WSR 16-20-003
PERMANENT RULES
UTILITIES AND TRANSPORTATION COMMISSION

[Docket UT-160196, General Order R-587—Filed September 22, 2016, 8:50 a.m., effective October 23, 2016]

Reviser's note: The material contained in this filing exceeded the page-count limitations of WAC 1-21-040 for appearance in this issue of the Register. It will appear in the 16-21 issue of the Register.

WSR 16-20-011
PERMANENT RULES
DEPARTMENT OF REVENUE

[Filed September 23, 2016, 10:32 a.m., effective October 24, 2016]

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

Purpose: Incorporates language from E3SHB 1713, 2016 1st sp. sess., chapter 29, Laws of 2016. This statutory language amends RCW 82.04.4277 concerning the tax deduction for amounts received as compensation for providing chemical dependency services under a government-funded program. The deduction's expiration date is also extended to January 1, 2020.

Citation of Existing Rules Affected by this Order: Amending WAC 458-20-169 Nonprofit organization.

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

Other Authority: RCW 82.04[.]4277.

Adopted under notice filed as WSR 16-14-081 on July 1, 2016.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 1, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.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 23, 2016.

Kevin Dixon
Rules Coordinator

AMENDATORY SECTION (Amending WSR 16-07-047, filed 3/14/16, effective 4/14/16)

WAC 458-20-169 Nonprofit organizations. (1) **Introduction.** Unlike the tax systems of most states and the federal government, Washington's tax system, including its primary business tax, applies to the activities of nonprofit organizations. Washington's business and occupation (B&O) tax is imposed on all entities that generate gross receipts or proceeds, unless there is a specific statutory exemption or deduction. This rule explains how the B&O, retail sales, and use taxes apply to activities often performed by nonprofit organizations. Although some nonprofit organizations may be subject to other taxes (e.g., public utility or insurance premium taxes on income from utility or insurance activities), these taxes are not discussed in this rule. The rule describes the most common B&O, retail sales, and use tax exemptions and deductions that are specifically provided to nonprofit organizations by state law. Other exemptions or deductions not specific to nonprofit organizations may also apply.

(a) **Examples.** This rule contains examples that identify a number of facts and then state a conclusion. These examples should be used only as a general guide. The tax results of other situations must be determined after a review of all facts and circumstances.

(b) **Other rules that may be relevant.** Rules in the following list may contain additional relevant information for nonprofit organizations:

(i) WAC 458-20-167 Educational institutions, school districts, student organizations, and private schools;

(ii) WAC 458-20-168 Hospitals, nursing homes, assisted living facilities, adult family homes and similar health care facilities;

(iii) WAC 458-20-183 Amusement, recreation, and physical fitness services;

(iv) WAC 458-20-249 Artistic or cultural organizations; and

(v) WAC 458-20-256 Trade shows, conventions and seminars.

(2) **Registration requirements.** Nonprofit organizations with $12,000 or more per year in gross receipts from sales, and/or gross income from services subject to the B&O tax, or that are required to collect or pay to the department of revenue (department) retail sales tax or any other tax or fee which the department administers (regardless of the level of annual gross receipts) must register with the department. Nonprofit organizations with less than twelve thousand dollars per year in gross receipts and that are not required to collect retail sales tax or any other tax or fee administered by the department are not required to register with the department. For more information on whether registration with the department is required see WAC 458-20-101.

(3) **Filing excise tax returns.** Nonprofit organizations making retail sales that require the collection of retail sales tax must file an excise tax return, regardless of the annual level of gross receipts or gross income and whether or not any B&O tax is due. For information on when a taxpayer may qualify for a small business B&O tax credit, see WAC 458-20-104. The excise tax return with payment is generally filed on a monthly basis. Under certain conditions the department may authorize taxpayers to file and remit payment on either a quarterly or an annual basis. For information on how reporting frequencies are assigned to taxpayers see WAC 458-20-22801.

Nonprofit organizations that do not have retail sales tax to remit, but are required to register, do not have to file an excise tax return if they meet certain statutory requirements (e.g., annual gross income of less than $28,000) and are

placed on an "active nonreporting" status by the department. For additional information on whether an organization qualifies for the "active nonreporting" status see WAC 458-20-101.

(4) **General tax reporting responsibilities.** While Washington state law provides some tax exemptions and deductions specifically for nonprofit organizations, these organizations otherwise have the same tax-reporting responsibilities as for-profit organizations.

(a) **Business and occupation tax.** Chapter 82.04 RCW imposes a B&O tax on every person with substantial nexus in Washington (see RCW 82.04.067) engaged in business activities within this state, unless the income is specifically exempt or deductible under state law. The B&O tax applies to the value of products, gross proceeds of sales, or gross income of the business, as the case may be. RCW 82.04.220.

(i) **Common B&O tax classifications.** Chapter 82.04 RCW provides a number of classifications that apply to specific activities. The most common B&O tax classifications applying to income received by nonprofit organizations are the retailing, wholesaling, and service and other activities classifications. RCW 82.04.250, 82.04.270, and 82.04.290. If an organization engages in more than one kind of business activity, it must report the gross income from each activity under the appropriate tax classification. RCW 82.04.440(1).

(ii) **Measure of tax.** The most common measures of the B&O tax are "gross proceeds of sales" and "gross income of the business." RCW 82.04.070 and 82.04.080, respectively. These measures include the value proceeding or accruing from the sale of tangible personal property or services rendered without any deduction for the cost of property sold, cost of materials used, labor costs, discounts paid, delivery costs, taxes, losses, or any other expenses.

(b) **Retail sales tax.** A nonprofit organization must collect and remit retail sales tax on all retail sales, unless the sale is specifically exempt by statute. Examples of retail sales tax exemptions that may apply to nonprofit organizations are those for sales of certain food products (see WAC 458-20-244, Food and food ingredients), construction materials purchased by a health or social welfare organization for new construction of alternative housing to be licensed as a family foster home for youth in crisis (see RCW 82.08.02915), and fund-raising activities (see subsection (5)(g) of this rule). New construction includes renovating an existing structure to provide new housing for youth in crisis.

A nonprofit organization must pay retail sales tax when it purchases goods or retail services for its own use as a consumer, unless the purchase is specifically exempt by statute. Items purchased for resale without intervening use are purchases at wholesale and are not subject to the retail sales tax if the seller takes from the buyer a copy of the buyer's reseller permit. The reseller permit documents the wholesale nature of any sale. Reseller permits replaced resale certificates effective January 1, 2010. For additional information on reseller permits see WAC 458-20-102.

(c) **Use tax.** The use tax is imposed on every person, including nonprofit organizations, using tangible personal property within this state as a consumer, unless such use is specifically exempt by statute. The use tax applies only if retail sales tax has not previously been paid on the item. The rate of tax is the same as the sales tax rate that applies at the location where the property is first used.

