC 388-513-1320;

(b) Resides in a medical institution as described in WAC 388-513-1395; or

(c) Receives waiver services under a medically needy in-home waiver (MNIW) according to WAC 388-515-1550 or a medically needy residential waiver (MNRW) according to WAC 388-515-1540.

(2) An SSI-related individual who lives in a department contracted alternate living facility may be eligible for MN coverage under the rules described in WAC 388-513-1305.

(3) An individual may be eligible for MN coverage under this chapter when he or she is:

(a) Not covered under subsection (1) and (2) of this section; and

(b) Eligible for categorically needy (CN) medical coverage in all other respects except that his or her CN countable income is above the CN income standard.

(4) MN coverage may be available if the individual is:

(a) A child;

(b) A pregnant woman;

(c) A refugee;

(d) An SSI-related individual including an aged, blind or disabled individual with countable income under the CN income standard, who is an ineligible spouse of an SSI recipient; or

(e) A hospice client with countable income which is above the special income level (SIL).

(5) An individual who is not eligible for CN medical and who is applying for MN coverage has the right to income deductions in addition to, or instead of, those used to arrive at CN countable income. Deductions to income are applied to each month of the base period to determine MN countable income. The following deductions are used to calculate countable income for MN:

(a) The agency disregards the difference between the MNIL described in WAC 182-519-0050 and the federal benefit rate (FBR) established by the Social Security Administration each year. The FBR is the one person Supplemental Security Income (SSI) payment standard;

(b) All health insurance premiums, with the exception of medicare Part A, Part B, Part C and Part D premiums expected to be paid by the individual or family member during the base period(s);

((~~(b)~~)) (c) Any allocations to a spouse or to dependents for an SSI-related individual who is married or who has dependent children. Rules for allocating income are described in WAC ((~~388-475-0900~~)) 182-512-0900 through 182-512-0960;

((~~(c)~~)) (d) For an SSI-related individual who is married and lives in the same home as his or her spouse who receives home and community based waiver services under chapter 388-515 WAC, an income deduction equal to the medically needy income level (MNIL) minus the nonapplying spouse's income; and

((~~(d)~~)) (e) A child or pregnant woman who is applying for MN coverage is eligible for income deductions allowed under TANF/SFA rules and not under the rules for CN programs based on the federal poverty level. See WAC ((~~388-450-0210(4)~~)) 182-109-0001(4) for exceptions to the TANF/SFA rules which apply to medical programs and not to the cash assistance program.

(6) The MNIL for individuals who qualify for MN coverage under subsection (1) of this section is based on rules in chapter 388-513 and 388-515 WAC.

(7) The MNIL for all other individuals is described in WAC ((~~388-478-0070~~)) 182-519-0050. If an individual has countable income which is at or below the MNIL, he or she is certified as eligible for up to twelve months of MN medical coverage.

(8) If an individual has countable income which is over the MNIL, the countable income that exceeds the ((~~department's~~)) agency's MNIL standards is called "excess income."

(9) When individuals have "excess income" they are not eligible for MN coverage until they provide evidence to the ((~~department~~)) agency or its designee of medical expenses incurred by themselves, their spouse or family members who live in the home for whom they are financially responsible. See WAC ((~~388-519-0110(8)~~)) 182-519-0110(8). An expense has been incurred when:

(a) The individual has received the medical treatment or medical supplies, is financially liable for the medical expense but has not yet paid the bill; or

(b) The individual has paid for the expense within the current or retroactive base period described in WAC ((~~388-519-0110~~)) 182-519-0110.

(10) Incurred medical expenses or obligations may be used to offset any portion of countable income that is over the MNIL. This is the process of meeting "spenddown."

(11) The ((~~department~~)) agency or its designee calculates the amount of an individual's spenddown by multiplying the monthly excess income amount by the number of months in the certification period as described in WAC ((~~388-519-0110~~)) 182-519-0110. The qualifying medical expenses must be greater than or equal to the total calculated spenddown amount.

(12) An individual who is considered for MN coverage under this chapter may not spenddown excess resources to become eligible for the MN program. Under this chapter individuals are ineligible for MN coverage if their resources exceed the program standard in WAC ((~~388-478-0070~~)) 182-519-0050. An individual who is considered for MN coverage under WAC 388-513-1395, ((~~388-505-0250~~)) 182-514-0250 or ((~~388-505-0255~~)) 182-514-0255 is allowed to spenddown excess resources.

(13) There is no automatic redetermination process for MN coverage. An individual must submit an application for each eligibility period under the MN program.

(14) An individual who requests a timely administrative hearing under WAC 388-458-0040 is not eligible for continued benefits beyond the end of the original certification date under the ((~~medically needy~~)) MN program.

AMENDATORY SECTION (Amending WSR 09-08-003, filed 3/19/09, effective 4/19/09)

WAC 388-519-0110 Spenddown of excess income for the medically needy program. (1) An individual who applies for medical assistance and is eligible for medically needy (MN) coverage with a spenddown may choose a three month or a six month base period. A base period is a time period used to compute the amount of the spenddown liability. The months must be consecutive calendar months unless one of the conditions in subsection (4) of this section applies.

(2) A base period begins on the first day of the month, in which an individual applies for medical assistance, subject to the exceptions in subsection (4) of this section.

(3) An individual may request a separate base period to cover the time period up to three calendar months immediately prior to the month of application. This is called a retroactive base period.

(4) A base period may vary from the terms in subsections (1), (2), or (3) of this section if:

(a) A three month base period would overlap a previous eligibility period; or

(b) The individual has countable resources that are over the applicable standard for any part of the required base period; or

(c) The ((~~client~~)) individual is not or will not be able to meet the TANF-related or SSI-related requirement for the required base period; or

(d) The individual is eligible for categorically needy (CN) coverage for part of the required base period; or

(e) The ((~~client~~)) individual was not otherwise eligible for MN coverage for each of the months of the retroactive base period.

(5) An individual's spenddown liability is calculated by the ((~~department~~)) agency or its designee. The MN countable income from each month of the base period is compared to the effective medically needy income level (MNIL) described in WAC 182-519-0050. Income which is over the effective MNIL standard (based on the individual's household size) in each month in the base period is added together to determine the total spenddown amount. ((~~The MNIL standard is found at http://www.dshs.wa.gov/pdf/esa/manual/standards_C_MedAsstChart.pdf and is updated annually in January.~~))

(6) If household income varies and an individual's MN countable income falls below the effective MNIL for one or more months, the difference is used to offset the excess income in other months of the base period. If this results in a spenddown amount of zero dollars and cents, see WAC ((~~388-519-0100(7)~~)) 182-519-0100(7).

(7) If an individual's income decreases, the ((~~department~~)) agency or its designee approves CN coverage for each month in the base period when the individual's countable income and resources are equal to or below the applicable CN standards. Children under the age of nineteen and pregnant women who become CN eligible in any month of the base period remain continuously eligible for CN coverage for the remainder of the certification even if there is a subsequent increase in income.

(8) Once an individual's spenddown amount has been determined, qualifying medical expenses are deducted. To be considered a qualifying medical expense, the expense must:

(a) Be an expense for which the individual is financially liable;

(b) Not have been used to meet another spenddown;

(c) Not be the confirmed responsibility of a third party. The ((~~department~~)) agency or its designee allows the entire expense if the third party has not confirmed its coverage of the expense within:

(i) Forty-five days of the date of service; or

(ii) Thirty days after the base period ends.

(d) Be an incurred expense for the individual:

(i) The individual's spouse;

(ii) A family member, residing in the home of the individual, for whom the individual is financially responsible; or

(iii) A relative, residing in the home of the individual, who is financially responsible for the individual.

(e) Meet one of the following conditions:

(i) Be an unpaid liability at the beginning of the base period;

(ii) Be for medical services either paid or unpaid and incurred during the base period;

(iii) Be for medical services incurred and paid during the three month retroactive base period if eligibility for medical assistance was not established in that base period. Paid expenses that meet this requirement may be applied towards the current base period; or

(iv) Be for medical services incurred during a previous base period and either unpaid or paid for, if it was necessary for the individual to make a payment due to delays in the certification for that base period.

(9) An exception to the provisions in subsection (8) of this section exists for qualifying medical expenses that have been paid on behalf of the individual by a publicly administered program during the current or the retroactive base period. The ((~~department~~)) agency or its designee uses the qualifying medical expenses to meet the spenddown liability. To qualify for this exception the program must:

(a) Not be federally funded or make the payments from federally matched funds;

(b) Not pay the expenses prior to the first day of the retroactive base period; and

(c) Provide proof of the expenses paid on behalf of the individual.

(10) Once the ((~~department~~)) agency or its designee has determined that the expenses meet the definition of a qualified expense as defined in subsection (8) or (9) of this section, the expenses are subtracted from the spenddown liability to determine the date the individual is eligible for medical coverage to begin. Qualifying medical expenses are deducted in the following order:

(a) First, medicare and other health insurance deductibles, coinsurance charges, enrollment fees, copayments and premiums that are the individual's responsibility under medicare Part A, Part B, Part C and Part D. (Health insurance premiums are income deductions under WAC ((~~388-519-0100(5)~~)) 182-519-0100(5));

(b) Second, medical expenses incurred and paid by the individual during the three month retroactive base period if

eligibility for medical assistance was not established in that base period;

(c) Third, current payments on, or unpaid balance of, medical expenses incurred prior to the current base period which have not been used to establish eligibility for medical coverage in any other base period. The ((~~department~~)) agency or its designee sets no limit on the age of an unpaid expense; however, the expense must still be a current liability and be unpaid at the beginning of the base period;

(d) Fourth, other medical expenses that would not be covered by the ((~~department's~~)) agency's or its designee's medical programs, minus any third party payments which apply to the charges. The items or services allowed as a medical expense must have been provided or prescribed by a licensed health care provider;

(e) Fifth, other medical expenses which have been incurred by the individual during the base period that are potentially payable by the MN program (minus any confirmed third party payments that apply to the charges), even if payment is denied for these services because they exceed the ((~~department~~)) agency's or its designee's limits on amount, duration or scope of care. Scope of care is described in WAC ((~~388-501-0060~~)) 182-501-0060 and ((~~388-501-0065~~)) 182-501-0065; and

(f) Sixth, other medical expenses that have been incurred by the individual during the base period that are potentially payable by the MN program (minus any confirmed third party payments that apply to the charges) and that are within the ((~~department~~)) agency's or its designee's limits on amount, duration or scope of care.

(11) If an individual submits verification of qualifying medical expenses with his or her application that meets or exceeds the spenddown liability, he or she is eligible for MN medical coverage for the remainder of the base period unless their circumstances change. See WAC 388-418-0005 to determine which changes must be reported to the ((~~department~~)) agency or its designee. The beginning of eligibility is determined as described in WAC ((~~388-416-0020~~)) 182-504-0020.

(12) If an individual cannot meet the spenddown amount at the time the application is submitted, the individual is not eligible until he or she provides proof of additional qualifying expenses that meet the spenddown liability.

(13) Each dollar of a qualifying medical expense may count once against a spenddown period that leads to eligibility for MN coverage. However, medical expenses may be used more than once under the following circumstances:

(a) The individual did not meet his or her total spenddown liability and become eligible in a previous base period and the bill remains unpaid; or

(b) The medical expense was a bill incurred and paid within three months of the current application and the ((~~department~~)) agency or its designee could not establish eligibility for medical assistance for the individual in the retroactive base period.

(14) The individual must provide the proof of qualifying medical expenses to the ((~~department~~)) agency or its designee. The deadline for providing medical expense information is thirty days after the base period ends unless there is a good reason for delay.

(15) Once an individual meets the spenddown requirement and the certification begin date has been established, newly identified expenses cannot be considered toward that spenddown unless there is a good reason for the delay in submitting the expense or there was ((~~a department~~)) an error by the agency or its designee in determining the correct begin date.

(16) Good reasons for delay in providing medical expense information to the ((~~department~~)) agency or its designee include, but are not limited to:

(a) The individual did not receive a timely bill from his or her medical provider or insurance company;

(b) The individual has medical issues that prevents him or her from submitting proof in a timely manner; or

(c) The individual meets the criteria for needing a supplemental accommodation under chapter 388-472 WAC.

(17) The ((~~department~~)) agency or its designee is not responsible to pay for any expense or portion of an expense that has been used to meet an individual's spenddown liability. If an expense is potentially payable under the MN program, and only a portion of the medical expense has been assigned to meet spenddown, the medical provider may not bill the individual for more than the amount which was assigned to the remaining spenddown liability, or accept or retain any additional amount for the covered service from the individual. Any additional amount may be billed to the ((~~department~~)) agency or its designee. See WAC ((~~388-502-0160~~)) 182-502-0160, Billing a client.

(18) The ((~~department~~)) agency or its designee determines whether any payment is due to the medical provider on medical expenses that have been partially assigned to meet a spenddown liability, according to WAC ((~~388-502-0100~~)) 182-502-0100.

(19) If the medical expense assigned to spenddown was incurred outside of a period of MN eligibility, or if the expense is not the type that is covered by the ((~~department's~~)) agency's or its designee's medical assistance programs, the ((~~department~~)) agency or its designee is not responsible for any portion of the bill.

NEW SECTION

The following sections of the Washington Administrative Code is decodified as follows:

Old WAC Number	New WAC Number
388-519-0100	182-519-0100
388-519-0110	182-519-0110

WSR 12-20-013
PERMANENT RULES
SUPERINTENDENT OF PUBLIC INSTRUCTION

[Filed September 24, 2012, 9:55 a.m., effective October 25, 2012]

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

Purpose: WAC 392-343-019 Definition—Instructional space, amendment will implement legislative intent to

exclude colocated spaces on a "host" district inventory where more than one district jointly administers facilities such as skills centers or a new Delta STEM facility.

Citation of Existing Rules Affected by this Order: Amending WAC 392-343-019.

Statutory Authority for Adoption: RCW 28A.150.290.

Adopted under notice filed as WSR 12-16-075 on July 31, 2012.

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 0, Repealed 0.

Date Adopted: September 4, 2012.

Randy Dorn
Superintendent of
Public Instruction

AMENDATORY SECTION (Amending WSR 06-16-032, filed 7/25/06, effective 8/25/06)

WAC 392-343-019 Definition—Instructional space. As used in this chapter, the term "instructional space" means the gross amount of square footage calculated in accordance with the *American Institute of Architects, Document D101, The Architectural Area and Volume of Buildings*, latest edition, for a school facility utilized by a school district for the purpose of instructing students: Provided, That the following areas shall not be included in any calculation of instructional space:

(1) Exterior covered walkways, cantilevered or supported.

(2) Exterior porches including loading platforms.

(3) Areas located above instructional spaces which are either vacant or primarily housing mechanical and/or electrical equipment.

(4) Space used by central administrative personnel.

(5) Stadia and grandstands.

(6) Bus garages.

(7) Free-standing warehouse space specifically designed for that purpose.

(8) Portable facilities.

(9) Other square footage not otherwise available or related to direct instruction or instructional support of the education program in the district.

(10) The portion(s) of any space(s) constructed from grants made as a gift to a school district by a private entity or a public entity which:

(a) Is dedicated by the written terms of the grant to joint use by the school district for educational purposes and by the general public for community activities for the useful life of the space(s); and

(b) The school district board of directors has accepted the gift in accordance with the joint use terms of the grant: Provided, That this exception does not apply to space(s) jointly financed by two or more school districts.

(11) Facilities that are shared or collocated between multiple school districts pursuant to a written, lawful agreement, and that are jointly used by and/or benefit those school districts.

WSR 12-20-014

PERMANENT RULES

SUPERINTENDENT OF PUBLIC INSTRUCTION

[Filed September 24, 2012, 10:11 a.m., effective October 25, 2012]

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

Purpose: Changes to WAC 392-343-025 State funding assistance percentage—General and 392-343-045 Space allocations—Enrollment projections provision. Changes are necessary to respond to language in SSB 6002 for revised K-linear cohort projection methodology and new funding assistance percentages (matching) ratios affecting projects expected to qualify for school construction assistance program funding.

Citation of Existing Rules Affected by this Order: Amending WAC 392-343-025 and 392-343-045.

Statutory Authority for Adoption: RCW 28A.150.290.

Adopted under notice filed as WSR 12-16-076 on July 31, 2012.

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 0, Repealed 0.

Date Adopted: September 4, 2012.

Randy Dorn
Superintendent of
Public Instruction

AMENDATORY SECTION (Amending WSR 10-09-008, filed 4/8/10, effective 5/9/10)

WAC 392-343-025 State funding assistance percentage—General. (1) The state funding assistance percentage for which a school district is eligible, if otherwise qualified under prevailing statutory provisions and rules and regulations of the superintendent of public instruction, shall be determined in accordance with the state funding assistance percentage formula set forth in RCW 28A.525.166.

(2) In the event the state funding assistance percentage to any school district computed in accordance with RCW 28A.525.166(2) is less than twenty percent and such school district otherwise is eligible for state funding assistance under statutory provisions and the superintendent of public instruction regulations, the percentage for such district shall be twenty percent of the state allowable costs of the project.

(3) In addition to the computed state funding assistance percentage as stated above, a school district as provided in RCW 28A.525.166(3), shall be entitled to additional percentage points determined by the average percentage of growth for the past three years. One percent shall be added to the computed state funding assistance percentage for each average percent of student growth for the past three years, with a maximum addition of twenty percent. In no case shall the state funding assistance exceed one hundred percent of the maximum allowable cost of the project.

(4) For the purpose of calculating the state funding assistance percentage, the October student headcount (kindergarten through grade twelve students) shall be based on enrollment reported on the October P-223 form on or before the October due date. The headcount shall exclude alternative learning experience (ALE) students who reside outside the school district, as reported on the office of superintendent of public instruction (OSPI) school apportionment and financial services October alternative learning experience monthly enrollment report on or before the November due date.

In accordance with chapter 28A.525 RCW, as an alternative to the above headcount a school district may request the OSPI to increase the headcount by the difference in the number of ALE students, residing outside the district who physically attend the school for more than one hour per day, three days or more per week, compared to the number of ALE students, residing inside the district, that did not physically attend the school for more than one hour per day, three days or more per week.

Any school district requesting the above alternative calculation must do so on an OSPI school facilities and organization alternative calculation for alternative learning students form on or before December 31st of that year.

For purposes of this section (ALE) students shall be defined as in RCW 28A.150.325.

AMENDATORY SECTION (Amending WSR 10-09-008, filed 4/8/10, effective 5/9/10)

WAC 392-343-045 Space allocations—Enrollment projection provisions. In planning for construction of all school facilities, a school district shall estimate capacity needs on the basis of the following:

(1) A three or five-year cohort survival enrollment projection for growth districts, whichever is greater;

(2) A three or five-year cohort survival enrollment projection for a declining district, whichever is lesser;

(3) Actual enrollment of preschool students with developmental disabilities; and

(4) Supplemental information regarding district growth factors which may include but not be limited to the following types of information:

(a) County live birth rates;

(b) New housing starts;

(c) Utility/telephone hookups; and

(d) Economic/industrial expansion.

(5) For the purposes of this section, kindergarten students and students with developmental disabilities shall be counted as provided under WAC 392-343-035 and all other ((~~grade one through twelve students shall be counted as October count day full-time equivalent students as reported to the superintendent of public instruction: Provided, That a school district which has or has had an annual average full-time equivalent enrollment of over five hundred, and which applied for and received additional state basic education allocation moneys based upon an enrollment increase after the first of the month enrollment count, may use the average of the two highest monthly full-time equivalent enrollment counts during the school year~~)) October student headcount (kindergarten through grade twelve students) shall be based on enrollment reported on the October P-223 form reported on or before the October due date. The headcount shall exclude alternative learning experience (ALE) students who reside outside the school district, as reported on the office of superintendent of public instruction (OSPI) school apportionment and financial services October alternative learning experience monthly enrollment report on or before the November due date.

In accordance with chapter 28A.525 RCW, as an alternative to the above headcount a school district may request the OSPI to increase the headcount by the difference in the number of ALE students, residing outside the district who physically attend the school for more than one hour per day, three days or more per week, compared to the number of ALE students, residing inside the district, that did not physically attend the school for more than one hour per day, three days or more per week.

Any school district requesting the above alternative calculation must do so on an OSPI school facilities and organization alternative calculation for alternative learning students form on or before December 31st of that year. For purposes of this section (ALE) students shall be defined as in RCW 28A.150.325.

WSR 12-20-022
PERMANENT RULES
HEALTH CARE AUTHORITY
(Public Employees Benefits Board)

[Order 2012-01—Filed September 25, 2012, 11:06 a.m., effective November 1, 2012]

Effective Date of Rule: November 1, 2012.

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

1. Makes a technical amendment to domestic partner eligibility to comply with reciprocity requirements in state statute and clarify continuation coverage upon dissolution of a domestic partnership or same-sex marriage.

2. Amends employer group rules to implement ESSHB [E2SHB] 2319 authorizing the health benefit exchange to participate in PEBB benefits. Adds new rules detailing the employer group application process, evaluation criteria and participation requirements.

3. Amends special open enrollment rules to include certain residence changes, allow a change in enrollment consistent with an annual open enrollment change under another employer's plan and update the conditions that may create a continuity of care issue.

4. Adds a new rule to comply with federal and state laws regarding national medical support notices and court orders.

5. Makes technical amendments to retiree eligibility to remove an obsolete provision, provide clarity and correct technical errors.

6. Amends appeal rules to allow for indexing of significant administrative decisions, make a technical correction and allow for an extension to the deadline for the PEBB appeals committee to issue a written decision.

7. In addition to these specific changes, the health care authority conducted a full review of these chapters and made some changes for readability.

Citation of Existing Rules Affected by this Order: Repealing WAC 182-08-230 and 182-12-175; and amending chapters 182-08, 182-12 and 182-16 WAC.

Statutory Authority for Adoption: RCW 41.05.160.

Adopted under notice filed as WSR 12-16-074 on July 31, 2012.

Changes Other than Editing from Proposed to Adopted Version: WAC 182-08-015, 182-12-109, and 182-16-020 were all amended to remove the "higher education personnel board" from the definition of the "institutions of higher education." The higher education personnel board was abolished by the legislature and is no longer applicable for inclusion within the definition of "institutions of higher education."

WAC 182-12-171(3) all changes are withdrawn. The proposed changes require additional coordination with stakeholders.

Number of Sections Adopted in Order to Comply with Federal Statute: New 1, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 4, 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 5, Amended 1, Repealed 2.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 31, Repealed 2.

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: September 25, 2012.

Kevin M. Sullivan
Rules Coordinator

AMENDATORY SECTION (Amending Order 11-02, filed 10/26/11, effective 1/1/12)

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

((~~"Agency"~~)) "Authority" or "HCA" 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, the Washington health benefit exchange, tribal governments, school districts, and educational service districts participating in PEBB insurance coverage under contractual agreement as described in WAC ((~~182-08-230~~)) 182-08-245.

"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~~)) LTD 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 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 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 coverages or other employee benefits administered by the PEBB program within the ((~~HCA~~)) health care authority.

"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 medical coverage as required under WAC 182-12-128, or is on approved educational leave (((~~see WAC 182-12-128 and~~)) and obtains comprehensive group health plan coverage as allowed under WAC 182-12-136((~~,~~)).

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

WAC 182-08-120 Employer contribution. The employers' contribution must be used to provide insurance coverage for the basic life insurance benefit, the basic long-term disability insurance benefit, medical, and dental, and to establish a reserve for any remaining balance. There is no employer contribution available for any other insurance coverage for employees employed by state agencies.

AMENDATORY SECTION (Amending Order 11-02, filed 10/26/11, effective 1/1/12)

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

Premium payments. Public employees benefits board (PEBB) premiums 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 any month.

(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 health care authority (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 will be refunded using the following method:

(2) When a subscriber submits an enrollment change affecting subscriber or dependent eligibility, HCA may allow up to three months of accounting adjustments. HCA will refund to the individual or the employing agency any excess premium paid during the three month adjustment period, except as indicated in WAC 182-12-148(4).

(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. The written appeal must provide proof of the following:

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.

(4) If a federal government entity ((~~retroactively~~)) determines that an enrollee is retroactively 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 paid, and are due from the employing agency, subscriber or beneficiary to the HCA. Upon request, the HCA may develop a repayment plan designed to reduce hardship.

(6) HCA errors will be corrected by returning all excess premiums paid by the employing agency, subscriber, or beneficiary.

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

AMENDATORY SECTION (Amending Order 11-02, filed 10/26/11, effective 1/1/12)

WAC 182-08-197 When must newly eligible employees, or employees who regain eligibility for the employer contribution, select public employees benefits board (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 (sixty days for life insurance) after they become eligible for PEBB benefits under WAC 182-12-114. Newly eligible employees who do not return ((~~an~~)) enrollment forms to their employing agency indicating their medical ((~~and~~)), dental and LTD choice within thirty-one days and life insurance choice within sixty 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) Basic life insurance (unless the employing agency does not participate in this PEBB insurance coverage);

(d) Basic long-term disability insurance (unless the employing agency does not participate in this PEBB insurance coverage); and

(e) 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) Employees may apply for optional life and optional long-term disability 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 automatically 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 state agency no later than thirty-one days after they become eligible for PEBB benefits.

(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 state agency or PEBB designee no later than thirty-one days after becoming eligible for PEBB benefits.

(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~~)) regain eligibility 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~~)) regain eligibility for the employer contribution.

(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 11-02, filed 10/26/11, effective 1/1/12)

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 dependent((~~s~~)) or both. To make a health plan change, the subscriber must submit the appropriate enrollment forms (and a completed disenrollment form, if required) no later than sixty days after the event occurs. Employees submit the enrollment forms to their employing agency. All other subscribers submit the enrollment forms to the public employees benefits board (PEBB) program. Insurance coverage in the new health plan will begin the first day 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, insurance coverage will begin the month in which the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption occurs. Any one of the following events may create a special open enrollment:

(a) Subscriber acquires a new dependent due to:

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

(ii) 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) A child becoming eligible as a dependent with a disability;

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

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

(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 the subscriber must select a new health plan. If the subscriber does not select a new health plan, the PEBB program may change the subscriber's health plan as described in WAC 182-08-196;

(e) ((~~Subscriber receives~~)) A court order or national medical support ((~~order requiring the subscriber, the subscriber's spouse, or the subscriber's Washington state registered domestic partner~~)) notice (see also WAC 182-12-263) requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former registered domestic partner is not an eligible dependent);

(f) Subscriber or a subscriber's dependent becomes eligible for state premium assistance through medicaid or a state children's health insurance program (CHIP), or the subscriber or a subscriber's dependent loses eligibility for coverage under medicaid or CHIP;

(g) Subscriber or 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). The health care authority (HCA) may require evidence that the subscriber or subscriber's dependent is no longer eligible for an HSA;

(i) Subscriber or subscriber's dependent experiences a disruption of care that could function as a reduction in benefits for the subscriber or the subscriber's dependent((~~(s) due to~~)) for a specific condition or ongoing course of treatment. ((~~A~~)) The subscriber may not change their health plan election 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~~)) will consider but not limit its consideration to the following:

(i) Active cancer treatment such as chemotherapy or radiation therapy for up to ninety days or until medically stable; or

(ii) ((~~Recent~~)) Transplant (((~~(~~))within the last twelve months((~~)~~)); or

(iii) Scheduled surgery within the next sixty days (elective procedures within the next sixty days do not qualify for continuity of care); or

(iv) Recent major surgery still within the ((~~previous sixty days~~)) postoperative period of up to eight weeks; 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 11-02, filed 10/26/11, effective 1/1/12)

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.

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.

(a) **Premium payment plan.** 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 due to:

• Marriage;

• Registering a domestic partnership when the dependent is a tax dependent of the subscriber;

• 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's dependent no longer meets public employees benefits board (PEBB) eligibility criteria because:

• Employee has a change in marital status;

• Employee's domestic partnership with a domestic partner who is a tax dependent is dissolved or terminated;

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

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

• An eligible dependent dies.

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

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

(((~~(iv) Employee receives~~)) (v) Employee or an employee's dependent has a change in enrollment under another employer plan during its annual open enrollment that does not align with the PEBB program's annual open enrollment;

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

(vii) Employee's dependent has a change in residence from outside of the United States to within the United States;

(viii) A court order or national medical support ((~~order requiring~~)) notice (see also WAC 182-12-263) requires the employee or ((~~the employee's spouse~~)) any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former registered domestic partner is not an eligible dependent);

(((~~(v)~~))) (ix) Employee or employee's dependent becomes eligible for state premium assistance through medicaid or a state children's health insurance program (CHIP), or the employee or employee's dependent loses eligibility for coverage under medicaid or CHIP;

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

(((~~(vii)~~))) (xi) 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). The health care authority (HCA) may require evidence that the employee or employee's dependent is no longer eligible for an HSA;

(((~~(viii)~~))) (xii) Employee or employee's dependent experiences a disruption of care that could function as a reduction in benefits for the employee or the employee's dependent(((~~(s) due to~~))) for a specific condition or ongoing course of treatment. ((~~An~~)) The employee may not change their health plan election 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~~)) will consider but not limit its consideration to the following:

(A) Active cancer treatment such as chemotherapy or radiation therapy for up to ninety days or until medically stable; or

(B) ((~~Recent~~)) Transplant (((~~(~~))within the last twelve months((~~)~~)); or

(C) Scheduled surgery within the next sixty days (elective procedures within the next sixty days do not qualify for continuity of care); or

(D) Recent major surgery still within the ((~~previous sixty days~~)) postoperative period of up to eight weeks; 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) **Flexible spending account (FSA).** 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;

• Registering a domestic partnership if the domestic partner qualifies as a tax dependent of the subscriber;

• 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's dependent no longer meets PEBB eligibility criteria because:

• Employee has a change in marital status;

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

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

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

• An eligible dependent dies.

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

(((~~(iii) Employee receives~~)) (iv) A court order or national medical support ((~~order requiring~~)) notice requires the employee or ((~~the employee's spouse~~)) any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former registered domestic partner is not an eligible dependent);

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

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

(c) **Dependent care assistance program (DCAP).** 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;

• Registering a domestic partnership if the domestic partner qualifies as a tax dependent of the subscriber;

• 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 or an employee's dependent has a change in enrollment under another employer plan during its annual open enrollment that does not align with the PEBB program's annual open enrollment;

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

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

(((~~(v)~~)) (vi) 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.

NEW SECTION

WAC 182-08-235 Employer group application process. This section applies to employer groups as defined in WAC 182-08-015. An employer group may apply to obtain insurance coverage through a contract with the health care authority (HCA). The authority will approve or deny the application through the evaluation criteria described in WAC 182-08-240. To apply, the employer group must submit the documents and information described in this rule to the public employees benefits board (PEBB) program at least sixty days before the requested coverage effective date.

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

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

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

(c) Employer tax ID number (TIN); and

(d) A statement of whether the employer group is requesting only medical insurance or medical, dental, life and LTD insurance.

(2) A resolution from the employer group's governing body authorizing the purchase of PEBB benefits.

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

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

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

(b) Age;

(c) Gender;

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

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

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

(5) If the application is for a subset of the employer group's employees (e.g., bargaining unit), the employer group must provide a member level census file of all employees eligible under their current health plan who are not included on the member level census file in subsection (4) of this section. The file must include the same demographic data by member.

(6) In addition to the requirements of subsections (1) through (5) of this section, additional information is required based upon the total number of employees that the employer group employs who are eligible under their current health plan:

(a) Employer groups with fewer than eleven eligible employees must provide proof of current coverage or proof of prior coverage within the last twelve months.

(b) Employer groups with greater than three hundred but less than twenty-five hundred eligible employees must provide the following:

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

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

(c) Employer groups with greater than twenty-five hundred eligible employees must submit to an actuarial evalua-

tion of the group. The employer group must pay for the cost of the evaluation. This cost is nonrefundable. An employer group that is approved will not have to pay for an additional actuarial evaluation if it applies to add another bargaining unit within two years of the evaluation. Employer groups of this size must provide the following:

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

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

(iii) Executive summary of benefits;

(iv) Summary of benefits and certificate of coverage; and

(v) Summary of historical plan costs.

(d) The following definitions apply for purposes of this section:

(i) "Large claim" is defined as a member that received more than twenty-five thousand dollars in allowed cost for services in a quarter; and

(ii) An "ongoing large claim" is a claim where the patient is expected to need ongoing case management into the next quarter for which the expected allowed cost is greater than twenty-five thousand dollars in the quarter.

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

NEW SECTION

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

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

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

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

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

(2) Retirees and dependents included in the transfer unit are subject to the enrollment and eligibility rules outlined in chapters 182-08, 182-12 and 182-16 WAC.

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

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

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

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

NEW SECTION

WAC 182-08-240 How will the health care authority (HCA) decide to approve or deny an employer group application? Employer group applications for participation in insurance coverage provided through the public employees benefits board (PEBB) program are approved or denied by the health care authority (HCA) based upon the information and documents submitted by the employer group and the employer group evaluation (EGE) criteria described in this rule. The authority may automatically deny an employer group application if the employer group fails to provide the required information and documents described in WAC 182-08-235.

(1) Employer groups are evaluated as a single unit. To support this requirement the employer group must provide census data for all employees eligible to participate under the employer group's current health plan.

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

(3) The authority will determine which of the criteria in (a) though (d) of this subsection is used to evaluate the employer group based upon the total number of eligible employees in the single unit.

(a) **Micro groups** (a single unit of one to ten employees) must meet the following criteria in order to pass the EGE evaluation:

(i) Provide proof of current coverage or proof of prior coverage within the last twelve months; and

(ii) The member level census file demographic data must indicate a relative underwriting factor that is equal to or better than the relative underwriting factor for the nonmedicare PEBB risk pool as determined by the authority.

(b) **Small and medium groups** (a single unit of eleven to three hundred employees) must meet the following criterion in order to pass the EGE evaluation: The member level census file demographic data must indicate a relative underwriting factor that is equal to or better than the relative underwriting factor for the nonmedicare PEBB risk pool as determined by the authority.

(c) **Large groups** (a single unit of three hundred one to two thousand five hundred employees) must meet the following criteria in order to pass the EGE evaluation:

(i) The member level census file demographic data must indicate a relative underwriting factor that is equal to or better than the relative underwriting factor for the nonmedicare PEBB risk pool as determined by the authority;

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

• The frequency of large claims must be less than or equal to the historical benchmark frequency for the PEBB nonmedicare population; and

• The ongoing large claims management report must demonstrate that the frequency of ongoing large claims is less than or equal to the recurring benchmark frequency for the PEBB nonmedicare population.

(d) **Jumbo groups** (a single unit of two thousand five hundred one or more employees) must meet the following criteria in order to pass the actuarial evaluation:

(i) The member level census file demographic data must indicate a relative underwriting factor that is equal to or better than the relative underwriting factor for the nonmedicare PEBB risk pool as determined by the authority;

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

• The frequency of large claims must be less than or equal to the PEBB historical benchmark frequency for the PEBB nonmedicare population;

• The ongoing large claims management report must demonstrate that the frequency of ongoing large claims is less than or equal to the recurring benchmark frequency for the PEBB nonmedicare population;

(iii) Provide an executive summary of benefits;

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

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

(vi) The evaluation of criteria in (d)(iii), (iv) and (v) of this subsection must indicate that the historical cost of benefits for the employer group is equal to or less than the historical cost of the PEBB nonmedicare population for a comparable plan design.

(4) The group evaluation for a jumbo group is valid for two years after approval by the authority. If an employer group applies to add additional bargaining units after two years the group must be reevaluated.