A common application of the use tax occurs when items are purchased from an out-of-state seller who has no presence in Washington. When the out-of-state seller does not collect Washington's retail sales or use tax, the buyer is statutorily required to remit use tax directly to the department. For more information on use tax and the use of tangible personal property see WAC 458-20-178.

Except for fund-raising, use tax exemptions generally correspond to retail sales tax exemptions. For example, the use tax exemption for construction materials acquired by a health or social welfare organization for new construction of alternative housing for youth in crisis, to be licensed as a family foster home (RCW 82.12.02915) corresponds with the retail sales tax exemption described in subsection (4)(b) of this rule for purchasing these construction materials.

(i) **Use tax exemption for donated items.** RCW 82.12.02595 provides a use tax exemption for personal property donated to a nonprofit charitable organization. This exemption is available for the nonprofit charitable organization and the donor, if the donor did not previously use the personal property as a consumer. It also applies to the use of property by a donor who is incorporating the property into a nonprofit organization's real or personal property for no charge.

The exemption also applies to another person using property originally donated to a charitable nonprofit organization that is subsequently donated or bailed to that person by the charitable nonprofit organization, provided that person uses the property in furtherance of the charitable purpose for which the property was originally donated to the charitable nonprofit organization. For example, a hardware store donates an industrial pressure washer to a nonprofit community center for neighborhood cleanup, the community center bails this washer to people enrolled in its neighborhood improvement group for neighborhood clean-up projects. No use tax is due from any of the participants in these transactions. An example of a gift that would not qualify is when a car is donated to a church for its staff and the church gives that car to its pastor. The pastor must pay use tax on the car because it serves multiple purposes. It serves the church's charitable purpose, but it also acts as compensation to the pastor and is available for the pastor's personal use. The subsequent donation of property from the charity to another person must be solely for a charitable purpose. If the property is donated or bailed to the third party for a charitable purpose in line with the nonprofit organization's charitable activities, generally, no additional proof is required that this was the charitable purpose for which the property was originally donated.

(ii) **Use tax implications with respect to fund-raising activities.** Subsection (5)(g) of this rule explains that a retail sales tax exemption is available for certain fund-raising sales. However, there is usually no comparable use tax exemption provided to the buyer/user of property purchased at these fund-raising sales. While the nonprofit organization is not obligated to collect use tax from the buyer, the organization is encouraged to inform the buyer of the buyer's possible use tax obligation.

(iii) From October 1, 2013, through October 8, 2015, RCW 82.12.225 provided a use tax exemption for the use of any article of personal property, valued at less than ten thousand dollars, purchased or received as a prize in a contest of chance, as defined in RCW 82.04.285, from a nonprofit organization or a library. Effective October 9, 2015, chapter 32, Laws of 2015 3rd Sp. Sess. (ESB 6013), the exemption applies to qualifying personal property valued at less than twelve thousand dollars. This exemption only applies if the gross income from the sale by the nonprofit organization or library is exempt under RCW 82.04.3651. This exemption is scheduled to expire July 1, 2020.

(5) **Exemptions.** The following sources of income are specifically exempt from tax. As such, they should not be included or reported as gross income if the organization is required to file an excise tax return.

(a) **Adult family homes.** RCW 82.04.327 exempts from B&O tax amounts received by licensed adult family homes or adult family homes that are exempt from licensing under rules of the department of social and health services.

(b) **Nonprofit assisted living facilities.** RCW 82.04.-4262 exempts from B&O tax amounts received by a nonprofit assisted living facility licensed under chapter 18.20 RCW for providing room and domiciliary care to residents of the assisted living facility. Nonprofit assisted living facilities were formerly known as "nonprofit boarding homes" in the statute.

(c) **Camp or conference centers.** RCW 82.04.363 and 82.08.830 respectively exempt from B&O tax and retail sales tax amounts received by a nonprofit organization from the sale or furnishing of certain items or services at a camp or conference center conducted on property exempt from the property tax under RCW 84.36.030 (1), (2), or (3). For information about property tax exemptions that may apply see: WAC 458-16-210 (Nonprofit organizations or associations organized and conducted for nonsectarian purposes); WAC 458-16-220 (Church camps); and WAC 458-16-230 (Character building organizations).

Amounts received from the sale of the following items and services are exempt:

(i) Lodging, conference and meeting rooms, camping facilities, parking, and similar licenses to use real property;

(ii) Food and meals;

(iii) Books, tapes, and other products, including electronically transferred items, available exclusively to the participants at the camp, conference, or meeting and not available to the public at large.

(d) **Child care resource and referral services.** RCW 82.04.3395 exempts from B&O tax amounts received by nonprofit organizations for providing child care resource and referral services. Child care resource and referral services do not include child care services provided directly to children.

(e) **Credit and debt services.** RCW 82.04.368 exempts from B&O tax amounts received by nonprofit organizations for providing specialized credit and debt services. These services include:

(i) Presenting individual and community credit education programs including credit and debt counseling;

(ii) Obtaining creditor cooperation allowing a debtor to repay debt in an orderly manner;

(iii) Establishing and administering negotiated repayment programs for debtors; and

(iv) Providing advice or assistance to a debtor with regard to (i), (ii), or (iii) of this subsection.

(f) **Day care provided by churches.** RCW 82.04.339 exempts from B&O tax amounts received by a church for the care of children of any age for periods of less than twenty-four hours, provided the church is exempt from property tax under RCW 84.36.020.

(g) **Fund-raising.** RCW 82.04.3651 and 82.08.02573, respectively, exempt from B&O tax and retail sales tax amounts received from certain fund-raising activities.

These exemptions apply only to the fund-raising income received by the nonprofit organization. For example, commission income received by a nonprofit organization selling books owned by a for-profit entity on a consignment basis is exempt from tax only if the statutory requirements are satisfied. The nonprofit organization is generally responsible for collecting and remitting retail sales tax on the gross proceeds of sales when selling items for another person. For additional information on the taxability of sales by agents, auctioneers and other similar types of sellers see WAC 458-20-159.

(i) **What nonprofit organizations qualify?** Nonprofit organizations that qualify for this exemption are those that are:

(A) A tax-exempt nonprofit organization described by section 501 (c)(3) (educational and charitable), 501 (c)(4) (social welfare), or 501 (c)(10) (fraternal societies operating as lodges) of the Internal Revenue Code; or

(B) A nonprofit organization that would qualify for tax exemption under section 501 (c)(3), (4), or (10) except that it is not organized as a nonprofit corporation; or

(C) A nonprofit organization that does not pay its members, stockholders, officers, directors, or trustees any amounts from its gross income, except as payment for services rendered, does not pay more than reasonable compensation to any person for services rendered, and does not engage in a substantial amount of political activity. Political activity includes, but is not limited to, influencing legislation and participating in any campaign on behalf of any candidate for political office.

(ii) **Qualifying fund-raising activities.** For the purpose of this exemption, "fund-raising activity" means soliciting or accepting contributions of money or other property, or activities involving the anticipated exchange of goods or services for money between the soliciting organization and the organization or person solicited, for furthering the goals of the nonprofit organization.

(A) Money raised by a nonprofit charitable group from its annual telephone fund drive to fund its homeless shelters where nothing is promised in return for a donor's pledge is exempt as fund-raising contributions of money to further the goals of the nonprofit organization.

(B) A nonprofit group organized as a community playhouse has an annual telephone fund drive. The group gives the caller a mug, jacket, dinner, or vacation trip depending on the amount of pledge made over the phone. The community playhouse does not sell or exchange the mugs, jackets, dinners, or trips for cash or property, except during this pledge drive. The money is used to produce the next season's plays.

The money earned from the pledges is exempt from both B&O tax and retail sales tax to the extent these amounts represent an exchange of goods and services for money to further the goals of the nonprofit group. The money earned from the pledges above the value of the goods and services exchanged is exempt as a fund-raising contribution of money to further the goals of the nonprofit organization.

(C) A nonprofit group sells ice cream bars at booths leased during the two-week runs of three county fairs, for a total of six weeks during the year, to fund youth camps maintained by the nonprofit group. The money earned from the booths is exempt from both B&O tax and retail sales tax as a fund-raising exchange of goods for money to further the goals of the nonprofit group.

(iii) **Contributions of money or other property.** The term contributions includes grants, donations, endowments, scholarships, gifts, awards, and any other transfer of money or other property by a donor, provided the donor receives no significant goods, services, or benefits in return for making the gift. For example, an amount received by a nonprofit educational broadcaster from a group that conditions receipt on the nonprofit broadcaster airing its seminars is not a contribution regardless of how the amount paid is titled by the two organizations.

It is not unusual for the person making a gift to require some accountability for how the gift is used as a condition for receiving the gift or future gifts. Such gifts remain exempt, provided the "accountability" required does not result in a direct benefit to the donor (examples of direct benefits to a donor are: Money given for a report on the soil contamination levels of land owned by the donor, medical services provided to the donor or the donor's family, or market research benefiting the donor directly). This "accountability" can take the form of conditions or restrictions on the use of the gift for specific charitable purposes or can take the form of written reports accounting for the use of the gift. Public acknowledgment of a donor for the gift is not a significant service or benefit.

(iv) **Nonqualifying activities.** Fund-raising activity does not include the operation of a regular place of business in which services are provided or sales are made during regular hours such as a bookstore, thrift shop, restaurant, legal or health clinic, or similar business. It also does not include the operation of a regular place of business from which services are provided or performed during regular hours such as the provision of retail, personal, or professional services. A regular place of business and the regular hours of that business depend on the type of business being conducted.

(A) In the example demonstrating that an amount received by a nonprofit broadcaster was not a contribution because services were given in return for the funds, this activity must also be examined to see whether the exchange was for services as part of a fund-raising activity. The broadcaster is in the business of broadcasting programs. It has a regular site for broadcasting programs and broadcasts twenty-four hours every day. Broadcasting is a part of its business activity performed from a regular place of business during regular hours. The money received from the group with the requirement that its seminars be broadcast would not qualify as money received from a fund-raising activity even though the parties viewed the money as a "donation."

(B) A nonprofit organization that makes catalog sales throughout the year with a twenty-four hour telephone line for taking orders has a regular place of business at the location where the sales orders are processed and regular hours of twenty-four hours a day. Catalog sales are not exempt as fund-raising amounts even though the funds are raised for a nonprofit purpose.

(C) A nonprofit group organized as a community playhouse has three plays during the year at a leased theatre. The plays run for a total of six weeks and the group provides concessions at each of the performances. The playhouse has a regular place of business with regular hours for that type of business. The concessions are done at that regular place of business during regular hours. The concessions are not exempt as fund-raising activities even though amounts raised from the concessions may be used to further the nonprofit purpose of that group.

(D) A nonprofit student group, that raises money for scholarships and other educational needs, sets up an espresso stand that is open for two hours every morning during the school year. The espresso stand is a regular place of business with regular hours for that type of business. The money earned from the espresso stand is not exempt, even though the amounts are raised to further the student group's nonprofit purpose.

(v) **Fund-raising sales by libraries.** RCW 82.04.3651 provides that the sale of used books, used videos, used sound recording, or similar used information products in a library is not the operation of a regular place of business, if the proceeds are used solely to support the library. The library must be a free public library supported in whole or in part with money derived from taxes. RCW 27.12.010. In addition to the B&O tax exemption under RCW 82.04.3651, RCW 82.08.02573 provides a comparable retail sales tax exemption for the same sales made by a library.

(h) **Group training homes.** RCW 82.04.385 exempts from B&O tax amounts received from the department of social and health services for operating a nonprofit group training home. The amounts excluded from gross income must be used for the cost of care, maintenance, support, and training of developmentally disabled individuals. As defined in RCW 71A.22.020, a nonprofit group training home is an approved facility equipped, supervised, managed, and operated on a full-time nonprofit basis for the full-time care, treatment, training, and maintenance of individuals with developmental disabilities.

(i) **Sheltered workshops.** RCW 82.04.385 also exempts from B&O tax amounts received by a nonprofit organization for operating a sheltered workshop.

(i) **What is a sheltered workshop?** A sheltered workshop is that part of the nonprofit organization engaged in business activities that are performed primarily to provide evaluation and work adjusted services for a handicapped person or to provide gainful employment or rehabilitation services to a handicapped person. The sheltered workshop can be maintained on or off the premises of the nonprofit organization.

(ii) **What is meant by "gainful employment or rehabilitation services to a handicapped person"?** Gainful employment or rehabilitation services must be an interim step in the rehabilitation process that is provided because the person cannot be readily absorbed into the competitive labor market or because employment opportunities for the person do not exist during that time in the competitive labor market.

"Handicapped," for the purposes of this exemption, means a physical or mental disability that restricts normal achievement, including medically recognized addictions and learning disabilities. However, this term does not include social or economic disadvantages that restrict normal achievement (e.g., prior criminal history or low-income status).

(j) **Student loan services.** RCW 82.04.367 exempts from B&O tax amounts received by nonprofit organizations that are exempt from federal income tax under section 501 (c)(3) of the Internal Revenue Code that:

(i) Are guarantee agencies under the federal guaranteed student loan program or that issue debt to provide or acquire student loans; or

(ii) Provide guarantees for student loans made through programs other than the federal guaranteed student loan program.