(5) An entity whose employer group application is denied may appeal the authority's decision to the PEBB appeals committee through the process described in WAC 182-16-038.

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

NEW SECTION

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

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

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

(b) Sign a contract with the authority;

(c) Determine employee and dependent eligibility and terms of enrollment for PEBB insurance coverage in accordance with the criteria outlined in the employer group's contract with the authority;

(d) Determine eligibility in order to ensure the PEBB program's continued status as a governmental plan under Section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA) as amended. This means that only employees whose services are substantially all in the performance of essential governmental functions but not in the performance of commercial activities, whether or not those activities qualify as essential governmental functions may be considered eligible by the employer group; and

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

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

(a) The premium rate structure for K-12 school districts and educational service districts will be a composite rate equal to the rate charged to state agencies plus an amount equal to the employee premium based on health plan choice and family enrollment.

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

(b) The premium rate structure for employer groups other than districts described in (a) of this subsection will be a tiered rate based on health plan choice and family enrollment.

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

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

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

(5) Upon approval to purchase insurance through a contract with the authority, the employer group must provide a list of employees and dependents that are enrolled in COBRA benefits and the remaining number of months available to them based on their qualifying event. These employees and dependents may enroll in PEBB medical and dental as

COBRA enrollees for the remainder of the months available to them based on their qualifying event.

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

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

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 182-08-230	Participation in PEBB benefits by employer groups, including K-12 school districts and educational service districts.

AMENDATORY SECTION (Amending Order 11-02, filed 10/26/11, effective 1/1/12)

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

((~~"Agency" means the health care authority.~~)) "Authority" or "HCA" 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~~)) authority.

"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, the Washington health benefit exchange, tribal governments, school districts, and educational service districts participating in PEBB insurance coverage under ((~~contract~~)) contractual agreement as described in WAC ((~~182-08-230~~)) 182-08-245.

"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~~)) LTD 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 previ-

ously 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 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 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 coverages or other employee benefits administered by the PEBB program within ((~~HCA~~)) the health care authority.

"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 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 medical coverage as required under WAC 182-12-128, or is on approved educational leave (((~~see WAC 182-12-128 and 182-12-136~~))) and obtains comprehensive group health plan coverage as allowed under WAC 182-12-136.

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

WAC 182-12-111 Eligible entities and individuals. The following entities and individuals shall be eligible for public employees benefits board (PEBB) insurance coverage subject to the terms and conditions set forth below:

(1) State agencies. State agencies, as defined in WAC 182-12-109, are required to participate in all PEBB benefits. Insurance and health care contributions for ferry employees shall be governed by RCW 47.64.270.

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

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

(2) Employer groups((~~:~~)). Employer groups may apply to participate in PEBB insurance coverage((~~s~~)) for groups of employees described in subsection (a) of this section at the option of each employer group ((~~provided all of the following requirements are met~~)):

(a) All eligible employees of the entity must transfer ((~~to PEBB insurance coverage~~)) as a unit with the following exceptions:

• Bargaining units may elect to participate separately from the whole group; ((~~and~~))

• Nonrepresented employees may elect to participate separately from the whole group provided all nonrepresented employees join as a group((~~.~~

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

~~(c)~~)); and

• Members of the employer group's governing authority may participate as defined in the employer group's governing statutes and RCW 41.04.205.

(b) The employer group must ((~~submit to the HCA an application when it first applies, the contents of which will be specified by HCA. The application for employer groups, with the exception of school districts and educational service districts, is subject to review and approval by the HCA, and the decision to approve or deny the application shall be provided to the applying employer group by the HCA.~~

~~(d) Each employer group purchasing PEBB insurance coverage must sign a contract with the HCA. The employer group must abide by the eligibility, enrollment, and payment terms specified in the contract. Any subsequent changes to the contract must be submitted for approval in advance of the change.~~

~~(e) The employer group must maintain its PEBB insurance coverage participation at least one full year, and may end participation only at the end of a plan year.~~

~~(f) The employer group must give the HCA written notice of its intent to end PEBB insurance coverage participation at least sixty days before the effective date of termination. With the exception of retired and disabled employees of school districts or educational service districts, if the employer group ends PEBB insurance coverage, retired and disabled employees who began participating after September 15, 1991, are not eligible for PEBB insurance coverage beyond the mandatory extension requirements specified in WAC 182-12-146.~~

~~(g) Employees eligible for PEBB participation include only those employees whose services are substantially all in the performance of essential governmental functions but not in the performance of commercial activities, whether or not those activities qualify as essential governmental functions. Employer groups shall determine eligibility in order to ensure PEBB's continued status as a governmental plan under Section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA) as amended.~~)) apply through the process described in WAC 182-08-235. K-12 school district and educational service district applications do not have to include the census information required in WAC 182-08-235 (4) or (5). Employer group applications are subject to review and approval by the health care authority (HCA). With the exception of K-12 school districts and educational service districts, the authority will approve or deny an employer group's application based on the employer group eligibility criteria described in WAC 182-08-240.

(c) Employer groups participate through a contract with the authority as described in WAC 182-08-245.

(3) School districts and educational service districts((~~:~~)). In addition to subsection (2) of this section, the following applies to school districts and educational service districts:

(a) The HCA will collect an amount equal to the composite rate charged to state agencies plus an amount equal to the employee premium by health plan and family size as would be charged to state employees for each participating school district or educational service district.

(b) The HCA may collect these amounts in accordance with the district fiscal year, as described in RCW 28A.505.-030.

(4) The Washington health benefit exchange. In addition to subsection (2) of this section, the following provisions apply:

(a) The Washington health benefit exchange is subject to the same rules as an employing agency in chapters 182-08, 182-12 and 182-16 WAC.

(b) An employee of the Washington health benefit exchange is subject to the same rules as an employee of an employing agency in chapters 182-08, 182-12 and 182-16 WAC.

(5) Eligible nonemployees.

(a) Blind vendors means a "licensee" as defined in RCW 74.18.200: Vendors actively operating a business enterprise program facility in the state of Washington and deemed eligible by the department of services for the blind may voluntarily participate in PEBB insurance coverage.

(((~~(a)~~))) (i) Vendors that do not enroll when first eligible may enroll only during the annual open enrollment period offered by the HCA or the first day of the month following loss of other insurance coverage.

(((~~(b)~~))) (ii) Department of services for the blind will notify eligible vendors of their eligibility in advance of the date that they are eligible to apply for enrollment in PEBB insurance coverage.

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

(((~~(5) Eligible nonemployees:~~

~~(a)~~))) (b) Dislocated forest products workers enrolled in the employment and career orientation program pursuant to chapter 50.70 RCW shall be eligible for PEBB health plans while enrolled in that program.

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

(6) Individuals that are not eligible include:

(a) Adult family home providers as defined in RCW 70.128.010;

(b) Unpaid volunteers;

(c) Patients of state hospitals;

(d) Inmates;

(e) Employees of the Washington state convention and trade center as provided in RCW 41.05.110;

(f) Students of institutions of higher education as determined by their institutions; and

(g) Any others not expressly defined as employees under RCW 41.05.011.

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

WAC 182-12-113 What are the obligations of a state agency in the application of employee eligibility? (1) All state agencies must carry out all actions, policies, and guidance issued by the public employees benefits board (PEBB) program necessary for the operation of benefit plans, education of employees, claims administration, and appeals process including ((~~that~~)) those described in chapters 182-08, 182-12, and 182-16 WAC. State agencies must:

(a) Use the methods provided by the PEBB program to determine eligibility and enrollment in benefits, unless otherwise approved in writing;

(b) Provide eligibility determination reports with content and in a format designed and communicated by the PEBB program or otherwise as approved in writing by the PEBB program; and

(c) Carry out corrective action and pay any penalties imposed by the authority and established by the board when

the state agency's eligibility determinations fail to comply with the criteria under these rules.

(2) All state agencies must determine employee eligibility for PEBB benefits and employer contribution according to the criteria in WAC 182-12-114 and 182-12-131. State agencies must:

(a) Notify newly hired employees of PEBB rules and guidance for eligibility and appeal rights;

(b) Provide written notice to faculty who are potentially eligible for benefits and employer contribution of their potential eligibility under WAC 182-12-114(3) and 182-12-131;

(c) Inform an employee in writing whether or not he or she is eligible for benefits upon employment. The written communication must include a description of any hours that are excluded in determining eligibility and information about the employee's right to appeal eligibility and enrollment decisions;

(d) Routinely monitor all employees' eligible work hours to establish eligibility and maintain the employer contribution toward insurance coverage;

(e) Make eligibility determinations based on the criteria of the eligibility category that most closely describes the employee's work circumstances per the PEBB program's direction;

(f) Identify when a previously ineligible employee becomes eligible or a previously eligible employee loses eligibility; and

(g) Inform an employee in writing whether or not he or she is eligible for benefits and the employer contribution whenever there is a change in work patterns such that the employee's eligibility status changes. At the same time, state agencies must inform employees of the right to appeal eligibility and enrollment decisions.

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

WAC 182-12-123 Dual enrollment is prohibited. Public employees benefits board (PEBB) health plan coverage is limited to a single enrollment per individual.

(1) Effective January 1, 2002, individuals who have more than one source of eligibility for enrollment in PEBB health plan coverage (called "dual eligibility") are limited to one enrollment.

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

(3) Children eligible for medical and dental under two subscribers may be enrolled as a dependent under the health plan of only one subscriber.

(4) An employee who is eligible for the employer contribution to PEBB benefits due to employment in more than one PEBB-participating employing agency ((~~may~~)) must choose to enroll under only ((~~under~~)) one employing agency. ((~~The employee must choose to enroll in PEBB benefits under only one employing agency.~~))

Exception: Faculty who stack to establish or maintain eligibility under WAC 182-12-114(3) with two or more state institutions of higher education will be enrolled under the employing agency responsible to pay the employer contribution according to WAC 182-08-200(2).

AMENDATORY SECTION (Amending Order 11-02, filed 10/26/11, effective 1/1/12)

WAC 182-12-128 May an employee waive health plan enrollment? Employees must enroll in dental, basic life and basic long-term disability insurance (unless the employing agency does not participate in these public employees benefits board (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 a special open enrollment event((~~s~~)) occurs. The change in enrollment must be allowable under the Internal Revenue Code (IRC) and correspond to the event that creates the special open enrollment for either the employee, the employee's dependent, or both. Any one of the following events may create a special open enrollment:

(a) Employee acquires a new dependent due to:

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

(ii) 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) A child becoming eligible as a dependent with a disability;

(b) 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);

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

(d) Employee ((~~receives~~)) or an employee's dependent has a change in enrollment under another employer plan during its annual open enrollment that does not align with the PEBB program's annual open enrollment;

(e) Employee's dependent has a change in residence from outside of the United States to within the United States;

(f) A court order or national medical support ((~~order requiring~~)) notice (see also WAC 182-12-263) requires the employee((~~, spouse, or Washington state registered domestic partner~~)) or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former registered domestic partner is not an eligible dependent);

(((~~e~~))) (g) Employee or dependent becomes eligible for state premium assistance through medicaid or a state children's health insurance program (CHIP), or the employee or dependent loses eligibility 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 medical will begin the first day 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, enrollment in medical will begin the first of the month in which the event occurs.

AMENDATORY SECTION (Amending Order 11-02, filed 10/26/11, effective 1/1/12)

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 public employees benefits board (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 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 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 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 health care authority (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 10-02, filed 10/6/10, effective 1/1/11)

WAC 182-12-133 What options for continuation coverage are available to employees on certain types of leave or whose work ends due to a layoff? Employees who have established eligibility for PEBB benefits under WAC 182-12-114 have options for providing continuation coverage for themselves and their dependents by self-paying the full premium set by the HCA during temporary or permanent loss of the employer contribution toward insurance coverage.

(1) When an employee is no longer eligible for the employer contribution toward PEBB benefits due to an event described in (a) through (f) of this subsection, insurance coverage may be continued by self-paying the full premium set by the HCA, with no contribution from the employer. Employees may self-pay for a maximum of twenty-nine months. The employee must pay the premium amounts for insurance coverage as premiums become due. If premiums are more than sixty days delinquent, insurance coverage will end as of the last day of the month for which a full premium was paid. Employees may continue any combination of medical, dental and life insurance; however, only employees on approved educational leave or called in to active duty in the uniformed services as defined under the Uniformed Services Employment and Reemployment Rights Act (USERRA) may continue either basic or both basic and optional long-term

disability insurance. Employees in the following circumstances qualify to continue coverage under this subsection:

(a) The employee is on authorized leave without pay;

(b) The employee is on approved educational leave;

(c) The employee is receiving time-loss benefits under workers' compensation;

(d) The employee is called to active duty in the uniformed services as defined under the Uniformed Services Employment and Reemployment Rights Act (USERRA);

(e) The employee's employment ends due to a layoff as defined in WAC 182-12-109; or

(f) The employee is applying for disability retirement.

(2) The number of months that an employee self-pays the premium while eligible under subsection (1) of this section will count toward the total months of continuation coverage allowed under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). An employee who is no longer eligible for continuation coverage as described in subsection (1) of this section but who has not used the maximum number of months allowed under COBRA may continue medical and dental for the remaining difference in months by self-paying the premium under COBRA as described in WAC 182-12-146.

AMENDATORY SECTION (Amending Order 11-02, filed 10/26/11, effective 1/1/12)

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 optional 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 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 09-02, filed 11/17/09, effective 1/1/10)

WAC 182-12-146 What options for continuation coverage are available to subscribers and dependents who become eligible under COBRA? An enrollee can continue health plan coverage by self-paying the full premium set by the health care authority (HCA) in accordance with Consolidated Omnibus Budget Reconciliation Act (COBRA) regulations in the following circumstances:

(1) An employee((~~s and eligible~~)) or an employee's dependent((~~s~~)) who ((~~become ineligible~~)) loses eligibility for the employer contribution toward public employees benefits board (PEBB) insurance coverage and who ((~~qualify~~)) qualifies for continuation coverage under ((~~the Consolidated Omnibus Budget Reconciliation Act (~~))COBRA((~~)~~)) may continue ((~~their~~)) medical ((~~and~~)), dental ((~~by self-paying the full premium set by the HCA in accordance with COBRA statutes and regulations~~)), or both.

(2) An employee or an employee's dependent who ((~~is no longer eligible~~)) loses eligibility for continuation coverage ((~~as described~~)) in WAC 182-12-133, 182-12-138, 182-12-141, 182-12-142, or 182-12-148((~~,~~)) but who has not used the maximum number of months allowed under COBRA((~~,~~)) may continue medical ((~~and~~)), dental, or both for the remaining difference in months ((~~by self-paying the premium under COBRA as described in subsection (1) of this section~~)).

(3) A retired ((~~and~~)) or disabled employee((~~s~~)) who ((~~become ineligible~~)) loses eligibility for PEBB retiree insurance because an employer group, with the exception of school districts and educational service districts, ceases participation in PEBB insurance coverage may continue ((~~their~~)) medical ((~~and~~)), dental ((~~by self-paying the full premium set by the HCA, in accordance with COBRA statutes and regulations~~)), or both.

(4) A retired or disabled employee, or a dependent of a retired or disabled employee, who is no longer eligible to continue coverage under WAC 182-12-171 may continue medical, dental, or both.

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

WAC 182-12-148 What options for continuation coverage are available to employees during their appeal of dismissal? (1) Employees awaiting hearing of a dismissal action before any of the following may continue their insurance coverage by self-paying the full premium set by the health care authority (HCA), with no contribution from the employer, on the same terms as an employee who is granted leave as described in WAC 182-12-133:

(a) The personnel resources board;

(b) An arbitrator; or

(c) A grievance or appeals committee established under a collective bargaining agreement for union represented employees.

(2) If the dismissal is upheld, all insurance coverage will end at the end of the month in which the decision is entered, or the date to which premiums have been paid, whichever is ((~~earlier~~)) later, with the exception described in subsection (3) of this section.

(3) If the dismissal is upheld and the employee is eligible under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), the employee may continue medical and dental for the remaining months available under COBRA. See WAC 182-12-146 for information on COBRA. The number of months the employee self-paid premiums during the appeal will count toward the total number of months allowed under COBRA.

(4) If the board, arbitrator, committee, or court sustains the employee in the appeal and directs reinstatement of employer paid insurance coverage retroactively, the employing agency must forward to HCA the full employer contribution for the period directed by the board, arbitrator, commit-

tee, or court and collect from the employee the employee's share of premiums due, if any.

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

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

AMENDATORY SECTION (Amending Order 11-02, filed 10/26/11, effective 1/1/12)

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 public employees benefits board (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.

Note: If an enrollee who is entitled to medicare does not meet this procedural requirement, the enrollee is no longer eligible for enrollment in PEBB retiree insurance. The enrollee may continue PEBB health plan enrollment under COBRA (see WAC 182-12-146).

(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 requirement((s)) 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 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)) the department of retirement systems ((because their monthly retirement plan payment is below the minimum payment that can be paid)) offered the employee the choice between a lump sum actuarially equivalent payment and the ongoing monthly payment, as allowed by the plan.

• Employees who are members of a Plan 3 retirement, also called separated employees (defined in RCW 41.05.011 (((15))) (20)), are eligible if they meet their Plan 3 retirement plan's 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 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 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 the department of retirement systems ((~~requires this because their monthly retirement plan payment is below the minimum payment that can be paid~~)) offered the employee the choice between a lump sum actuarially equivalent payment and the ongoing monthly payment, as allowed by the plan or ((~~they~~)) the employee enrolled before 1995.

Employees who are members of a Plan 3 retirement, also called separated employees (defined in RCW 41.05.011((~~(15)~~)) (20)), are eligible if they meet their Plan 3 retirement plan's eligibility criteria when employer paid or COBRA coverage ends.