(k) **Grants received to fund education programs pertaining to litter control, waste reduction, recycling, and composting.** Effective July 24, 2015, RCW 82.04.755 provides a B&O tax exemption for grants received by a nonprofit organization from the matching fund competitive grant program established in RCW 70.93.180 (1)(b)(ii). This program provides funding for local or statewide education programs designed to help the public with litter control, waste reduction, recycling, and composting of primarily products upon which litter tax is imposed. For information on the state litter tax program, see chapter 82.19 RCW. The requirements for the grants are listed in RCW 70.93.180 (1)(b)(ii). Chapter 15, Laws of 2015 (ESHB 1060).

(6) **B&O tax deduction of payments made to health or social welfare organizations.**

(a) **Compensation from public entities.** RCW 82.04.4297 provides a B&O tax deduction to health or social welfare organizations for amounts received from the United States, any instrumentality of the United States, the state of Washington, or any municipal corporation or political subdivision of the state of Washington as compensation for or to support health or social welfare services, rendered by a health or social welfare organization, as defined in RCW 82.04.431, or by a municipal corporation or political subdivision. These deductible amounts should be included in the gross income reported on the excise tax return, entered on the deduction page, and then deducted on the return when determining the amount of the organization's taxable income. A deduction is not allowed, however, for amounts that are received under an employee benefit plan.

(b) **Mental health services or chemical dependency services under a government-funded program.** RCW 82.04.4277 provides a B&O tax deduction for health or social welfare organizations for amounts received as compensation for providing mental health services or chemical dependency services under a government-funded program.

(i) The following definitions apply to (b) of this subsection unless the context clearly requires otherwise:

(A) "Chemical dependency" has the same meaning as provided in RCW 70.96A.020;

(B) "Health and social welfare organization" has the meaning provided in RCW 82.04.431; and

(C) "Mental health services" and "behavioral health organization" have the meanings provided in RCW 71.24.025.

(ii) The deduction for amounts received as compensation for providing chemical dependency services under a government-funded program is effective April 1, 2016. Regional support networks, which are renamed behavioral health organizations effective April 1, 2016, may also deduct from the measure of tax amounts received from the state of Washington for distribution to health or social welfare organizations eligible to deduct the distribution under RCW 82.04.4277.

(iii) Persons claiming deductions under RCW 82.04.4277 must file an annual report with the department. ((~~See~~)) Refer to RCW 82.32.534 and WAC 458-20-267 for information regarding filing an annual report.

(iv) These deductions are scheduled to expire ((~~August 1, 2016~~)) January 1, 2020.

(c) **Child welfare services.** RCW 82.04.4275 provides a B&O tax deduction for health or social welfare organizations for amounts received as compensation for providing child welfare services under a government-funded program. Persons may also deduct from the measure of tax amounts received from the state of Washington for distribution to health or social welfare organizations eligible to deduct the distribution under RCW 82.04.4275(1).

(d) **What is a health or social welfare organization?** A health or social welfare organization is an organization, including any community action council, providing health or social welfare services as defined in subsection (6)(e) of this rule. To be exempt under RCW 82.04.4297, a corporation must satisfy all of the following conditions:

(i) Be a corporation sole under chapter 24.12 RCW or a domestic or foreign not-for-profit corporation under chapter 24.03 RCW. A corporation providing professional services as authorized under chapter 18.100 RCW does not qualify as a health or social welfare organization;

(ii) Be governed by a board of not less than eight individuals who are not paid corporate employees when the organization is a not-for-profit corporation;

(iii) Not pay any part of its corporate income directly or indirectly to its members, stockholders, officers, directors, or trustees except as executive or officer compensation or as services rendered by the corporation in accordance with its purposes and bylaws to a member, stockholder, officer, or director or as an individual;

(iv) Only pay compensation to corporate officers and executives for actual services rendered. This compensation must be at a level comparable to like public service positions within Washington;

(v) Have irrevocably dedicated its corporate assets to health or social welfare activities. Upon corporate liquidation, dissolution, or abandonment, any distribution or transfer of corporate assets may not inure directly or indirectly to the

benefit of any member or individual, except for another health or social welfare organization;

(vi) Be duly licensed or certified as required by law or regulation;

(vii) Use government payments to provide health or social welfare services;

(viii) Make its services available regardless of race, color, national origin, or ancestry; and

(ix) Provide access to the corporation's books and records to the department's authorized agents upon request.

(e) **Qualifying health or welfare services.** The term "health or social welfare services" includes and is limited to:

(i) Mental health, drug, or alcoholism counseling or treatment;

(ii) Family counseling;

(iii) Health care services;

(iv) Therapeutic, diagnostic, rehabilitative, or restorative services for the care of the sick, aged, physically-disabled, developmentally-disabled, or emotionally-disabled individuals;

(v) Activities, including recreational activities, intended to prevent or ameliorate juvenile delinquency or child abuse;

(vi) Care of orphans or foster children;

(vii) Day care of children;

(viii) Employment development, training, and placement;

(ix) Legal services to the indigent;

(x) Weatherization assistance or minor home repairs for low-income homeowners or renters;

(xi) Assistance to low-income homeowners and renters to offset the cost of home heating energy, through direct benefits to eligible households or to fuel vendors on behalf of eligible households; and

(xii) Community services to low-income individuals, families and groups that are designed to have a measurable and potentially major impact on causes of poverty in communities of the state of Washington; and

(xiii) Temporary medical housing, as defined in RCW 82.08.997, if the housing is provided only:

(A) While the patient is receiving medical treatment at a hospital required to be licensed under RCW 70.41.090 or at an outpatient clinic associated with such hospital, including any period of recuperation or observation immediately following such medical treatment; and

(B) By a person that does not furnish lodging or related services to the general public.

WSR 16-20-016
PERMANENT RULES
DEPARTMENT OF REVENUE

[Filed September 26, 2016, 8:51 a.m., effective October 27, 2016]

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

Purpose: The department revised WAC 458-61A-208 to:

- Reflect a 2015 Washington state court of appeals decision holding that a sale by a receiver in a receivership proceeding did not qualify for an exemption from real estate excise tax as a sale made "upon execution of a judgment" under RCW 82.45.010 (3)(j);
- Remove an example that made it seem like all court-ordered sales were exempt from REET, which is an exemption not provided in the RCW;
- Amend an example where we provided that tax due on a deed in lieu of forfeiture transfer was subject to REET on the outstanding balance of the debt plus additional consideration, when the REET is only due on the additional consideration.

Citation of Existing Rules Affected by this Order: Amending WAC 458-61A-208 Foreclosure—Deeds in lieu of foreclosure—Sales pursuant to court order.

Statutory Authority for Adoption: RCW 82.45.150, 82.32.300, 82.01.060(2).

Adopted under notice filed as WSR 16-16-113 on August 2, 2016.

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.

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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 26, 2016.