((~~Employees who separate from employment due to total and permanent disability, 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;
- 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 11-02, filed 10/26/11, effective 1/1/12)

WAC 182-12-205 May a retiree defer enrollment in a public employees benefits board (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~~)) coverage begins January 1st ((~~after the annual open enrollment.~~)) of the following year; or

(ii) No later than sixty days after their comprehensive employer-sponsored medical ends. ((~~(~~))PEBB health plan ((~~will~~)) coverage begins 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~~)) coverage begins January 1st ((~~after the annual open enrollment.~~)) of the following year; or

(ii) No later than sixty days after the federal retiree medical ends. (((~~Enrollment in the~~)) PEBB health plan ((~~will~~)) coverage begins 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 a medicaid program that provides creditable coverage as defined in this chapter 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~~)) coverage begins January 1st ((~~after the annual open enrollment.~~))) of the following year; or

(ii) No later than sixty days after their medicaid coverage ends (((~~Enrollment in the~~)). PEBB health plan ((~~will~~)) coverage begins 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 11-02, filed 10/26/11, effective 1/1/12)

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 public employees benefits board (PEBB) program within health care authority (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(1); 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)~~))) (6) 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~~)) later 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 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 11-02, filed 10/26/11, effective 1/1/12)

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 public employees benefits board (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. 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 must notify the PEBB program, in writing, no later than sixty days after the date his or her dependent is no longer eligible under this section. See WAC 182-12-262 (2)(a) 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) Domestic partner.

(a) Effective January 1, 2010, ((~~Washington~~)) a state registered domestic partner((~~s~~)), as defined in RCW 26.60.020 (1).

(b) A domestic partner who was qualified under PEBB eligibility criteria as a domestic partner before January 1, 2010, and was continuously enrolled under the subscriber in a PEBB health plan or life insurance.

(c) 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~~)) a disability, mental illness, or intellectual or other developmental ((~~disabilities~~)) disability 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 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 11-02, filed 10/26/11, effective 1/1/12)

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 public employees benefits board (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.

(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 during a special open enrollment as described in subsection (3) 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** within sixty days of the date the dependent no longer~~)) **A dependent's eligibility for enrollment in health plan coverage ends the last day of the month the dependent** 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 subsections (3) and (4)(f) of this section.

(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 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 later of the event date or the date the form is received.

• 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 events may create a special open enrollment:

(a) Subscriber acquires a new dependent due to:

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

(ii) 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) A child becoming eligible as a dependent with a disability;

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

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

(d) Subscriber ((~~receives~~)) or subscriber's dependent has a change in enrollment under another employer plan during its annual open enrollment that does not align with the PEBB program's annual open enrollment;

(e) Subscriber's dependent has a change in residence from outside of the United States to within the United States;

(f) A court order or national medical support ((~~order requiring~~)) notice (see also WAC 182-12-263) requires the subscriber((~~, the subscriber's spouse, or the subscriber's Washington state registered domestic partner~~)) or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former registered domestic partner is not an eligible dependent);

((~~(e)~~)) (g) Subscriber or a subscriber's dependent becomes eligible for state premium assistance through medicaid or a state children's health insurance program (CHIP), or the subscriber or dependent loses eligibility 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 subscriber must provide 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~~)) a disability, 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.

NEW SECTION

WAC 182-12-263 National Medical Support Notice (NMSN) or court order. When a National Medical Support Notice (NMSN) or court order requires a subscriber to provide health plan coverage for a dependent child the following provisions apply:

(1) The subscriber may enroll the dependent child and request changes to his or her health plan coverage as described under subsection (3) of this section. Employees submit the appropriate forms to their employing agency. All other subscribers submit the appropriate forms to the PEBB program.

(2) If the subscriber fails to request enrollment or health plan coverage changes as directed by the NMSN or court order, the employing agency or the PEBB program may make enrollment or health plan coverage changes according to subsection (3) of this section upon request of:

(a) The child's other parent; or

(b) Child support enforcement program.

(3) Changes to health plan coverage or enrollment are allowed as directed by the NMSN or court order:

(a) The dependent will be enrolled under the subscriber's health plan coverage as directed by the NMSN or court order;

(b) An employee who has waived medical under WAC 182-12-128 will be enrolled in medical coverage as directed by the NMSN or court order, in order to enroll the dependent;

(c) The subscriber's selected health plan will be changed if directed by the NMSN or court order;

(d) If the dependent is already enrolled under another PEBB subscriber, the dependent will be removed from the other health plan coverage and enrolled as directed by the NMSN or court order.

(4) Health plan enrollment will begin the first day of the month following receipt of the NMSN or court order. If the NMSN or court order requires a change from the subscriber's selected health plan, the change will begin the first day of the month following receipt of the NMSN or court order.

AMENDATORY SECTION (Amending Order 11-02, filed 10/26/11, effective 1/1/12)

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~~)) as a survivor under public employees benefits board (PEBB) retiree insurance coverage ((~~as a surviving dependent~~)). An eligible ((~~surviving spouse, Washington state registered domestic partner, or child must~~)) survivor must submit the appropriate forms to 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~~)) An employee's spouse, state registered domestic partner or child who ((~~lose~~)) loses eligibility due to the death of an eligible employee may ((~~continue enrollment in a PEBB health plan~~)) enroll or defer 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) The employee's children may continue health plan enrollment until they lose eligibility under ((~~PEBB rules~~)) WAC 182-12-260.

(((~~(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.~~))

Note: If a spouse, state registered domestic partner, or child of an eligible employee is not eligible for a monthly retirement benefit, the dependent is not eligible to enroll as a survivor under retiree insurance coverage. However, the dependent may continue health plan enrollment as described in WAC 182-12-146.

(2) ((~~Dependents~~)) A retiree's spouse, state registered domestic partner or child who ((~~lose~~)) loses eligibility due to the death of ((~~a PEBB~~)) an eligible retiree may ((~~continue health plan~~)) enroll or defer enrollment as a survivor under retiree insurance.

(a) The retiree's spouse or ((~~Washington~~)) state registered domestic partner may continue health plan enrollment until death.

(b) The retiree's children may continue health plan enrollment until they lose eligibility under ((~~PEBB rules~~)) WAC 182-12-260.

(c) ((~~Dependents, who are~~)) If a spouse, state registered domestic partner or child of an eligible retiree is not enrolled in a PEBB health plan at the time of the retiree's death, ((~~are~~)) the dependent is eligible to enroll or defer enrollment in a PEBB health plan as a survivor under retiree insurance. ((~~A~~)) The dependent must submit the appropriate form(s) 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~~)) the dependent was not enrolled in a PEBB ((~~was deferred~~)) medical plan prior to the retiree's death.

(3) ((~~Surviving~~)) The spouse((~~s~~)), ((~~Washington~~)) state registered domestic partner((~~s~~)), or ((~~eligible children~~)) child of a deceased school district or educational service district employee ((~~who were not enrolled~~)) is eligible to enroll or defer enrollment in a health plan as a survivor under PEBB retiree insurance coverage at the time of the ((~~subscriber's~~)) employee's death ((~~may enroll in a PEBB health plan~~)) provided the employee died on or after October 1, 1993((~~, and~~)). The dependent((~~(s)~~)) must immediately ((~~began~~)) begin receiving a retirement benefit allowance under chapter 41.32, 41.35 or 41.40 RCW and submit the appropriate form to enroll or defer enrollment in a PEBB medical plan no later than sixty days after the date of the employee's death.

(a) The employee's spouse or ((~~Washington~~)) state registered domestic partner may continue health plan enrollment until death.

(b) The employee's children may continue health plan enrollment until they lose eligibility under ((~~PEBB rules~~)) WAC 182-12-260.

(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 a premium payment received by the authority is 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~~)) the dependent's enrollment ended due to the death of the employee or retiree, the PEBB program will reinstate ((~~health plan~~)) the survivor's enrollment without a gap subject to payment of premium.

(5) 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 182-12-270 What options for continuation coverage are available to dependents who cease to meet the eligibility criteria in WAC 182-12-260? If eligible, dependents may continue health plan enrollment under one of the continuation coverage options in subsection (1) or (2) of this section by self-paying the full premiums set by the health care authority (HCA), with no contribution from the employer, following their loss of eligibility under the subscriber's health plan coverage. The public employees benefits board (PEBB) program must receive the appropriate forms as outlined in the *PEBB Initial Notice of COBRA and Continuation Coverage Rights*. Options for continuing health plan enrollment are based on the reason that eligibility was lost.

(1) Spouses, ((~~Washington~~)) state registered domestic partners, or children who lose eligibility due to the death of an employee or retiree may be eligible to continue health plan enrollment under provisions of WAC 182-12-250 or 182-12-265; or

(2) Dependents who lose eligibility because they no longer meet the eligibility criteria in WAC 182-12-260 are eligible to continue health plan enrollment under provisions of the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). See WAC 182-12-146 for more information on COBRA.

Exception: A ((~~qualified domestic partner~~)) dependent who loses eligibility because ((~~he or she no longer meets the eligibility criteria in WAC 182-12-260~~)) a domestic partnership or same-sex marriage is dissolved may continue health plan enrollment under an extension of PEBB insurance coverage for a maximum of thirty-six months.

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

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 182-12-175	May a local government entity or tribal government entity applying for participation in PEBB insurance coverage include their retirees in the transfer unit?

AMENDATORY SECTION (Amending Order 08-03, filed 10/1/08, effective 1/1/09)

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

AMENDATORY SECTION (Amending Order 11-02, filed 10/26/11, effective 1/1/12)

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

((~~"Agency"~~)) "Authority" or "HCA" 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, the Washington health benefit exchange, tribal governments, school districts, and educational service districts participating in PEBB insurance coverage under contractual agreement as described in WAC ((~~182-08-230~~)) 182-08-245.

"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.

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

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

"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.

"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 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 coverages or other employee benefits administered by the PEBB program within the ((~~HCA~~)) health care authority.

"PEBB program" means the program within the HCA which administers insurance and other benefits for eligible employees (as defined in WAC 182-12-114), eligible retired and disabled employees ((~~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.

"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.

AMENDATORY SECTION (Amending Order 11-02, filed 10/26/11, effective 1/1/12)

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

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

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

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

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

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

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

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

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

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

WAC 182-16-030 How can an employee or an employee's dependent appeal a decision made by a state agency about eligibility or enrollment in benefits? (1) An eligibility or enrollment decision made by an employing state agency may be appealed by submitting a written request for review to the employing state agency. The employing state agency must receive the request for review within thirty days of the date of the initial denial notice. The contents of the request for review are to be provided in accordance with WAC 182-16-040.

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

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

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

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

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

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

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

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

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

AMENDATORY SECTION (Amending Order 11-02, filed 10/26/11, effective 1/1/12)

WAC 182-16-032 How can a decision made by the public employees benefits board (PEBB) program regarding eligibility, enrollment, or premium payments; or a decision made by an employer group regarding life insurance or ((~~long-term disability~~)) LTD insurance be appealed? (1) An eligibility, enrollment, or premium payment decision made by the public employees benefits board (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~~)) LTD 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.

(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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

AMENDATORY SECTION (Amending Order 08-03, filed 10/1/08, effective 1/1/09)

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

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

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

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

AMENDATORY SECTION (Amending Order 11-02, filed 10/26/11, effective 1/1/12)

WAC 182-16-050 How can an enrollee or entity request a hearing if aggrieved by a decision made by the public employees benefits board (PEBB) appeals committee? (1) Any party aggrieved by a decision of the public employees benefits board (PEBB) appeals committee, may request an administrative hearing.

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

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

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

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

(6) Within ninety days after the hearing record is closed, the director or his or her designee shall render a decision which shall be the final decision of the ((~~agency~~)) authority. A copy of that decision shall be mailed to all parties.

NEW SECTION

WAC 182-16-060 Index of significant decisions. (1) A final decision may be relied upon, used, or cited as precedent by a party if the final order has been indexed in the authority's index of significant decisions in accordance with RCW 34.05.473 (1)(b).

(2) The index of significant decisions is available to the public at the health care authority (HCA) internet page. As decisions are indexed they will be linked on this page. For additional information on how to obtain a copy of the index, contact the HCA hearing representative.

(3) A final decision published in the index of significant decisions may be removed from the index when:

(a) A precedential published decision entered by the court of appeals or the supreme court reverses an indexed final decision; or

(b) HCA determines that the indexed final decision is no longer precedential due to changes in statute, rule or policy.

WSR 12-20-029
PERMANENT RULES
HEALTH CARE AUTHORITY
(Medicaid Program)

[Filed September 26, 2012, 5:07 p.m., effective October 27, 2012]

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

Purpose: The health care authority is performing the following actions:

1. Removing any references to the general assistance-unemployable (GA-U) program in WAC 182-550-4900 and 182-550-5150 and replacing them with references to the medical care services (MCS) program.

2. Clarifying in WAC 182-550-5150 that only inpatient hospital services are eligible for payment under the MCS program.

3. Establishing a rule for payment to hospitals for providing services to noncitizen children that do not qualify for Title XIX.

Citation of Existing Rules Affected by this Order: Amending WAC 182-550-4900 and 182-550-5150.

Statutory Authority for Adoption: RCW 41.05.021.

Adopted under notice filed as WSR 12-17-043 on August 8, 2012.

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 1, 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 1, Amended 2, Repealed 0.

Date Adopted: September 26, 2012.

Kevin M. Sullivan
Rules Coordinator

AMENDATORY SECTION (Amending WSR11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-4900 Disproportionate share hospital (DSH) payments—General provisions. (1) As required by section 1902 (a)(13)(A) of the Social Security Act (42 U.S.C. 1396 (a)(13)(A)) and RCW 74.09.730, the ((~~department~~)) medicaid agency makes payment adjustments to eligible hospitals that serve a disproportionate number of low-income clients with special needs. These adjustments are also known as disproportionate share hospital (DSH) payments.

(2) No hospital has a legal entitlement to any DSH payment. A hospital may receive DSH payments only if:

(a) It satisfies the requirements of 42 U.S.C. 1396r-4;

(b) It satisfies all the requirements of ((~~department~~)) agency rules and policies; and

(c) The legislature appropriates sufficient funds.

(3) For purposes of eligibility for DSH payments, the following definitions apply:

(a) "Base year" means the twelve-month medicare cost report year that ended during the calendar year immediately preceding the year in which the state fiscal year (SFY) for which the DSH application is being made begins.

(b) "Case mix index (CMI)" means the average of diagnosis related group (DRG) weights for all of an individual hospital's DRG-paid medicaid claims during the SFY two years prior to the SFY for which the DSH application is being made.

(c) "Charity care" means necessary hospital care rendered to persons unable to pay for the hospital services or unable to pay the deductibles or coinsurance amounts required by a third-party payer. The charity care amount is determined in accordance with the hospital's published charity care policy.

(d) "DSH reporting data file (DRDF)" means the information submitted by hospitals to the ((~~department~~)) agency which the ((~~department~~)) agency uses to verify medicaid client eligibility and applicable inpatient days.

(e) "Hospital-specific DSH cap" means the maximum amount of DSH payments a hospital may receive from the ((~~department~~)) agency during a SFY. If a hospital does not qualify for DSH, the ((~~department~~)) agency will not calculate

the hospital-specific DSH cap and the hospital will not receive DSH payments.

(f) "Inpatient medicaid days" means inpatient days attributed to clients eligible for Title XIX medicaid programs. Excluded from this count are inpatient days attributed to clients eligible for state administered programs, medicare Part A, Title XXI, the refugee program and the TAKE CHARGE program.

(g) "Low income utilization rate (LIUR)" the sum of two percentages:

(i) The ratio of payments received by the hospital for patient services provided to clients under medicaid (including managed care), plus cash subsidies received by the hospital from state and local governments for patient services, divided by total payments received by the hospital from all patient categories; plus

(ii) The ratio of inpatient charity care charges less inpatient cash subsidies received by the hospital from state and local governments, less contractual allowances and discounts, divided by total charges for inpatient services.

(h) "Medicaid inpatient utilization rate (MIPUR)" is calculated as a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to clients who (for such days) were eligible for medical assistance during the base year (regardless of whether such clients received medical assistance on a fee-for-service basis or through a managed care entity), and the denominator of which is the total number of the hospital's inpatient days in that period. "Inpatient days" include each day in which a person (including a newborn) is an inpatient in the hospital, whether or not the person is in a specialized ward and whether or not the person remains in the hospital for lack of suitable placement elsewhere.

(i) "Medicare cost report year" means the twelve-month period included in the annual cost report a medicare-certified hospital or institutional provider is required by law to submit to its fiscal intermediary.

(j) "Nonrural hospital" means a hospital that:

(i) Is not participating in the "full cost" public hospital certified public expenditure (CPE) payment program as described in WAC ((~~388-550-4650~~)) 182-550-4650;

(ii) Is not designated as an "institution for mental diseases (IMD)" as defined in WAC ((~~388-550-2600~~)) 182-550-2600 (2)(d);

(iii) Is not a small rural hospital as defined in (n) of this subsection; and

(iv) Is located in the state of Washington or in a designated bordering city. For DSH purposes, the ((~~department~~)) agency considers as nonrural any hospital located in a designated bordering city.

(k) "Obstetric services" means routine, nonemergency obstetric services and the delivery of babies.

(l) "Service year" means the one year period used to measure the costs and associated charges for hospital services. The service year may refer to a hospital's fiscal year or medicare cost report year, or to a state fiscal year.

(m) "Statewide disproportionate share hospital (DSH) cap" is the maximum amount per SFY that the state can distribute in DSH payments to all qualifying hospitals during a SFY.

(n) "Small rural hospital" means a hospital that:

(i) Is not participating in the "full cost" public hospital certified public expenditure (CPE) payment program as described in WAC ((~~388-550-4650~~)) 182-550-4650;

(ii) Is not designated as an "institution for mental diseases (IMD)" as defined in WAC ((~~388-550-2600~~)) 182-550-2600 (2)(d);

(iii) Has fewer than seventy-five acute beds;

(iv) Is located in the state of Washington; and

(v) Is located in a city or town with a nonstudent population of no more than seventeen thousand eight hundred six in calendar year 2008, as determined by population data reported by the Washington state office of financial management population of cities, towns and counties used for the allocation of state revenues. This nonstudent population is used for SFY 2010, which begins July 1, 2009. For each subsequent SFY, the nonstudent population is increased by two percent.

(o) "Uninsured patient" is a person without creditable coverage as defined in 45 C.F.R. 146.113. (An "insured patient," for DSH program purposes, is a person with creditable coverage, even if the insurer did not pay the full charges for the service.) To determine whether a service provided to an uninsured patient may be included for DSH application and calculation purposes, the ((~~department~~)) agency considers only services that would have been covered and paid through the ((~~department's~~)) agency's fee-for-service process.

(4) To be considered for a DSH payment for each SFY, a hospital must meet the criteria in this section:

(a) DSH application requirement.

(i) Only a hospital located in the state of Washington or in a designated bordering city is eligible to apply for and receive DSH payments. An institution for mental disease (IMD) owned and operated by the state of Washington is exempt from the DSH application requirement.

(ii) A hospital that meets DSH program criteria is eligible for DSH payments in any SFY only if the ((~~department~~)) agency receives the hospital's DSH application by the deadline posted on the ((~~department's website~~)) agency's web site.

(b) DSH application review and correction period.

(i) This subsection applies only to DSH applications that meet the requirements under (a) of this subsection.

(ii) The ((~~department~~)) agency reviews and may verify any information provided by the hospital on a DSH application. However, each hospital has the responsibility for ensuring its DSH application is complete and accurate.

(iii) If the ((~~department~~)) agency finds that a hospital's application is incomplete or contains incorrect information, the ((~~department~~)) agency will notify the hospital. The hospital must resubmit a new, corrected application. The ((~~department~~)) agency must receive the new DSH application from the hospital by the deadline for corrected DSH applications posted on the ((~~department's website~~)) agency's web site.

(iv) If a hospital finds that its application is incomplete or contains incorrect information, it may choose to submit changes and/or corrections to the DSH application. The ((~~department~~)) agency must receive the corrected, complete, and signed DSH application from the hospital by the deadline for corrected DSH applications posted on the ((~~department's website~~)) agency's web site.

(c) Official DSH application.

(i) The ((~~department~~)) agency considers as official the last signed DSH application submitted by the hospital as of the deadline for corrected DSH applications. A hospital cannot change its official DSH application. Only those hospitals with an official DSH application are eligible for DSH payments.

(ii) If the ((~~department~~)) agency finds that a hospital's official DSH application is incomplete or contains inaccurate information that affects the hospital's LIDSH payment(s), the hospital does not qualify for, will not receive, and cannot retain, LIDSH payment(s). Refer to WAC ((~~388-550-5000~~)) 182-550-5000.

(5) A hospital is a disproportionate share hospital for a specific SFY if the hospital satisfies the medicaid inpatient utilization rate (MIPUR) requirement (discussed in (a) of this subsection), and the obstetric services requirement (discussed in (b) of this subsection).

(a) The hospital must have a MIPUR ((~~greater than~~)) of one percent or more; and

(b) Unless one of the exceptions described in (i)(A) or (B) of this subsection applies, the hospital must have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to eligible individuals.

(i) The obstetric services requirement does not apply to a hospital that:

(A) Provides inpatient services predominantly to individuals younger than age eighteen; or

(B) Did not offer nonemergency obstetric services to the general public as of December 22, 1987, when section 1923 of the Social Security Act was enacted.

(ii) For hospitals located in rural areas, "obstetrician" means any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

(6) To determine a hospital's MIPUR, the ((~~department~~)) agency uses inpatient days as follows:

(a) The total inpatient days on the official DSH application if this number is greater than the total inpatient hospital days on the medicare cost report; and

(b) The MMIS medicaid days as determined by the DSH reporting data file (DRDF) process if the Washington state medicaid days on the official DSH application do not match the eligible days on the final DRDF. If the hospital did not submit a DRDF, the ((~~department~~)) agency uses paid medicaid days from MMIS.

(7) The ((~~department~~)) agency administers the following DSH programs (depending on legislative budget appropriations):

(a) Low income disproportionate share hospital (LIDSH);

(b) Institution for mental diseases disproportionate share hospital (IMDDSH):

(c) ((~~General assistance-unemployable~~)) Medical care services disproportionate share hospital (((~~GAUDSH~~))) (MCSDSH);

(d) Small rural disproportionate share hospital (SRDSH);

(e) Small rural indigent assistance disproportionate share hospital (SRIADSH);

(f) Nonrural indigent assistance disproportionate share hospital (NRIADSH);

(g) Public hospital disproportionate share hospital (PHDSH); ((~~and~~))

(h) Psychiatric indigent inpatient disproportionate share hospital (PIIDSH); and

(i) Children's health program disproportionate share hospital (CHPDSH).

(8) Except for IMDDSH, the ((~~department~~)) agency allows a hospital to receive any one or all of the DSH payment it qualifies for, up to the individual hospital's DSH cap (see subsection (10) of this section) and provided that total DSH payments do not exceed the statewide DSH cap. See WAC ((~~388-550-5130~~)) 182-550-5130 regarding IMDDSH. To be eligible for payment under multiple DSH programs, a hospital must meet:

(a) The basic requirements in subsection (5) of this section; and

(b) The eligibility requirements for the particular DSH payment, as discussed in the applicable DSH program WAC.

(9) For each SFY, the ((~~department~~)) agency calculates DSH payments for each DSH program for eligible hospitals using data from each hospital's base year. The ((~~department~~)) agency does not use base year data for GAUDSH and PIIDSH payments, which are calculated based on specific claims data.

(10) The ((~~department's~~)) agency's total DSH payments to a hospital for any given SFY cannot exceed the hospital-specific DSH cap for that SFY. Except for critical access hospitals (CAHs), the ((~~department~~)) agency determines a hospital's DSH cap as follows. The ((~~department~~)) agency:

(a) Uses the overall ratio of costs-to-charges (RCC) to determine costs for:

(i) Medicaid services, including medicaid services provided under managed care organization (MCO) plans; and

(ii) Uninsured charges; then

(b) Subtracts all payments related to the costs derived in (a) of this subsection; then

(c) Makes any adjustments required and/or authorized by federal statute or regulation.

(11) A CAH's DSH cap is based strictly on the cost to the hospital of providing services to medicaid clients served under MCO plans, and uninsured patients. To determine a CAH's DSH cap amount, the ((~~department~~)) agency:

(a) Uses the overall RCC to determine costs for:

(i) Medicaid services provided under MCO plans; and

(ii) Uninsured charges; then

(b) Subtracts the total payments made by, or on behalf of, the medicaid clients serviced under MCO plans, and uninsured patients.

(12) In any given federal fiscal year, the total of the ((~~department's~~)) agency's DSH payments cannot exceed the statewide DSH cap as published in the federal register.

(13) If the ((~~department's~~)) agency's DSH payments for any given federal fiscal year exceed the statewide DSH cap, the ((~~department~~)) agency will adjust DSH payments to each hospital to account for the amount overpaid. The ((~~department~~)) agency makes adjustments in the following program order:

(a) PHDSH;

(b) SRIADSH;
(c) SRDSH;
(d) NRIADSH;
(e) ((~~GAUDSH~~)) MCSDSH;
(f) CHPDSH;
(((~~f~~))) (g) PIIDSH;
(((~~g~~))) (h) IMDDSH; and
(((~~h~~))) (i) LIDSH.

(14) If the statewide DSH cap is exceeded, the ((~~department~~)) agency will recoup DSH payments made under the various DSH programs, in the order of precedence described in subsection (13) of this section, starting with PHDSH, until the amount exceeding the statewide DSH cap is reduced to zero. See specific program WACs for description of how amounts to be recouped are determined.

(15) The total amount the ((~~department~~)) agency may distribute annually under a particular DSH program is capped by legislative appropriation, except for PHDSH, GAUDSH, and PIIDSH, which are not fixed amounts. Any changes in payment amount to a hospital in a particular DSH program means a redistribution of payments within that DSH program. When necessary, the ((~~department~~)) agency will recoup from hospitals to make additional payments to other hospitals within that DSH program.

(16) If funds in a specific DSH program need to be redistributed because of legislative, administrative, or other state action, only those hospitals eligible for that DSH program will be involved in the redistribution.

(a) If an individual hospital has been overpaid by a specified amount, the ((~~department~~)) agency will recoup that overpayment amount from the hospital and redistribute it among the other eligible hospitals in the DSH program. The additional DSH payment to be given to each of the other hospitals from the recouped amount is proportional to each hospital's share of the particular DSH program.

(b) If an individual hospital has been underpaid by a specified amount, the ((~~department~~)) agency will pay that hospital the additional amount owed by recouping from the other hospitals in the DSH program. The amount to be recouped from each of the other hospitals is proportional to each hospital's share of the particular DSH program.

(17) All information related to a hospital's DSH application is subject to audit by the ((~~department~~)) agency or its designee. The ((~~department~~)) agency determines the extent and timing of the audits. For example, the ((~~department~~)) agency or its designee may choose to do a desk review of an individual hospital's DSH application and/or supporting documentation, or audit all hospitals that qualified for a particular DSH program after payments have been distributed under that program.

(18) If a hospital's submission of incorrect information or failure to submit correct information results in DSH overpayment to that hospital, the ((~~department~~)) agency will recoup the overpayment amount, in accordance with the provisions of RCW 74.09.220 and 43.20B.695.

(19) DSH calculations use fiscal year data, and DSH payments are distributed based on funding for a specific SFY. Therefore, unless otherwise specified, changes and clarifications to DSH program rules apply for the full SFY in which the rules are adopted.

NEW SECTION

WAC 182-550-5300 Payment method—Children's health program disproportionate share hospital (CHP-DSH). (1) Effective July 1, 2011, a hospital is eligible for the children's health program disproportionate share hospital (CHPDSH) payment if funding is legislatively appropriated and if the hospital:

(a) Meets the criteria in WAC 182-550-4900;

(b) Is an in-state or designated bordering city hospital; or

(c) Provides services to low-income, children's health program (CHP) clients who, because of their citizenship status, are not eligible for medicaid nonemergency health coverage and who are encountering a nonemergency medical condition.

(2) Hospitals qualifying for CHPDSH payments will receive a per claim payment for inpatient and outpatient claims at the equivalent medicaid rate.

(3) The agency determines the CHPDSH payment for each eligible hospital in accordance with:

(a) WAC 182-550-2800 for inpatient hospital claims submitted for CHP clients; and

(b) WAC 182-550-7000 through 182-550-7600 and other sections in chapter 182-550 WAC that pertain to outpatient hospital claims submitted for CHP clients.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-5150 Payment method—((~~General assistance-unemployable~~)) Medical care services disproportionate share hospital (((~~(GAUDSH)~~))) (MCSDSH). (1) A hospital is eligible for the ((~~general assistance-unemployable~~)) medical care services disproportionate share hospital (((~~(GAUDSH)~~))) (MCSDSH) payment if the hospital:

(a) Meets the criteria in WAC ((~~388-550-4900~~)) 182-550-4900;

(b) Is an in-state or designated bordering city hospital;

(c) Provides services to clients eligible under the medical care services program; and

(d) Has a medicaid inpatient utilization rate (MIPUR) of one percent or more.

(2) The ((~~department~~)) medicaid agency determines the ((~~GAUDSH~~)) MCSDSH payment for each eligible hospital in accordance with((~~:~~

~~(a)~~)) WAC ((~~388-550-4800~~)) 182-550-4800 for inpatient hospital claims submitted for ((~~general assistance-unemployable (GAU)~~)) medical care services (MCS) clients((~~; and~~

~~(b) WAC 388-550-7000 through 388-550-7600 and other sections in chapter 388-550 WAC that pertain to outpatient hospital claims submitted for GAU clients~~)).

(3) The ((~~department~~)) agency makes ((~~GAUDSH~~)) MCSDSH payments to a hospital on a claim-specific basis for inpatient services.

WSR 12-20-030
PERMANENT RULES
PROFESSIONAL EDUCATOR STANDARDS BOARD

[Filed September 27, 2012, 10:05 a.m., effective October 28, 2012]

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

Purpose: Amends WAC 181-78A-105 to clarify procedures to initial approval request for an educator preparation program. Technical edits to outdated language.

Citation of Existing Rules Affected by this Order: Amending X [WAC 181-78A-105].

Statutory Authority for Adoption: RCW 28A.410.210.

Adopted under notice filed as WSR 12-16-070 on July 31, 2012.

Changes Other than Editing from Proposed to Adopted Version: Errors resulting from prior rule changes detected and corrected.

A final cost-benefit analysis is available by contacting David Brenna, 600 Washington Street South, Room 400, Olympia, WA 98504-7236, phone (360) 725-6238, fax (360) 586-4548, e-mail david.brenna@k12.wa.us.

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 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: September 20, 2012.

David Brenna
Senior Policy Analyst

AMENDATORY SECTION (Amending WSR 11-15-049, filed 7/15/11, effective 8/15/11)

WAC 181-78A-105 Procedures for initial approval of an educator preparation program. Each institution or organization desiring to establish a preparation program shall comply with the following:

(1) ((~~Advise the professional educator standards board of its desire to establish a preparation program.~~)) Submit a form declaring an intent to offer a new educator certification program.

(a) The declaration of intent will be posted on the professional educator standards board web site as public notice.

(b) The program will be contacted to begin the preproposal.

(2) Develop ((~~with the assistance of the professional education advisory board~~)) a written ((~~preproposal~~)) plan which addresses all preproposal components ((~~adopted and~~)) published by the professional educator standards board ((~~and~~)).

(a) Submit such plan to the designated official of the professional educator standards board for review and comment.

(((~~(3) Submit such plan~~)) (b) After the designated official verifies the preproposal is complete, the preproposal will be brought to the professional educator standards board.

(3) The institution or organization may be granted approval for full proposal development or denied approval of the preproposal.

(a) If denied, the institution or organization may resubmit its plan based upon suggestions of the professional educator standards board.

(((~~(a)~~)) (b) If the preproposal is approved, the institution or organization shall comply with the following:

(i) Establish the appropriate professional education advisory board pursuant to WAC 181-78A-205;

(ii) Develop with assistance of the professional education advisory board a written plan which ((~~includes the following~~)) addresses all final proposal components including:

(A) ((~~Timelines for the implementation of all applicable program approval standards during the first year of the program;~~

~~(B) The criteria that the program will use to assess, in multiple ways over time, its candidates' knowledge and skills including evidence related to positive impact on student learning (WAC 181-78A-205(4));~~

~~(C)~~)) How the professional education advisory board was involved in program development, including a letter of support; and

(((~~(D)~~))) (B) Letters of support from ((~~partnership~~)) partner districts and/or ((~~other~~)) agencies.

(iii) Present the written plan to the professional educator standards board.

(((~~(A)~~))) (4) The program may be ((~~conditionally~~)) approved in a specific location(s) for a period of up to twenty-seven months following the beginning of instruction. The institution or organization shall notify the professional educator standards board when instruction has begun((~~. If not approved, the institution or organization may resubmit its revised plan or request a contested hearing via an appeal team appointed by the professional educator standards board~~)).

If approval is denied, the institution or organization may resubmit its plan based upon the suggestions of the professional educator standards board.

(((~~(B)~~))) (5) Prior to the expiration of approval, staff of the professional educator standards board shall conduct a site visit ((~~and/or other forms of documentation~~)) to determine if the program is in full compliance with the ((~~1997~~)) program approval standards; provided that ((~~a college/university~~)) an institution with an approved residency principal program which adds an approved program administrator program is not required to have a site visit of the program administrator program until the next regularly scheduled site visit of that institution.

(((~~(b) If denied, the institution or organization may resubmit its plan based upon the suggestions of the professional educator standards board.~~))

WSR 12-20-032
PERMANENT RULES
DEPARTMENT OF LICENSING
[Filed September 27, 2012, 1:21 p.m., effective October 28, 2012]

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

Purpose: Amend WAC 308-56A-460 to update the market value threshold for reporting total loss vehicles to the department of licensing. As directed by RCW 46.12.600, the department is raising the market value threshold amount for reporting a vehicle as a total loss by the percentage increase in the average expenditure for "used cars and trucks" published in the Consumer Price Index (CPI), compiled by the federal Bureau of Labor Statistics. The threshold is being raised from $7660 to $7880.

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

Statutory Authority for Adoption: RCW 46.01.110, 46.12.600.

Adopted under notice filed as WSR 12-17-040 on August 8, 2012.

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 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 0, Repealed 0.

Date Adopted: September 27, 2012.

Damon Monroe
Rules Coordinator

AMENDATORY SECTION (Amending WSR 11-22-034, filed 10/26/11, effective 11/26/11)

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 46.12.600 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 46.12.600 by the vehicle's owner;

(c) A salvage vehicle as defined in RCW 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 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 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 46.12.600 is also required.

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

(4) **How is the market value threshold amount determined?** Using the current market value threshold amount described in RCW 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 46.12.600 has been met. The certificate of title will be branded according to WAC 308-56A-530**.**

(6) **What documentation is required to obtain a certificate of 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 title:

(a) Application for certificate of title as described in RCW 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 46.16A.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 12-20-044
PERMANENT RULES
PUGET SOUND CLEAN AIR AGENCY

[Filed September 28, 2012, 4:46 p.m., effective November 1, 2012]

Effective Date of Rule: November 1, 2012.

Purpose: To adjust the maximum civil penalty amount for inflation and update the federal regulation reference date.

Citation of Existing Rules Affected by this Order: Amending Regulation I, Sections 3.11 and 3.25.

Statutory Authority for Adoption: Chapter 70.94 RCW.