Kevin Dixon
Rules Coordinator

AMENDATORY SECTION (Amending WSR 14-09-053, filed 4/15/14, effective 5/16/14)

WAC 458-61A-208 ((~~Foreclosure—~~))Transfers pursuant to deeds of trust, foreclosure proceedings, executions of a judgment, deeds in lieu of foreclosure((~~—Sales pursuant to court order~~)), and contract forfeiture. (1) **Introduction.** The real estate excise tax does not apply to any transfer or conveyance made pursuant to:

(a) A deed of trust in a foreclosure proceeding;

(b) An order of sale by a court in any mortgage, deed of trust, or lien foreclosure proceeding ((~~or upon~~));

(c) An execution of a judgment as provided in chapters 6.17 and 6.21 RCW;

(d) A deed in lieu of foreclosure to satisfy a mortgage or deed of trust; or

(e) A cancellation or forfeiture of a vendee's interest in a contract for the sale of real property.

(2) **Examples.** This rule contains examples that, while not exhaustive, illustrate some of the circumstances in which a transfer may or may not qualify for this exemption. These examples should be used only as a general guide. The taxabil-

ity of each transaction must be determined after a review of all the facts and circumstances.

(3) **Deed of trust.** The real estate excise tax does not apply to the foreclosure sale of real property by the trustee under the terms of a deed of trust, whether to the beneficiary listed on that deed or to a third party.

(4) **Court-ordered sale in a foreclosure proceeding.**

(a) **Application to foreclosure proceedings only.** The real estate excise tax does not apply to an order or sale by a court in any mortgage, deed of trust, or lien foreclosure proceeding. RCW 82.45.010 (3)(j). This exemption does not apply to court-ordered sales in proceedings other than a mortgage, deed of trust, or lien foreclosure proceeding (such as a sale negotiated in a receivership proceeding; see subsection (5)(c) of this section) (generally, any type of negotiated sale is taxable unless an exemption applies, and the exemption here does not apply to negotiated sales outside of mortgage, deed of trust, or lien foreclosure proceedings).

(b) **Reporting requirements**. Real estate excise tax affidavits which state claims for this tax exemption must cite the cause number of the foreclosure proceeding on the affidavit and the transfer document. In order to claim this exemption, a copy of the court decision must be available and provided to the county treasurer or the department ((~~upon~~)) on request.

(((~~(2) **Examples.** The following examples, while not exhaustive, illustrate some of the circumstances in which a transfer may or may not qualify for this exemption. These examples should be used only as a general guide. The taxability of each transaction must be determined after a review of all the facts and circumstances.~~

~~(a)~~)) (c) **Examples.**

Example 1. Joan and Sam are friends. They decide to jointly purchase real property worth $100,000 as tenants in common. One year later, they decide to end their co-ownership of the property. Joan and Sam cannot agree on how the property should be divided. They both obtain legal counsel and go to court to resolve the issue. The court orders that Sam will deed his interest in the real property to Joan and Sam will be paid $65,000 for his interest in the property. ((~~No~~)) Real estate excise tax is due on the transfer ((~~since~~)) because the transfer ((~~is pursuant to a court ordered sale.~~

~~(b)~~)), while ordered by the court, is not ordered by the court in a mortgage, deed of trust, or lien foreclosure proceeding.

Example 2. Rather than ((~~going to trial~~)) end their co-ownership, Joan and Sam agree to ((~~a settlement during the course of their negotiations. The attorneys draft an agreeable settlement under which Sam will get the property and Joan will be paid $75,000. The settlement agreement is presented to the court and the judge signs off on the agreement. Tax is due on the transfer because this is not a court ordered sale.~~

~~(3) **Foreclosure and contract forfeiture.**~~)) continue owning the property. After a few years, however, Joan and Sam fail to make payments on their mortgage and their lender forecloses. The court orders a sale of the property in a mortgage foreclosure proceeding. Real estate excise tax is not due on the transfer.

(5) **Execution of a judgment.**

(a) **Sheriff's sale.** The real estate excise tax does not apply to a transfer of real property made upon execution of a judgment under chapters 6.17 (dealing with executions of a judgment) and 6.21 RCW (dealing with sales made due to an execution of a judgment, known generally as sheriff's sales), which refers to a writ of execution by the court ordering a sale of real property by a county sheriff. A real estate excise tax affidavit must be filed with the county, and a copy of the writ of execution must be available and provided to the county treasurer or department on request.

(b) The real estate excise tax applies to a subsequent sale or assignment of the right of redemption and the certificate of purchase that result from the sheriff's sale. The taxable consideration includes any payment given or promised to be given. It also includes the amount of underlying encumbrance, the payment of which is necessary for the exercise of the right of redemption.

(c) **Receivers.** The real estate excise tax applies to a sale by a receiver appointed by a court to give effect to the court's judgment under RCW 7.60.025 (dealing with the appointment of receivers).

(d) **Examples.**

Example 3. Bill sells property to Sam on a contract. After one year, Sam stops making payments on the contract. Bill obtains a judgment against Sam for nonpayment, and the court issues a writ of execution to enforce the judgment. At the Sheriff's sale, Bill obtains a certificate of purchase. Sam obtains the right of redemption. Sam is unable to make payment to redeem the right of redemption during the redemption period. When the redemption period is over, Bill turns the certificate of purchase over to the Sheriff. The Sheriff issues a Sheriff's deed to Bill. No real estate tax is due on the issuance of the Sheriff's deed to Bill.

Example 4. Alternatively, at the Sheriff's sale, Bill obtains a certificate of purchase. Sam obtains the right of redemption. To exercise the right of redemption, the holder must remit $50,000 to the Sheriff. Sam sells the right of redemption to Jerry for $10,000. Real estate excise tax is due on $60,000 for the transfer of the right of redemption from Sam to Jerry. Jerry exercises the right of redemption by paying $50,000 to the Sheriff. The Sheriff issues a Sheriff's deed to Jerry. No real estate tax is due on the issuance of the Sheriff's deed to Jerry. Two affidavits should be completed and filed together: One for the taxable transfer between Sam and Jerry for the right of redemption with tax paid, and a second one claiming the exemption from the Sheriff's sale to Jerry when the deed is presented.

(6) **Deed in lieu of foreclosure.** The real estate excise tax does not apply to the following transfers where no additional consideration passes:

(a) A transfer by deed in lieu of foreclosure to satisfy a mortgage or deed of trust; or

(b) A transfer from a contract purchaser to the contract holder in lieu of forfeiture of a contract of sale upon default of the underlying obligation((~~; or~~)).

(c) **Examples.**

Example 5. Sally sells real property to Frank. Frank obtains a $150,000 loan from Easy Bank. The bank secures the loan with a deed of trust on the real property. Frank is unable to make the payments on the loan. Frank transfers the property back to Easy Bank by deed in lieu of foreclosure to

satisfy the deed of trust. No real estate excise tax is due on the transfer.

Example 6. Mel sells real property to George. George obtains a $100,000 loan from Zephyr Bank. The bank secures the loan with a deed of trust on the real property. George is unable to make the payments on the loan. George obtains a second loan of $25,000 from Sam. Sam secures his loan with a second deed of trust on the real property. Sam's deed of trust is in junior position to Zephyr Bank's deed of trust. Later, George can't make payments to either the bank or Sam. At this time, George owes the bank $95,000 and Sam $23,000. George transfers the real property to Sam by deed in lieu of foreclosure to satisfy Sam's junior deed of trust. The debt to Zephyr Bank (the senior position debt) remains unpaid on the property at the time of transfer. The transfer is partially exempt and partially taxable. The deed in lieu of the junior position debt is exempt. The senior position debt to the bank that remains outstanding on the property at the time of the transfer meets the definition of consideration and is subject to tax. Tax would be due on $95,000.

Example 7. Joe purchases a manufactured home and has it installed in a mobile home park. Joe signs a contract with the mobile home park owner to pay $300 in monthly rent. If the rent is not paid, the contract states that the park owner has a lien against the manufactured home. Joe is injured and moves in with relatives in another state. Joe does not pay rent for six months. The park owner takes title to the mobile home under the authority of the rent contract, and puts it up for sale to recover his interest for back rent. The park owner sells the manufactured home to Mimi. No tax is due on the transfer to the park owner, since that transfer was to satisfy a lien on the property. Real estate excise tax is due on the sale to Mimi.

(7) **Contract forfeiture.** The real estate excise tax does not apply where no additional consideration passes in a transfer occurring through the cancellation or forfeiture of a vendee's interest in a contract for the sale of real property, regardless of whether the contract contains a forfeiture clause, such as a declaration of forfeiture made under the provisions of RCW 61.30.070.

(((~~(d) **Examples.** The following examples, while not exhaustive, illustrate some of the circumstances in which a transfer may or may not qualify for this exemption. These examples should be used only as a general guide. The taxability of each transaction must be determined after a review of all the facts and circumstances.~~

~~(i) Meg sells real property to Julie on a real estate contract. The contract price is $65,000. Julie makes payments for one year and then loses her job and can't make payments on the contract. Julie feels that she has some equity in the property, but she and Meg disagree on how to resolve the issue. Eventually, they come to an agreement. Meg will pay Julie $1,500; Julie will sign a deed in lieu of forfeiture and transfer the property to Meg. At the time of the deed in lieu of forfeiture, the outstanding balance of the contract was $61,000. Even though the transfer was by a deed in lieu of forfeiture, there is additional consideration passing (the $1,500). The transfer is subject to tax. The taxable selling price is $62,500, which is the total of the outstanding contract balance that was canceled plus the $1,500 paid to Julie.~~

~~(ii) Sally sells real property to Frank. Frank obtains a $150,000 loan from Easy Bank. The bank secures the loan with a deed of trust on the real property. Frank is unable to make the payments on the loan. Frank transfers the property back to Easy Bank by deed in lieu of foreclosure to satisfy the deed of trust. No real estate excise tax is due on the transfer.~~

~~(iii) Mel sells real property to George. George obtains a $100,000 loan from Zephyr Bank. The bank secures the loan with a deed of trust on the real property. George is unable to make the payments on the loan. George obtains a second loan of $25,000 from Sam. Sam secures his loan with a second deed of trust on the real property. Sam's deed of trust is in junior position to Zephyr Bank's deed of trust. Later, George can't make payments to either the bank or Sam. At this time, George owes the Bank $95,000 and Sam $23,000. George transfers the real property to Sam by deed in lieu of foreclosure to satisfy Sam's junior deed of trust. The debt to Zephyr Bank (the senior position debt) remains unpaid on the property at the time of transfer. The transfer is partially exempt and partially taxable. The deed in lieu of the junior position debt is exempt. The senior position debt to the bank that remains outstanding on the property at the time of the transfer meets the definition of consideration and is subject to tax. Tax would be due on $95,000.~~

~~(iv) Joe purchases a manufactured home and has it installed in a mobile home park. Joe signs a contract with the mobile home park owner to pay $300 in monthly rent. If the rent is not paid, the contract states that the park owner has a lien against the manufactured home. Joe is injured and moves in with relatives in another state. Joe does not pay rent for six months. The park owner, takes title to the mobile home under the authority of the rent contract, and puts it up for sale to recover his interest for back rent. The park owner sells the manufactured home to Mimi. No tax is due on the transfer to the park owner, since that transfer was to satisfy a lien on the property. Real estate excise tax is due on the sale to Mimi.~~

~~(4) **Deed of trust.** The real estate excise tax does not apply to the foreclosure sale of real property by the trustee under the terms of a deed of trust, whether to the beneficiary listed on that deed or to a third party.~~

~~(5)~~))) **Example 8.** Meg sells real property to Julie on a real estate contract. The contract price is $65,000. Julie makes payments for one year and then loses her job and can't make payments on the contract. Julie feels that she has $1,500 in equity in the property. They agree that Meg will pay Julie $1,500 for her equity in the property and Julie will sign a deed in lieu of forfeiture and transfer the property to Meg. At the time of the deed in lieu of forfeiture, the outstanding balance of the contract was $61,000. Even though the transfer was by a deed in lieu of forfeiture, there is additional consideration passing (the $1,500). The transfer is subject to tax on the additional consideration of $1,500.

(8) **Assignment of indebtedness.** A transfer from a servicing agent, who has acquired real property under this section, to the actual owner of the indebtedness that was foreclosed upon is not subject to real estate excise tax. In order to claim this exemption, a copy of the assignment of the indebtedness or a copy of the trustee's deed identifying the servicing agent as an agent for the actual owner must be available and

provided to the county treasurer or the department ((~~upon~~)) on request.

((~~For example,~~)) **Example 9.** Gil sells real property to Max. Max obtains a $125,000 loan from Zone Finance. The finance company secures the loan with a deed of trust on real property. Zone Finance sells the loan to Federal National Mortgage Association (Fannie Mae). The finance company becomes the servicing agent for the loan. Max can't make payments on the loan. Due to nonpayment on the debt, the Trustee (under the authority of the Deed of Trust) conducts a Trustee's sale of the real property. The Trustee transfers the property to the Zone Finance via a Trustee's Deed. No real estate excise tax is due on that transfer. Zone Finance Company transfers real property to Fannie Mae, the actual owner of the debt. No real estate excise tax is due on that transfer.