Adopted under notice filed as WSR 12-17-141 on August 21, 2012.

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: September 27, 2012.

Craig Kenworthy
Executive Director

AMENDATORY SECTION

REGULATION I, SECTION 3.11 CIVIL PENALTIES

(a) Any person who violates any of the provisions of chapter 70.94 RCW or any of the rules or regulations in force pursuant thereto, may incur a civil penalty in an amount not to exceed ((~~$17,057.00~~)) $17,279.00, per day for each violation.

(b) Any person who fails to take action as specified by an order issued pursuant to chapter 70.94 RCW or Regulations I, II, and III of the Puget Sound Clean Air Agency shall be liable for a civil penalty of not more than ((~~$17,057.00~~)) $17,279.00, for each day of continued noncompliance.

(c) Within 30 days of the date of receipt of a Notice and Order of Civil Penalty, the person incurring the penalty may apply in writing to the Control Officer for the remission or mitigation of the penalty. To be considered timely, a mitigation request must be actually received by the Agency, during regular office hours, within 30 days of the date of receipt of a Notice and Order of Civil Penalty. This time period shall be calculated by excluding the first day and including the last, unless the last day is a Saturday, Sunday, or legal holiday, and then it is excluded and the next succeeding day that is not a Saturday, Sunday, or legal holiday is included. The date stamped by the Agency on the mitigation request is prima facie evidence of the date the Agency received the request.

(d) A mitigation request must contain the following:

(1) The name, mailing address, telephone number, and telefacsimile number (if available) of the party requesting mitigation;

(2) A copy of the Notice and Order of Civil Penalty involved;

(3) A short and plain statement showing the grounds upon which the party requesting mitigation considers such order to be unjust or unlawful;

(4) A clear and concise statement of facts upon which the party requesting mitigation relies to sustain his or her grounds for mitigation;

(5) The relief sought, including the specific nature and extent; and

(6) A statement that the party requesting mitigation has read the mitigation request and believes the contents to be true, followed by the party's signature.

The Control Officer shall remit or mitigate the penalty only upon a demonstration by the requestor of extraordinary circumstances such as the presence of information or factors not considered in setting the original penalty.

(e) Any civil penalty may also be appealed to the Pollution Control Hearings Board pursuant to chapter 43.21B RCW and chapter 371-08 WAC. An appeal must be filed with the Hearings Board and served on the Agency within 30 days of the date of receipt of the Notice and Order of Civil Penalty or the notice of disposition on the application for relief from penalty.

(f) A civil penalty shall become due and payable on the later of:

(1) 30 days after receipt of the notice imposing the penalty;

(2) 30 days after receipt of the notice of disposition on application for relief from penalty, if such application is made; or

(3) 30 days after receipt of the notice of decision of the Hearings Board if the penalty is appealed.

(g) If the amount of the civil penalty is not paid to the Agency within 30 days after it becomes due and payable, the Agency may bring action to recover the penalty in King County Superior Court or in the superior court of any county in which the violator does business. In these actions, the procedures and rules of evidence shall be the same as in an ordinary civil action.

(h) Civil penalties incurred but not paid shall accrue interest beginning on the 91st day following the date that the penalty becomes due and payable, at the highest rate allowed by RCW 19.52.020 on the date that the penalty becomes due and payable. If violations or penalties are appealed, interest shall not begin to accrue until the 31st day following final resolution of the appeal.

(i) To secure the penalty incurred under this section, the Agency shall have a lien on any vessel used or operated in violation of Regulations I, II, and III which shall be enforced as provided in RCW 60.36.050.

AMENDATORY SECTION

REGULATION I, SECTION 3.25 FEDERAL REGULATION REFERENCE DATE

Whenever federal regulations are referenced in Regulation I, II, or III, the effective date shall be July 1, ((~~2011~~)) 2012.

WSR 12-20-045
PERMANENT RULES
PUGET SOUND CLEAN AIR AGENCY

[Filed September 28, 2012, 4:47 p.m., effective November 1, 2012]

Effective Date of Rule: November 1, 2012.

Purpose: Exclude bulk gasoline plants from the specific NESHAP criteria in our registration program.

Citation of Existing Rules Affected by this Order: Amending Regulation I, Section 5.03.

Statutory Authority for Adoption: Chapter 70.94 RCW.

Adopted under notice filed as WSR 12-17-142 on August 21, 2012.

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: September 27, 2012.

Craig Kenworthy
Executive Director

AMENDATORY SECTION

REGULATION I, SECTION 5.03 APPLICABILITY OF REGISTRATION PROGRAM

(a) The requirements of this article shall apply only to:

(1) Sources subject to a federal emission standard under:

(A) 40 CFR Part 60 (except Subparts B, S, BB, and AAA, and the provisions of Subpart IIII pertaining to owners and operators of emergency stationary compression ignition internal combustion engines);

(B) 40 CFR Part 61 (except Subparts B, H, I, K, Q, R, T, W, and the provisions of Subpart M pertaining to asbestos on roadways, asbestos demolition and renovation activities, and asbestos spraying);

(C) 40 CFR Part 62; or

(D) 40 CFR Part 63 (except Subpart LL, the provisions of Subparts S and MM pertaining to kraft and sulfite pulp mills, the provisions of Subpart ZZZZ pertaining to emergency and limited-use stationary reciprocating internal combustion engines, Subpart BBBBBB pertaining to bulk gasoline plants, and Subparts WWWWW, CCCCCC, HHHHHH, WWWWWW, XXXXXX, YYYYYY, and ZZZZZZ);

(2) Sources with a federally enforceable emission limitation established in order to avoid operating permit program applicability under Article 7 of this regulation;

(3) Sources with annual emissions:

(A) Greater than or equal to 2.50 tons of any single hazardous air pollutant (HAP);

(B) Greater than or equal to 6.25 tons of total hazardous air pollutants (HAP); or

(C) Greater than or equal to 25.0 tons of carbon monoxide (CO), nitrogen oxides (NO_x), particulate matter ($PM_{2.5}$ or

PM_{10}), sulfur oxides (SO_x), or volatile organic compounds (VOC);

(4) Sources subject to the following sections of Regulation I, II, or III:

(A) Refuse burning equipment subject to Section 9.05 of Regulation I (including crematories);

(B) Fuel burning equipment or refuse burning equipment burning oil that exceeds any limit in Section 9.08 of Regulation I and sources marketing oil to such sources;

(C) Fuel burning equipment subject to Section 9.09 of Regulation I with a rated heat input greater than or equal to 1 MMBtu/hr of any fuel other than natural gas, propane, butane, or distillate oil, or greater than or equal to 10 MMBtu/hr of any fuel;

(D) Sources with spray-coating operations subject to Section 9.16 of Regulation I;

(E) Petroleum refineries subject to Section 2.03 of Regulation II;

(F) Gasoline loading terminals subject to Section 2.05 of Regulation II;

(G) Gasoline dispensing facilities subject to Section 2.07 of Regulation II;

(H) Volatile organic compound storage tanks subject to Section 3.02 of Regulation II;

(I) Can and paper coating facilities subject to Section 3.03 of Regulation II;

(J) Motor vehicle and mobile equipment coating operations subject to Section 3.04 of Regulation II;

(K) Flexographic and rotogravure printing facilities subject to Section 3.05 of Regulation II;

(L) Polyester, vinylester, gelcoat, and resin operations subject to Section 3.08 of Regulation II;

(M) Aerospace component coating operations subject to Section 3.09 of Regulation II;

(N) Crushing operations subject to Section 9.18; or

(O) Ethylene oxide sterilizers subject to Section 3.07 of Regulation III;

(5) Sources with any of the following gas or odor control equipment having a rated capacity of greater than or equal to 200 cfm ($\geq$4" diameter inlet):

(A) Activated carbon adsorption;

(B) Afterburner;

(C) Barometric condenser;

(D) Biofilter;

(E) Catalytic afterburner;

(F) Catalytic oxidizer;

(G) Chemical oxidation;

(H) Condenser;

(I) Dry sorbent injection;

(J) Flaring;

(K) Non-selective catalytic reduction;

(L) Refrigerated condenser;

(M) Selective catalytic reduction; or

(N) Wet scrubber;

(6) Sources with any of the following particulate control equipment having a rated capacity of greater than or equal to 2,000 cfm ($\geq$10" diameter inlet):

(A) Baghouse;

(B) Demister;

(C) Electrostatic precipitator;

(D) HEPA (high efficiency particulate air) filter;

(E) HVAF (high velocity air filter);

(F) Mat or panel filter;

(G) Mist eliminator;

(H) Multiple cyclones;

(I) Rotoclone;

(J) Screen;

(K) Venturi scrubber;

(L) Water curtain; or

(M) Wet electrostatic precipitator;

(7) Sources with a single cyclone having a rated capacity of greater than or equal to 20,000 cfm ($\geq$27" diameter inlet);

(8) Sources with any of the following equipment:

(A) Asphalt batch plants;

(B) Burn-off ovens;

(C) Coffee roasters;

(D) Commercial composting with raw materials from off-site;

(E) Commercial smokehouses with odor control equipment;

(F) Concrete batch plants (ready-mix concrete);

(G) Galvanizing;

(H) Iron or steel foundries;

(I) Microchip or printed circuit board manufacturing;

(J) Rendering plants;

(K) Rock crushers or concrete crushers;

(L) Sewage treatment plants with odor control equipment;

(M) Shipyards;

(N) Steel mills;

(O) Wood preserving lines or retorts; or

(P) Dry cleaners using perchloroethylene; and

(9) Sources with equipment (or control equipment) that has been determined by the Control Officer to warrant registration through review of a Notice of Construction application under Section 6.03(a) or a Notification under Section 6.03(b) of this regulation, due to the amount and nature of air contaminants produced, or the potential to contribute to air pollution, and with special reference to effects on health, economic and social factors, and physical effects on property.

(b) The requirements of this article shall not apply to:

(1) Motor vehicles;

(2) Nonroad engines or nonroad vehicles as defined in Section 216 of the federal Clean Air Act;

(3) Sources that require an operating permit under Article 7 of this regulation;

(4) Solid fuel burning devices subject to Article 13 of this regulation; or

(5) Any source, including any listed in Sections 5.03 (a)(4) through 5.03 (a)(9) of this regulation, that has been determined through review by the Control Officer not to warrant registration, due to the amount and nature of air contaminants produced or the potential to contribute to air pollution, and with special reference to effects on health, economic and social factors, and physical effects on property.

(c) It shall be unlawful for any person to cause or allow the operation of any source subject to registration under this section, unless it meets all the requirements of Article 5 of this regulation.

(d) An exemption from new source review under Article 6 of this regulation shall not be construed as an exemption from registration under this article. In addition, an exemption from registration under this article shall not be construed as an exemption from any other provision of Regulation I, II, or III.

WSR 12-20-046
PERMANENT RULES
PUGET SOUND CLEAN AIR AGENCY

[Filed September 28, 2012, 4:47 p.m., effective November 1, 2012]

Effective Date of Rule: November 1, 2012.

Purpose: Maintain exemption for small boilers and heaters, which have less than 10 MMBtu/hr heat input, from the notice of construction program.

Citation of Existing Rules Affected by this Order: Amending Regulation I, Section 6.03.

Statutory Authority for Adoption: Chapter 70.94 RCW.

Adopted under notice filed as WSR 12-17-143 on August 21, 2012.

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: September 27, 2012.

Craig Kenworthy
Executive Director

AMENDATORY SECTION

REGULATION I, SECTION 6.03 NOTICE OF CONSTRUCTION

(a) It shall be unlawful for any person to cause or allow the establishment of a new source, or the replacement or substantial alteration of control equipment installed on an existing source, unless a "Notice of Construction application" has been filed and an "Order of Approval" has been issued by the Agency. The exemptions in Sections 6.03 (b) and (c) of this regulation shall not apply to:

(1) Any project that qualifies as construction, reconstruction, or modification of an affected facility within the meaning of 40 CFR Part 60 (New Source Performance Standards), except for Subpart AAA (New Residential Wood Heaters), Subpart BB (Kraft Pulp Mills), Subpart S (Primary Aluminum Reduction Plants), Subpart OOO (Nonmetallic Mineral Processing Plants), and Subpart IIII pertaining to owners and operators of emergency stationary compression ignition internal combustion engines; and for relocation of affected facilities under Subpart I (Hot Mix Asphalt Facilities) for which an Order of Approval has been previously issued by the Agency;

(2) Any project that qualifies as a new or modified source within the meaning of 40 CFR 61.02 (National Emission Standards for Hazardous Air Pollutants), except for Subpart B (Radon from Underground Uranium Mines), Subpart H (Emissions of Radionuclides other than Radon from Department of Energy Facilities), Subpart I (Radionuclides from Federal Facilities other than Nuclear Regulatory Commission Licensees and not covered by Subpart H), Subpart K (Radionuclides from Elemental Phosphorus Plants), Subpart Q (Radon from Department of Energy Facilities), Subpart R (Radon from Phosphogypsum Stacks), Subpart T (Radon from Disposal of Uranium Mill Tailings), Subpart W (Radon from Operating Mill Tailings), and for demolition and renovation projects subject to Subpart M (Asbestos);

(3) Any project that qualifies as a new source as defined under 40 CFR 63.2 (National Emission Standards for Hazardous Air Pollutants for Source Categories), except for the provisions of Subpart M (Dry Cleaning Facilities) pertaining to area source perchloroethylene dry cleaners, Subpart LL (Primary Aluminum Reduction Plants), the provisions of Subpart S (Pulp and Paper Industry) and Subpart MM (Chemical Recovery Combustion Sources at Kraft, Soda, Sulfite, and Stand-Alone Semichemical Pulp Mills) pertaining to kraft and sulfite pulp mills, the provisions of Subpart ZZZZ (Reciprocating Internal Combustion Engines) pertaining to emergency and limited-use stationary reciprocating internal combustion engines, Subpart DDDDD (Industrial, Commercial, and Institutional Boilers and Process Heaters), Subpart WWWWW (Hospitals: Ethylene Oxide Sterilizers), Subpart CCCCCC (Gasoline Dispensing Facilities), Subpart HHHHHH (Paint Stripping and Miscellaneous Surface Coating Operations), Subpart WWWWWW (Plating and Polishing Operations), Subpart XXXXXX (Nine Metal Fabrication and Finishing Source Categories), Subpart YYYYYY (Ferroalloys Production Facilities), and Subpart ZZZZZZ (Aluminum, Copper, and Other Nonferrous Foundries);

(4) Any new major stationary source or major modification as defined under WAC 173-400-030; and

(5) Any stationary source previously exempted from review that is cited by the Agency for causing air pollution under Section 9.11 of this regulation.

(b) **Notifications.** A Notice of Construction application and Order of Approval are not required for the new sources identified in this section, provided that a complete notification is filed with the Agency. It shall be unlawful for any person to cause or allow establishment of a new source identified in this section unless a complete notification has been filed with the Agency:

Liquid Storage and Transfer

(1) Storage tanks used exclusively for:

(A) Gasoline dispensing and having a rated capacity of ≥1,001 gallons, PROVIDED THAT they are installed in accor-

dance with the current California Air Resources Board Executive Orders;

(B) Organic liquids with a true vapor pressure of 2.2-4.0 psia and having a rated capacity of 20,000-39,999 gallons; or

(C) Organic liquids with a true vapor pressure of 0.5-0.75 psia and having a rated capacity ≥40,000 gallons.

(2) Loading and unloading equipment used exclusively for the storage tanks exempted above, including gasoline dispensers at gasoline stations.

Relocation of Portable Batch Plants

(3) Relocation of the following portable facilities: asphalt batch plants, nonmetallic mineral processing plants, and concrete batch plants for which an Order of Approval has been previously issued by the Agency. *All the conditions in the previously issued Order of Approval remain in effect.*

Dry Cleaning

(4) Unvented, dry-to-dry, dry-cleaning equipment that is equipped with refrigerated condensers to recover the cleaning solvent.

Printing

(5) Non-heatset, web offset presses and wholesale, sheet-fed offset presses (lithographic or letterpress) using exclusively soy-based or kerosene-like oil-based inks, fountain solutions with ≤6% VOC by volume or ≤8.5% if refrigerated to <60º F, and cleaning solvents with a vapor pressure ≤25mm Hg or a VOC content ≤30% by volume.

Water Treatment

(6) Industrial and commercial wastewater evaporators (except flame impingement) used exclusively for wastewater generated on-site that meets all discharge limits for disposal into the local municipal sewer system (including metals, cyanide, fats/oils/grease, pH, flammable or explosive materials, organic compounds, hydrogen sulfide, solids, and food waste). *A letter from the local sewer district documenting compliance is required in order to use this exemption.*

Sanding Equipment

(7) Sanding equipment controlled by a fabric filter with an airflow of 2,000-5,000 cfm and an air-to-cloth ratio of <3.5:1 (for reverse-air or manual cleaning) or <12:1 (for pulse-jet cleaning).

Ventilation and Control Equipment

(8) Vacuum-cleaning systems used exclusively for industrial, commercial, or residential housekeeping purposes controlled by a fabric filter with an airflow of 2,000-5,000 cfm and an air-to-cloth ratio of <3.5:1 (for mechanical or manual cleaning) or <12:1 (for pulse-jet cleaning).

(9) Replacement of an existing paint spray booth that has previously received an Order of Approval, with like kind equipment and for spray coating operations that continue to operate consistent with the previously issued Order of Approval. *All the conditions in the previously issued Order of Approval remain in effect.*

Miscellaneous

(10) Any source not otherwise exempt under Section 6.03(c) of this regulation that has been determined through review of a Notice of Construction application by the Control Officer not to warrant an Order of Approval because it has a de minimis impact on air quality and does not pose a threat to human health or the environment.

Coffee Roasters

(11) Batch coffee roasters with a maximum rated capacity of 10 lbs per batch or less.