(((~~(6) **Sheriff's sale.**~~

~~(a) **Introduction.** The real estate excise tax does not apply to a transfer of real property made by a county sheriff pursuant to a court decree. A real estate excise tax affidavit must be filed with the county.~~

~~(b) The real estate excise tax applies to a subsequent sale or assignment of the right of redemption and the certificate of purchase that result from the sheriff's sale. The taxable consideration includes any payment given or promised to be given. It also includes the amount of underlying encumbrance, the payment of which is necessary for the exercise of the right of redemption.~~

~~(c) **Examples.**~~

~~(i) Bill sells property to Sam on a contract. After one year, Sam stops making payments on the contract. Bill obtains a judgment against Sam for nonpayment. At the Sheriff's sale, Bill obtains a certificate of purchase. Sam obtains the right of redemption. Sam is unable to make payment to redeem the right of redemption during the redemption period. When the redemption period is over, Bill turns the certificate of purchase over to the Sheriff. The Sheriff issues a Sheriff's Deed to Bill. No real estate tax is due on the issuance of the Sheriff's deed to Bill.~~

~~(ii) Alternatively, at the Sheriff's sale, Bill obtains a certificate of purchase. Sam obtains the right of redemption. To exercise the right of redemption, the holder must remit $50,000 to the Sheriff. Sam sells the right of redemption to Jerry for $10,000. Real estate excise tax is due on $60,000 for the transfer of the right of redemption from Sam to Jerry. Jerry exercises the right of redemption by paying $50,000 to the Sheriff. The Sheriff issues a Sheriff's Deed to Jerry. No real estate tax is due on the issuance of the Sheriff's deed to Jerry.~~

~~(7)~~)) (9) **Documentation.** In addition to the documentation requirements set forth in subsections (1) and (((~~(5)~~)) (8) of this ((~~section~~)) rule, a copy of the recorded original mortgage, deed of trust, contract of sale, or lien document must be available and provided to the county treasurer or the department ((~~upon~~)) on request.

WSR 16-20-017
PERMANENT RULES
OLYMPIC REGION CLEAN AIR AGENCY

[Filed September 26, 2016, 9:19 a.m., effective October 27, 2016]

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

Purpose: Adoption of the federal air regulations allows Olympic Region Clean Air Agency (ORCAA) to directly enforce these regulations. It will also allow ORCAA to seek delegation from the United States Environmental Protection Agency (EPA) to enforce the federal air regulations on behalf of EPA which lessens the reporting burden on businesses within our jurisdiction.

Citation of Existing Rules Affected by this Order: Repealing ORCAA Regulations Rule 8.16; and amending ORCAA Regulations Rule 6.1, Rule 6.1.1, Rule 8.14, Rule 8.15.

Statutory Authority for Adoption: Chapter 70.94 RCW.

Adopted under notice filed as WSR 16-15-085 on July 19, 2016.

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 14, 2016.

Francea L. McNair
Executive Director

Reviser's note: The material contained in this filing exceeded the page-count limitations of WAC 1-21-040 for appearance in this issue of the Register. It will appear in the 16-21 issue of the Register.

WSR 16-20-020
PERMANENT RULES
OLYMPIC REGION CLEAN AIR AGENCY

[Filed September 26, 2016, 12:47 p.m., effective October 29, 2016]

Effective Date of Rule: October 29, 2016.

Purpose: This revision will better align our rule with rules of other state and local agencies. This will ease some of the frustration of companies that operate within differing jurisdictions.

Citation of Existing Rules Affected by this Order: Amending ORCAA Regulations Rule 6.3.

Statutory Authority for Adoption: Chapter 70.94 RCW.

Adopted under notice filed as WSR 16-15-066 on July 18, 2016.

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 14, 2016.

Francea L. McNair
Executive Director

Reviser's note: The material contained in this filing exceeded the page-count limitations of WAC 1-21-040 for appearance in this issue of the Register. It will appear in the 16-21 issue of the Register.

WSR 16-20-022
PERMANENT RULES
DEPARTMENT OF HEALTH

[Filed September 27, 2016, 9:50 a.m., effective October 28, 2016]

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

Purpose: Chapter 246-70 WAC, Marijuana product compliance; creating a new chapter establishing rules to implement RCW 69.50.375 regarding marijuana products beneficial for medical use by qualifying patients. This includes product types, quality assurance testing (pesticides, mycotoxins, heavy metals, terpenes), product labeling, employing [employee] training, and safe handling. This filing replaces emergency rules filed on September 12, 2016, WSR 16-19-023.

Statutory Authority for Adoption: RCW 69.50.375.

Other Authority: RCW 80.08.9998.

Adopted under notice filed as WSR 16-12-058 on May 26, 2016.

Changes Other than Editing from Proposed to Adopted Version: WAC 246-70-030, added definitions of "tablet" and "intermediate products," and amended the definition of "lot" to ensure weight limits are consistent with the liquor and cannabis board regulations. WAC 246-70-040(2), added tablets to the list of acceptable high THC compliant products. WAC 246-70-050(1), amended to allow product testing at harvest or when a concentrate is created.

A final cost-benefit analysis is available by contacting Susan Reynolds, Washington State Department of Health, P.O. Box 47852, Olympia, WA 98504-7852, phone (360) 236-2820, fax (360) 236-2901, e-mail medicalmarijuana@doh.wa.gov.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 9, 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 9, Amended 0, Repealed 0.

Date Adopted: September 27, 2016.

John Wiesman, DrPH, MPH
Secretary

Chapter 246-70 WAC

MARIJUANA PRODUCT COMPLIANCE

NEW SECTION

WAC 246-70-010 Findings. Anecdotal and limited scientific evidence indicates that the use of marijuana may be beneficial to alleviate the symptoms of certain physical and mental conditions. However, due to the current federal classification of marijuana as a schedule 1 controlled substance, scientific research has not been performed that would allow for standardized indications of particular strains, which can vary radically in cannabinoid composition; standard, reproducible formula or dosage; or accepted standards for drug purity, potency and quality for the various conditions for which the medical use of marijuana may be authorized. At this time, the decision of what marijuana products may be beneficial is best made by patients in consultation with their health care practitioners. For this reason, the department will not limit the types of products available to qualifying patients. Instead, the department intends to create standards for products that any consumer can rely upon to be reasonably safe and meet quality assurance measures.

NEW SECTION

WAC 246-70-020 Applicability of WSLCB rules. The requirements in this chapter are in addition to all WSLCB requirements in chapter 314-55 WAC. They are intended to build upon all other requirements for licensed marijuana producers, processors and retailers, and certified third-party labs.

NEW SECTION

WAC 246-70-030 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Allowed pesticide" means a pesticide registered by the Washington state department of agriculture under chapter

15.58 RCW as allowed for use in the production, processing, and handling of marijuana.

(2) "Batch" means a quantity of marijuana-infused product containing material from one or more lots of marijuana.

(3) "CBD concentration" means the percent of cannabidiol content per dry weight of any part of the plant *Cannabis*, or per volume or weight of marijuana product.

(4) "Certified third-party testing lab" means a laboratory certified by the WSLCB or its vendor under WAC 314-55-102.

(5) "Data base" means the medical marijuana authorization data base created pursuant to RCW 69.51A.230.

(6) "Department" means the Washington state department of health.

(7) "Designated provider" has the same meaning as RCW 69.51A.010(4).