(c) **Exemptions.** A Notice of Construction application and Order of Approval are not required for the following new sources, provided that sufficient records are kept to document the exemption:

Combustion

(1) Fuel-burning equipment (except when combusting pollutants generated by a non-exempt source) having a rated capacity:

(A) <10 million Btu per hour heat input burning exclusively distillate fuel oil, natural gas, propane, butane, biodiesel that meets ASTM D 6751 specifications (or any combination thereof);

(B) <0.5 million Btu per hour heat output burning waste-derived fuel (including fuel oil not meeting the specifications in Section 9.08 of this regulation); or

(C) <1 million Btu per hour heat input burning any other fuel.

(2) All stationary gas turbines with a rated heat input <10 million Btu per hour.

(3) Stationary internal combustion engines having a rated capacity:

(A) <50 horsepower output;

(B) Used solely for instructional purposes at research, teaching, or educational facilities; or

(C) Portable or standby units operated <500 hours per year, PROVIDED THAT they are not operated at a facility with a power supply contract that offers a lower rate in exchange for the power supplier's ability to curtail energy consumption with prior notice.

(4) Relocation of portable, stationary internal combustion engines or gas turbines for which an Order of Approval has been previously issued by the Agency.

(5) All nonroad compression ignition engines subject to 40 CFR Part 89 and land-based nonroad compression engines subject to 40 CFR Part 1039.

Metallurgy

(6) Crucible furnaces, pot furnaces, or induction furnaces with a capacity ≤1,000 pounds, PROVIDED THAT no sweating or distilling is conducted, and PROVIDED THAT only precious metals, or an alloy containing >50% aluminum, magnesium, tin, zinc, or copper is melted.

(7) Crucible furnaces or pot furnaces with a capacity ≤450 cubic inches of any molten metal.

(8) Ladles used in pouring molten metals.

(9) Foundry sand-mold forming equipment.

(10) Shell core and shell-mold manufacturing machines.

(11) Molds used for the casting of metals.

(12) Die casting machines with a rated capacity ≤1,000 pounds that are not used for copper alloys.

(13) Equipment used for heating metals immediately prior to forging, pressing, rolling, or drawing, if any combustion equipment is also exempt.

(14) Forming equipment used exclusively for forging, rolling, or drawing of metals, if any combustion equipment is also exempt.

(15) Heat treatment equipment used exclusively for metals, if any combustion equipment is also exempt.

(16) Equipment used exclusively for case hardening, carburizing, cyaniding, nitriding, carbonitriding, siliconizing, or diffusion treating of metals, if any combustion equipment is also exempt.

(17) Atmosphere generators used in connection with metal heat-treating processes.

(18) Sintering equipment used exclusively for metals other than lead, PROVIDED THAT no coke or limestone is used, if any combustion equipment is also exempt.

(19) Welding equipment and oxygen/gaseous fuel cutting equipment.

(20) Soldering or brazing, or equipment, including brazing ovens.

(21) Equipment used exclusively for surface preparation, passivation, deoxidation, and/or stripping that meets all of the following tank content criteria:

(A) ≤50 grams of VOC per liter;

(B) No acids other than boric, formic, acetic, phosphoric, sulfuric, or ≤12% hydrochloric; and

(C) May contain alkaline oxidizing agents, hydrogen peroxide, salt solutions, sodium hydroxide, and water in any concentration.

Associated rinse tanks and waste storage tanks used exclusively to store the solutions drained from this equipment are also exempt. (This exemption does not include anodizing, hard anodizing, chemical milling, circuit board etching using ammonia-based etchant, electrocleaning, or the stripping of chromium, except sulfuric acid and/or boric acid anodizing with a total bath concentration of ≤20% by weight and using ≤10,000 amp-hours per day, or phosphoric acid anodizing with a bath concentration of ≤15% by weight of phosphoric acid and using ≤20,000 amp-hours per day.)

(22) Equipment used exclusively for electrolytic plating (except the use of chromic and/or hydrochloric acid) or electrolytic stripping (except the use of chromic, hydrochloric, nitric, or sulfuric acid) of brass, bronze, copper, iron, tin, zinc, precious metals, and associated rinse tanks and waste storage tanks used exclusively to store the solutions drained from this equipment. Also, equipment used to electrolytically recover metals from spent or pretreated plating solutions that qualify for this exemption.

Ceramics and Glass

(23) Kilns used for firing ceramic-ware or artwork, if any combustion equipment is also exempt.

(24) Porcelain enameling furnaces, porcelain enameling drying ovens, vitreous enameling furnaces, or vitreous enameling drying ovens, if any combustion equipment is also exempt.

(25) Hand glass melting furnaces, electric furnaces, and pot furnaces with a capacity ≤1,000 pounds of glass.

(26) Heat-treatment equipment used exclusively for glass, if any combustion equipment is also exempt.

(27) Sintering equipment used exclusively for glass PROVIDED THAT no coke or limestone is used, if any combustion equipment is also exempt.

Plastics and Rubber and Composites

(28) Equipment used exclusively for conveying and storing plastic pellets.

(29) Extrusion equipment used exclusively for extruding rubber or plastics where no organic plasticizer is present, or for pelletizing polystyrene foam scrap.

(30) Equipment used for extrusion, compression molding, and injection molding of plastics, PROVIDED THAT the VOC content of all mold release products or lubricants is ≤1% by weight.

(31) Injection or blow-molding equipment for rubber or plastics, PROVIDED THAT no blowing agent other than compressed air, water, or carbon dioxide is used.

(32) Presses or molds used for curing, post-curing, or forming composite products and plastic products, PROVIDED THAT the blowing agent contains no VOC or chlorinated compounds.

(33) Presses or molds used for curing or forming rubber products and composite rubber products with a ram diameter ≤26 inches, PROVIDED THAT it is operated at ≤400ºF.

(34) Ovens used exclusively for the curing or forming of plastics or composite products, where no foam-forming or expanding process is involved, if any combustion equipment is also exempt.

(35) Ovens used exclusively for the curing of vinyl plastisols by the closed-mold curing process, if any combustion equipment is also exempt.

(36) Equipment used exclusively for softening or annealing plastics, if any combustion equipment is also exempt.

(37) Hot wire cutting of expanded polystyrene foam and woven polyester film.

(38) Mixers, roll mills, and calenders for rubber or plastics where no material in powder form is added and no organic solvents, diluents, or thinners are used.

Material Working and Handling

(39) Equipment used for mechanical buffing (except tire buffers), polishing, carving, cutting, drilling, grinding, machining, planing, pressing, routing, sawing, stamping, or turning of wood, ceramic artwork, ceramic precision parts, leather, metals, plastics, rubber, fiberboard, masonry, glass, silicon, semiconductor wafers, carbon, graphite, or composites. This exemption also applies to laser cutting, drilling, and machining of metals.

(40) Hand-held sanding equipment.

(41) Sanding equipment controlled by a fabric filter with an airflow of <2,000 cfm.

(42) Equipment used exclusively for shredding of wood (e.g., tub grinders, hammermills, hoggers), or for extruding, pressing, handling, or storage of wood chips, sawdust, or wood shavings.

(43) Paper shredding and associated conveying systems and baling equipment.

(44) Hammermills used exclusively to process aluminum and/or tin cans.

(45) Tumblers used for the cleaning or deburring of metal products without abrasive blasting.

Abrasive Blasting

(46) Portable abrasive blasting equipment used at a temporary location to clean bridges, water towers, buildings, or similar structures, PROVIDED THAT any blasting with sand (or silica) is performed with ≥66% by volume water.

(47) Portable vacuum blasting equipment using steel shot and vented to a fabric filter.

(48) Hydroblasting equipment using exclusively water as the abrasive.

(49) Abrasive blasting cabinets vented to a fabric filter, PROVIDED THAT the total internal volume of the cabinet is ≤100 cubic feet.

(50) Shot peening operations, PROVIDED THAT no surface material is removed.

Cleaning

(51) Solvent cleaning:

(A) Non-refillable, hand-held aerosol spray cans of solvent; or

(B) Closed-loop solvent recovery systems with refrigerated or water-cooled condensers used for recovery of waste solvent generated on-site.

(52) Steam-cleaning equipment.

(53) Unheated liquid solvent tanks used for cleaning or drying parts:

(A) With a solvent capacity ≤10 gallons and containing ≤5% by weight perchloroethylene, methylene chloride, carbon tetra-chloride, chloroform, 1,1,1-trichloroethane, trichloroethylene, or any combination thereof;

(B) Using a solvent with a true vapor pressure ≤0.6 psi containing ≤5% by weight perchloroethylene, methylene chloride, carbon tetrachloride, chloroform, 1,1,1-trichloroethane, trichloro-ethylene, or any combination thereof;

(C) With a remote reservoir and using a solvent containing ≤5% by weight perchloroethylene, methylene chloride, carbon tetra-chloride, chloroform, 1,1,1-trichloroethane, trichloroethylene, or any combination thereof; or

(D) With a solvent capacity ≤2 gallons; or

(E) Using solutions with a Volatile Organic Compound (VOC) content of ≤1% by weight and no identified Hazardous Air Pollutant (HAP), and are heated below the boiling point of the solution.

(54) Hand-wipe cleaning.

Coating, Resin, and Adhesive Application

(55) Powder-coating equipment.

(56) Portable coating equipment and pavement stripers used exclusively for the field application of architectural coatings and industrial maintenance coatings to stationary structures and their appurtenances or to pavements and curbs.

(57) High-volume low-pressure (HVLP) spray-coating equipment having a cup capacity ≤8 fluid ounces, PROVIDED THAT it is not used to coat >9 square feet per day and is not used to coat motor vehicles or aerospace components.

(58) Airbrushes having a cup capacity ≤2 fluid ounces and an airflow of 0.5-2.0 cfm.

(59) Hand-held aerosol spray cans having a capacity of ≤1 quart of coating and hand-held brush and rollers for coating application.

(60) Spray-coating equipment used exclusively for application of automotive undercoating or bed liner materials with a flash point >100º F.

(61) Ovens associated with an exempt coating operation, if any combustion equipment is also exempt.

(62) Ovens associated with a coating operation that are used exclusively to accelerate evaporation, if any combustion equipment is also exempt. (Note: The coating operation is not necessarily exempt.)

(63) Radiation-curing equipment using ultraviolet or electron beam energy to initiate a chemical reaction forming a polymer network in a coating.

(64) Hand lay, brush, and roll-up resins equipment and operations.

(65) Equipment used exclusively for melting or applying of waxes or natural and synthetic resins.

(66) Hot-melt adhesive equipment.

(67) Any adhesive application equipment that exclusively uses materials containing <1% VOC by weight and <0.1% HAP.

(68) Equipment used exclusively for bonding of linings to brake shoes, where no organic solvents are used.

Printing

(69) Retail, sheet-fed, non-heatset offset presses (lithographic or letter-press).

(70) Presses using exclusively UV-curable inks.

(71) Presses using exclusively plastisols.

(72) Presses using exclusively water-based inks (<1.5 lbs VOC per gallon, excluding water, or <10% VOC by volume) and cleaning solvents without VOC.

(73) Presses used exclusively for making proofs.

(74) Electrostatic, ink jet, laser jet, and thermal printing equipment.

(75) Ovens used exclusively for exempt printing presses, if any combustion equipment is also exempt.

Photography

(76) Photographic process equipment by which an image is reproduced upon material sensitized by radiant energy, excluding equipment using perchloroethylene.

Liquid Storage and Transfer

(77) Storage tanks permanently attached to a motor vehicle.

(78) Storage tanks used exclusively for:

(A) Liquefied gases, including any tanks designed to operate in excess of 29.7 psia without emissions;

(B) Asphalt at a facility other than an asphalt roofing plant, asphalt processing plant, hot mix asphalt plants, or petroleum refinery;

(C) *Any* liquids (other than asphalt) that also have a rated capacity ≤1,000 gallons;

(D) Organic liquids (other than gasoline or asphalt) that also have a rated capacity <20,000 gallons;

(E) Organic liquids (other than asphalt) with a true vapor pressure <2.2 psia (e.g., ASTM spec. fuel oils and lubricating oils) that also have a rated capacity <40,000 gallons;

(F) Organic liquids (other than asphalt) with a true vapor pressure <0.5 psia that also have a rated capacity ≥40,000 gallons;

(G) Sulfuric acid or phosphoric acid with an acid strength ≤99% by weight;

(H) Nitric acid with an acid strength ≤70% by weight;

(I) Hydrochloric acid or hydrofluoric acid tanks with an acid strength ≤30% by weight;

(J) Aqueous solutions of sodium hydroxide, sodium hypochlorite, or salts, PROVIDED THAT the surface of the solution contains ≤1% VOC by weight;

(K) Liquid soaps, liquid detergents, vegetable oils, fatty acids, fatty esters, fatty alcohols, waxes, and wax emulsions;

(L) Tallow or edible animal fats intended for human consumption and of sufficient quality to be certifiable for United States markets;

(M) Water emulsion intermediates and products, including latex, with a VOC content ≤5% by volume or a VOC composite partial pressure of ≤0.1 psi at 68ºF; or

(N) Wine, beer, or other alcoholic beverages.

(79) Loading and unloading equipment used exclusively for the storage tanks exempted above.

(80) Loading and unloading equipment used exclusively for transferring liquids or compressed gases into containers having a rated capacity <60 gallons, except equipment transferring >1,000 gallons per day of liquid with a true vapor pressure >0.5 psia.

(81) Equipment used exclusively for the packaging of sodium hypochlorite-based household cleaning or pool products.

Mixing

(82) Mixing equipment, PROVIDED THAT no material in powder form is added and the mixture contains <1% VOC by weight.

(83) Equipment used exclusively for the mixing and blending of materials at ambient temperature to make water-based adhesives.

(84) Equipment used exclusively for the manufacture of water emulsions of waxes, greases, or oils.

(85) Equipment used exclusively for the mixing and packaging of lubricants or greases.

(86) Equipment used exclusively for manufacturing soap or detergent bars, including mixing tanks, roll mills, plodders, cutters, wrappers, where no heating, drying, or chemical reactions occur.

(87) Equipment used exclusively to mill or grind coatings and molding compounds in a paste form, PROVIDED THAT the solution contains <1% VOC by weight.

(88) Batch mixers with a rated working capacity ≤55 gallons.

(89) Batch mixers used exclusively for paints, varnishes, lacquers, enamels, shellacs, printing inks, or sealers, PROVIDED THAT the mixer is equipped with a lid that contacts ≥90% of the rim.

Water Treatment

(90) Oil/water separators, except those at petroleum refineries.

(91) Water cooling towers and water cooling ponds not used for evaporative cooling of process water, or not used for evaporative cooling of water from barometric jets or from barometric condensers, and in which no chromium compounds are contained.

(92) Equipment used exclusively to generate ozone and associated ozone destruction equipment for the treatment of cooling tower water or for water treatment processes.

(93) Municipal sewer systems, including wastewater treatment plants and lagoons, PROVIDED THAT they do not use anaerobic digesters or chlorine sterilization. This exemption does not include sewage sludge incinerators.

(94) Soil and groundwater remediation projects involving <15 pounds per year of benzene or vinyl chloride, <500 pounds per year of perchloroethylene, and <1,000 pounds per year of toxic air contaminants.

Landfills and Composting

(95) Passive aeration of soil, PROVIDED THAT the soil is not being used as a cover material at a landfill.

(96) Closed landfills that do not have an operating, active landfill gas collection system.

(97) Non-commercial composting.

Agriculture, Food, and Drugs

(98) Equipment used in agricultural operations, in the growing of crops, or the raising of fowl or animals.

(99) Insecticide, pesticide, or fertilizer spray equipment.

(100) Equipment used in retail establishments to dry, cook, fry, bake, or grill food for human consumption, including charbroilers, smokehouses, barbecue units, deep fat fryers, cocoa and nut roasters, but not including coffee roasters.

(101) Cooking kettles (other than deep frying equipment) and confection cookers where all the product in the kettle is edible and intended for human consumption.

(102) Bakery ovens with a total production of yeast leavened bread products <10,000 pounds per operating day, if any combustion equipment is also exempt.

(103) Equipment used to dry, mill, grind, blend, or package <1,000 tons per year of dry food products such as seeds, grains, corn, meal, flour, sugar, and starch.

(104) Equipment used to convey, transfer, clean, or separate <1,000 tons per year of dry food products or waste from food production operations.

(105) Storage equipment or facilities containing dry food products that are not vented to the outside atmosphere, or that handle <1,000 tons per year.

(106) Equipment used exclusively to grind, blend, package, or store tea, cocoa, spices, coffee, flavor, fragrance extraction, dried flowers, or spices, PROVIDED THAT no organic solvents are used in the process.

(107) Equipment used to convey or process materials in bakeries or used to produce noodles, macaroni, pasta, food mixes, and drink mixes where products are edible and intended for human consumption, PROVIDED THAT no organic solvents are used in the process. This exemption does not include storage bins located outside buildings.

(108) Brewing operations at facilities producing <3 million gallons per year of beer.

(109) Fermentation tanks for wine (excluding tanks used for the commercial production of yeast for sale).

(110) Equipment used exclusively for tableting, or coating vitamins, herbs, or dietary supplements, PROVIDED THAT no organic solvents are used in the process.

(111) Equipment used exclusively for tableting or packaging pharmaceuticals and cosmetics, or coating pharmaceutical tablets, PROVIDED THAT no organic solvents are used.

Quarries, Nonmetallic Mineral Processing Plants, and Concrete and Asphalt Batch Plants

(112) Portable nonmetallic mineral processing plants.

(113) Fixed nonmetallic mineral processing plants.

(114) (Reserved).

(115) Mixers and other ancillary equipment at concrete batch plants (or aggregate product production facilities) with a rated capacity <15 cubic yards per hour.

(116) Concrete mixers with a rated working capacity of ≤1 cubic yard.

(117) Drilling or blasting (explosives detonation).

(118) Asphaltic concrete crushing/recycling equipment with a throughput <5,000 tons per year.

Construction

(119) Asphalt paving application.

(120) Asphalt (hot-tar) roofing application.

(121) Building construction or demolition, except that notification of demolitions is required under Section 4.03 of Regulation III.

Ventilation and Control Equipment

(122) Comfort air-conditioning systems, or ventilating systems (forced or natural draft), PROVIDED THAT they are not designed or used to control air contaminants generated by, or released from, sources subject to Notice of Construction.

(123) Refrigeration units, except those used as, or in conjunction with, air pollution control equipment.

(124) Refrigerant recovery and/or recycling units, excluding refrigerant reclaiming facilities.

(125) Emergency ventilation systems used exclusively to contain and control emissions resulting from the failure of a compressed gas storage system.

(126) Emergency ventilation systems used exclusively to scrub ammonia from refrigeration systems during process upsets or equipment breakdowns.

(127) Negative air machines equipped with HEPA filters used to control asbestos emissions from demolition/renovation activities.

(128) Portable control equipment used exclusively for storage tank degassing.

(129) Vacuum-cleaning systems used exclusively for industrial, commercial, or residential housekeeping purposes controlled by a fabric filter with an airflow <2,000 cfm.

(130) Control equipment used exclusively for sources that are exempt from Notice of Construction under Section 6.03(c) of this regulation.

(131) Routine maintenance, repair, or similar parts replacement of control equipment.

Testing and Research

(132) Laboratory testing and quality assurance/control testing equipment used exclusively for chemical and physical analysis, teaching, or experimentation, used specifically in achieving the purpose of the analysis, test, or teaching activity. Non-production bench scale research equipment is also included.

Miscellaneous

(133) Single-family and duplex dwellings.

(134) Oxygen, nitrogen, or rare gas extraction and liquefaction equipment, if any combustion equipment used to power such equipment is also exempt.

(135) Equipment, including dryers, used exclusively for dyeing, stripping, or bleaching of textiles where no organic solvents, diluents, or thinners are used, if any combustion equipment used to power such equipment is also exempt.

(136) Chemical vapor sterilization equipment where no ethylene oxide is used, and with a chamber volume of ≤2 cubic feet used by healthcare facilities.

(137) Ozone generators that produce <1 pound per day of ozone.

(138) Fire extinguishing equipment.

(d) Each Notice of Construction application and Section 6.03(b) notification shall be submitted on forms provided by the Agency and shall be accompanied by the appropriate fee as required by Section 6.04 of this regulation. Notice of Construction applications shall also include any additional information required to demonstrate that the requirements of this Article are met. Notice of Construction applications shall also include an environmental checklist or other documents demonstrating compliance with the State Environmental Policy Act.

WSR 12-20-047
PERMANENT RULES
PUGET SOUND CLEAN AIR AGENCY

[Filed September 28, 2012, 4:48 p.m., effective November 1, 2012]

Effective Date of Rule: November 1, 2012.

Purpose: Update the agency's fees for agricultural burning permits to reflect 2012 statewide fee increases made by ecology and the agricultural burning practices and research task force. Our proposed amendments are also deleting the specific language regarding the fee distribution with ecology. It is duplicative of the ecology rule and not relevant to our permitting work with applicants.

Citation of Existing Rules Affected by this Order: Amending Regulation I, Section 8.05.

Statutory Authority for Adoption: Chapter 70.94 RCW.

Adopted under notice filed as WSR 12-17-144 on August 21, 2012.

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: September 27, 2012.

Craig Kenworthy
Executive Director

AMENDATORY SECTION

REGULATION I, SECTION 8.05 AGRICULTURAL BURNING PERMITS

(a) **Applicability.** This section applies to burning permits related to agricultural operations. The definitions and requirements contained in chapter 173-430 WAC also apply to this section; provided that if there is a conflict between this section and chapter 173-430 WAC, this section governs.

(b) **General Requirements.** Agricultural burning will be permitted if the following requirements are met:

(1) The natural vegetation being burned is generated from the property of the commercial agricultural operation; and

(2) Burning is necessary for crop propagation or rotation, disease or pest control; and

(3) Burning is a best management practice as established by the Agricultural Burning Practices and Research Task Force (established in RCW 70.94.6528 as referenced in chapter 173-430 WAC); or the burning practice is approved in writing by the Washington State Cooperative Extension Service or the Washington State Department of Agriculture; or the burning is conducted by a governmental entity with specific agricultural burning needs, such as irrigation districts, drainage districts, and weed control boards; and

(4) The proposed burning will not cause a violation of any Agency regulation.

(c) **Permit Applications.** Agricultural burning permits shall be approved by the Agency prior to burning.

(1) The permit application shall be submitted on forms provided by the Agency and shall include:

(A) A copy of the applicant's most recent year's Schedule F (as filed with the Internal Revenue Service);

(B) A written review by the local fire district or fire marshal indicating their endorsement that local requirements have been met; and

(C) A permit fee as required below:

Burn Type	Minimal Fee	Variable Fee
(i) Field Burning of vegetative residue on an area of land used in an agricultural operation. *(does not include pile burning)*	((~~$30~~)) $37.50 for the first 10 acres. (((~~$15 each for the Agency and Ecology administration.~~)))	((~~$3~~)) $3.75 for each additional acre. (((~~$1.25 each per acre for the Agency and Ecology administration, and $.50 per acre for the research fund.~~)))
(ii) Spot Burning of an unforeseen and unpredicted small area where burning is reasonably necessary and no practical alternative to burning exists.	((~~$30~~)) $37.50 for 10 acres or less. (((~~$15 each for the Agency and Ecology administration.~~)))	None.
(iii) Pile Burning of stacked vegetative residue from an agricultural operation.	$80 for the first ((~~100~~)) 80 tons. (((~~$16 each for the Agency administration and the research fund, and $48 for Ecology administration.~~)))	((~~$.50~~)) $1.00 for each additional ton. (((~~$.10 each per ton for the Agency administration and the research fund, and $.30 per ton for Ecology administration.~~)))

(2) Any refunds of the variable fee portion of a permit fee are issued in accordance with chapter 173-430 WAC.

(d) **Permit Action and Content.**

(1) The Agency will act on a complete application within 7 days of receipt.

(2) All agricultural burning permits shall contain conditions that are necessary to minimize emissions.

(3) All permits shall expire 12 months from date of issuance.

(e) **Permit Denial.** All denials shall become final within 15 days unless the applicant petitions the Control Officer for reconsideration, stating the reasons for reconsideration. The Control Officer shall then consider the petition and shall within 30 days issue a permit or notify the applicant in writing of the reason(s) for denial. (For more information on the appeal process, see Section 3.17 of this regulation.)

WSR 12-20-072

PERMANENT RULES

PROFESSIONAL EDUCATOR STANDARDS BOARD

[Filed October 3, 2012, 8:45 a.m., effective November 3, 2012]

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

Purpose: Technical edits to WAC 181-79A-223. Corrects language consistent with rest of section. Applies requirements across all certificates.

Citation of Existing Rules Affected by this Order: Amending x [WAC 181-79A-223].

Statutory Authority for Adoption: RCW 28A.410.210.

Adopted under notice filed as WSR 12-12-084 on June 6, 2012.

A final cost-benefit analysis is available by contacting David Brenna, 600 Washington Street South, Room 252, Olympia, WA 98504-7236, phone (360) 725-6238, fax (360) 586-4548, e-mail david.brenna@k12.wa.us.

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 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 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 2, 2012.

David Brenna
Senior Policy Analyst

AMENDATORY SECTION (Amending WSR 12-02-024, filed 12/28/11, effective 1/28/12)

WAC 181-79A-223 Academic and experience requirements for certification—School nurse, school occupational therapist, school physical therapist((~~[,] [and]~~)) and school speech-language pathologist or audiologist((~~[, or school social worker]~~)). Candidates for school nurse, school occupational therapist, school physical therapist((~~[,] [and]~~)) and school speech-language pathologist or audiologist((~~[, and school social worker]~~)) certification shall apply directly to the professional education and certification office. Such candidates shall complete the following requirements, in addition to those set forth in WAC 181-79A-150, except state approved college/university professional preparation program((~~: [Provided, That it shall not be necessary for any candidate who holds a master's or doctorate degree to obtain the specified master's degree if the candidate provides satisfactory evidence to the superintendent of public instruction that he or she has completed all course work requirements relevant to the required master's degree and has satisfactorily completed a comprehensive examination required in such master's degree program: Provided, That if any candidate has been awarded a master's degree without a comprehensive examination, the candidate, as a condition for certification, shall successfully complete the Praxis II exam in the appropriate role.]~~)).

(1) School nurse.

(a) Initial.

(i) The candidate shall hold a valid license as a registered nurse (RN) in Washington state.

(ii) The candidate shall hold a baccalaureate degree or higher in nursing from a program accredited by the National League for Nursing Accrediting Commission or the Commission on Collegiate Nursing Education.

(iii) The candidate shall successfully complete thirty clock hours or three quarter hours (two semester hours) of course work approved by the professional educator standards board which will include the following course outcomes in which candidates will:

(A) Demonstrate an understanding of school and special education law;

(B) Understand and demonstrate knowledge of working within the culture of the schools, creating an environment that fosters safety, health, and learning for the students;

(C) Demonstrate knowledge of appropriate resources in the school setting;

(D) Demonstrate knowledge of collaboration with team members which may include parents, teachers, administrators, and others to support learning outcomes for all students;

(E) Demonstrate knowledge of how to support the outcomes for all students through strategies such as scientifically based practices, collaborative teaming, and ethical decision making;

(F) ((~~Recognize ways ESAs can~~)) Use national, state, and local policies, as well as professional standards, to support decision making in educational settings and inform professional growth planning;

(G) Demonstrate an understanding of the use of human, community, and technological resources. Provided, That an individual who meets all other requirements but who has not completed the required course work shall be issued a temporary permit valid for one hundred eighty calendar days which will allow the individual to practice in the role. The candidate shall verify to OSPI the completion of the required course work during the one hundred eighty-day period.

(b) Continuing.

(i) The candidate shall have completed the requirements for the initial certificate as a school nurse and have completed forty-five quarter hours (thirty semester hours) of postbaccalaureate course work in education, nursing, or other health sciences.

(ii) The candidate shall provide documentation of one hundred eighty days of full-time equivalent or more employment in the respective role with an authorized employer—i.e., school district, educational service district, state agency, college or university, private school, or private school system—and at least thirty days of such employment with the same employer.

(2) School occupational therapist.

(a) Initial.

(i) The candidate shall hold a valid license as an occupational therapist in Washington state.

(ii) The candidate shall hold a baccalaureate (or higher) degree from an American Occupational Therapy Association approved program in occupational therapy.

(iii) The candidate shall successfully complete thirty clock hours or three quarter hours (two semester hours) of course work approved by the professional educator standards board which will include the following course outcomes in which candidates will:

(A) Demonstrate an understanding of school and special education law;

(B) Understand and demonstrate knowledge of working within the culture of the schools, creating an environment that fosters safety, health, and learning for the students;

(C) Demonstrate knowledge of appropriate resources in the school setting;

(D) Demonstrate knowledge of collaboration with team members which may include parents, teachers, administrators, and others to support learning outcomes for all students;

(E) Demonstrate knowledge of how to support the outcomes for all students through strategies such as scientifically based practices, collaborative teaming, and ethical decision making;

(F) ((~~Recognize ways ESAs can~~)) Use national, state, and local policies, as well as professional standards, to sup-

port decision making in educational settings and inform professional growth planning;

(G) Demonstrate an understanding of the use of human, community, and technological resources. Provided, That an individual who meets all other requirements but who has not completed the required course work shall be issued a temporary permit valid for one hundred eighty calendar days which will allow the individual to practice in the role. The candidate shall verify to OSPI the completion of the required course work during the one hundred eighty-day period.

(b) Continuing.

(i) The candidate shall have completed the requirements for the initial certificate as a school occupational therapist and have completed at least fifteen quarter hours (ten semester hours) of course work beyond the baccalaureate degree in occupational therapy, other health sciences or education.

(ii) The candidate shall provide documentation of one hundred eighty days of full-time equivalent or more employment in the respective role with an authorized employer—i.e., school district, educational service district, state agency, college or university, private school, or private school system—and at least thirty days of such employment with the same employer.

(3) School physical therapist.

(a) Initial.

(i) The candidate shall hold a valid license as a physical therapist in Washington state.

(ii) The candidate shall hold a baccalaureate (or higher) degree from an American Physical Therapy Association accredited program in physical therapy.

(iii) The candidate shall successfully complete thirty clock hours or three quarter hours (two semester hours) of course work approved by the professional educator standards board which will include the following course outcomes in which candidates will:

(A) Demonstrate an understanding of school and special education law;

(B) Understand and demonstrate knowledge of working within the culture of the schools, creating an environment that fosters safety, health, and learning for the students;

(C) Demonstrate knowledge of appropriate resources in the school setting;

(D) Demonstrate knowledge of collaboration with team members which may include parents, teachers, administrators, and others to support learning outcomes for all students;

(E) Demonstrate knowledge of how to support the outcomes for all students through strategies such as scientifically based practices, collaborative teaming, and ethical decision making;

(F) ((~~Recognize ways ESAs can~~)) Use national, state, and local policies, as well as professional standards, to support decision making in educational settings and inform professional growth planning;

(G) Demonstrate an understanding of the use of human, community, and technological resources. Provided, That an individual who meets all other requirements but who has not completed the required course work shall be issued a temporary permit valid for one hundred eighty calendar days which will allow the individual to practice in the role. The candidate shall verify to OSPI the completion of the required course work during the one hundred eighty-day period.

(b) Continuing.

(i) The candidate shall have completed the requirements for the initial certificate as a school physical therapist and have completed fifteen quarter hours (ten semester hours) of course work beyond the baccalaureate degree in physical therapy, other health sciences or education.

(ii) The candidate shall provide documentation of one hundred eighty days of full-time equivalent or more employment in the respective role with an authorized employer—i.e., school district, educational service district, state agency, college or university, private school, or private school system—and at least thirty days of such employment with the same employer.

(4) School speech-language pathologist or audiologist.

(a) Initial.

(i) The candidate shall have completed all course work (except special project or thesis) for a master's degree from a college or university program accredited by the American Speech and Hearing Association (ASHA) with a major in speech pathology or audiology. Such program shall include satisfactory completion of a written comprehensive examination: Provided, That if any candidate has not completed a written comprehensive examination, the candidate may present verification from ASHA of a passing score on the National Teacher's Examination in speech pathology or audiology as a condition for certification.

(ii) The candidate shall successfully complete thirty clock hours or three quarter hours (two semester hours) of course work approved by the professional educator standards board which will include the following outcomes in which candidates will:

(A) Demonstrate an understanding of school and special education law;

(B) Understand and demonstrate knowledge of working within the culture of the schools, creating an environment that fosters safety, health, and learning for the students;

(C) Demonstrate knowledge of appropriate resources in the school setting;

(D) Demonstrate knowledge of collaboration with team members which may include parents, teachers, administrators, and others to support learning outcomes for all students;

(E) Demonstrate knowledge of how to support the outcomes for all students through strategies such as scientifically based practices, collaborative teaming, and ethical decision making;

(F) ((~~Recognize ways ESAs can~~)) Use national, state, and local policies, as well as professional standards, to support decision making in educational settings and inform professional growth planning;

(G) Demonstrate an understanding of the use of human, community, and technological resources. Provided, That an individual who meets all other requirements but who has not completed the required course work shall be issued a temporary permit valid for one hundred eighty calendar days which will allow the individual to practice in the role. The candidate shall verify to OSPI the completion of the required course work during the one hundred eighty-day period.

(b) Continuing.

(i) The candidate shall hold a master's degree with a major in speech pathology or audiology.

(ii) The candidate shall provide documentation of one hundred eighty days of full-time equivalent or more employment in the respective role with an authorized employer—i.e., school district, educational service district, state agency, college or university, private school, or private school system—and at least thirty days of such employment with the same employer.

((~~[(5) School social worker.~~

~~(a) Initial.~~

~~(i) The candidate shall hold an MSW from a regionally accredited institution of higher learning.~~

~~(ii) The candidate shall successfully complete thirty clock hours or three quarter hours (two semester hours) of course work approved by the professional educator standards board which will include the following course outcomes in which candidates will:~~

~~(A) Demonstrate an understanding of school and special education law;~~

~~(B) Understand and demonstrate knowledge of working within the culture of the schools, creating an environment that fosters safety, health, and learning for the students;~~

~~(C) Demonstrate knowledge of appropriate resources in the school setting;~~

~~(D) Demonstrate knowledge of collaboration with team members which may include parents, teachers, administrators, and others to support learning outcomes for all students;~~

~~(E) Demonstrate knowledge of how to support the outcomes for all students through strategies such as scientifically based practices, collaborative teaming, and ethical decision making;~~

~~(F) Use national, state, and local policies, as well as professional standards, to support decision making in educational settings and inform professional growth planning;~~

~~(G) Demonstrate an understanding of the use of human, community, and technological resources. Provided, That an individual who meets all other requirements but who has not completed the required course work shall be issued a temporary permit valid for one hundred eighty calendar days which will allow the individual to practice in the role. The candidate shall verify to OSPI the completion of the required course work during the one hundred eighty-day period.~~

~~(iii) The candidate shall have a passing score on the Praxis II school social worker examination.~~

~~(b) Continuing.~~

~~(i) The candidate shall have completed the requirements for the initial certificate as a school social worker and have completed a professional growth plan or forty-five quarter hours (thirty semester hours) or four hundred fifty clock hours specific to the role of the school social worker.~~

~~(ii) The candidate shall provide documentation of one hundred eighty days of full-time equivalent or more employment in the respective role with an authorized employer—i.e., school district, educational service district, state agency, college or university, private school, or private school system—and at least thirty days of such employment with the same employer.~~]))