(8) "Harvest" means the marijuana plant material derived from plants of the same strain that were brought into cultivation at the same time, grown in the same manner and physical space, and gathered at the same time.

(9) "Imported cannabinoid" means any cannabinoid derived of the plant *Cannabis* with a THC concentration 0.3 percent or less that is not produced by a licensed marijuana producer.

(10) "Intermediate product" means marijuana flower lots or other material lots that have been converted by a marijuana processor to a marijuana concentrate or marijuana-infused product that must be further processed prior to retail sale.

(11) "Lot" means either of the following:

(a) The flowers from one or more marijuana plant(s) of the same strain. A single lot of flowers cannot weigh more than allowed by the WSLCB in chapter 314-55 WAC; or

(b) The trim, leaves, or other plant matter from one or more marijuana plant(s). A single lot of trim, leaves, or other plant matter cannot weigh more than allowed by the WSLCB in chapter 314-55 WAC.

(12) "Marijuana" means all parts of the plant *Cannabis*, whether growing or not, with a THC concentration greater than 0.3 percent on a dry weight basis; the seeds thereof; the resin extracted from any part of the plant; and every compound, manufacture, salt, derivative, mixture, or preparation of the plant, its seeds or resin. The term does not include the mature stalks of the plant, fiber produced from the stalks, oil or cake made from the seeds of the plant, any other compound, manufacture, salt, derivative, mixture, or preparation of the mature stalks (except the resin extracted therefrom), fiber, oil, or cake, or the sterilized seed of the plant which is incapable of germination.

(13) "Marijuana concentrates" or "concentrates" means products consisting wholly or in part of the resin extracted from any part of the plant *Cannabis* and having a THC concentration greater than ten percent.

(14) "Marijuana-infused products" means products that contain marijuana or marijuana extracts, are intended for human use, are derived from marijuana as defined in subsection (11) of this section, and have a THC concentration no greater than ten percent. The term "marijuana-infused products" does not include either usable marijuana or marijuana concentrates.

(15) "Marijuana processor" means a person licensed by the WSLCB under RCW 69.50.325 to process marijuana into marijuana concentrates, usable marijuana and marijuana-infused products, package and label marijuana concentrates, usable marijuana and marijuana-infused products for sale in retail outlets, and sell marijuana concentrates, usable marijuana and marijuana-infused products at wholesale to marijuana retailers.

(16) "Marijuana producer" means a person licensed by the WSLCB under RCW 69.50.325 to produce and sell marijuana at wholesale to marijuana processors and other marijuana producers.

(17) "Marijuana product" means marijuana, marijuana concentrates, usable marijuana, and marijuana-infused products as defined in this section.

(18) "Medical use of marijuana" has the same meaning as RCW 69.51A.010(16).

(19) "Plant" means a marijuana plant.

(20) "Production" includes the manufacturing, planting, cultivating, growing, or harvesting of marijuana.

(21) "Qualifying patient" or "patient" has the same meaning as RCW 69.51A.010(19).

(22) "Pesticide" means, but is not limited to: (a) Any substance or mixture of substances intended to prevent, destroy, control, repel, or mitigate any insect, rodent, snail, slug, fungus, weed, and any other form of plant or animal life or virus, except virus on or in a living person or other animal which is normally considered to be a pest; (b) any substance or mixture of substances intended to be used as a plant regulator, defoliant, or desiccant; and (c) any spray adjuvant. Pesticides include substances commonly referred to as herbicides, fungicides, insecticides, and cloning agents.

(23) "Recognition card" means a card issued to qualifying patients and designated providers by a marijuana retailer with a medical marijuana endorsement that has entered them into the medical marijuana data base.

(24) "Retail outlet" means a location licensed by the WSLCB under RCW 69.50.325 for the retail sale of usable marijuana and marijuana-infused products.

(25) "Retail outlet with a medical marijuana endorsement" means a location licensed by the WSLCB under RCW 69.50.325 for the retail sale of marijuana products to the public and, under RCW 69.50.375, to qualifying patients and designated providers for medical use.

(26) "Secretary" means the secretary of the department of health or the secretary's designee.

(27) "Tablet" means a solid preparation containing a single serving of THC. Tablets must not be formulated to be chewable, dispersible, effervescent, orally disintegrating, used as a suspension, or otherwise consumed in a manner other than swallowed whole. Tablets must not contain any added natural or artificial flavor or sweetener.

(28) "THC concentration" means the percent of Delta 9 tetrahydrocannabinol content per dry weight of any part of the plant *Cannabis*, or per volume or weight of marijuana product, or the combined percent of Delta 9 tetrahydrocannabinol and tetrahydrocannabinolic acid in any part of the plant *Cannabis* regardless of moisture content.

(29) "Tincture" means a solution containing marijuana extract. A single unit of tincture cannot exceed two fluid ounces.

(30) "Topical product" means a product intended for use only as an application to human body surfaces, does not cross the blood-brain barrier, and is not meant to be ingested by humans or animals.

(31) "Unit" means an individually packaged marijuana product containing up to ten servings or applications.

(32) "Usable marijuana" means dried marijuana flowers. The term "usable marijuana" does not include either marijuana-infused products or marijuana concentrates.

(33) "WSLCB" means the Washington state liquor and cannabis board.

NEW SECTION

WAC 246-70-040 Marijuana products compliant with this chapter. To be classified as a compliant marijuana product, the product must meet all requirements of this chapter. Compliant marijuana products must fall into one of the following classifications:

(1) General use.

(a) "General use compliant product" means any marijuana product approved by the WSLCB and meeting the requirements of this chapter including edible marijuana-infused products and marijuana products with CBD/THC ratios that do not qualify as "high CBD compliant products" under subsection (3) of this section.

(b) General use marijuana-infused compliant products may be packaged in servings or applications containing up to ten milligrams of active THC. A unit must not contain more than ten servings or applications and must not exceed one hundred total milligrams of active THC.

(c) General use compliant products must be labeled "Chapter 246-70 WAC, Compliant - General Use" and must use the logo found in WAC 246-70-090 to indicate compliance with this chapter.

(d) General use compliant products may be purchased by any adult age twenty-one or older, and qualifying patients between the ages of eighteen and twenty who are entered into the data base and hold a valid recognition card.

(e) General use compliant products may be sold at retail outlets and retail outlets with a medical marijuana endorsement.

(2) High THC.

(a) "High THC compliant product" means a marijuana product containing more than ten but no more than fifty milligrams of THC per serving or application and meeting the requirements of this chapter.

(b) The following is an exclusive list of marijuana products that may qualify for classification as a high THC compliant product:

(i) Capsules and tablets;

(ii) Tinctures;

(iii) Transdermal patches; and

(iv) Suppositories.

(c) No other marijuana products can be classified as a high THC compliant product or contain more than ten milligrams of active THC per serving or application.

(d) High THC compliant products may be packaged in servings or applications containing up to fifty milligrams of active THC. A unit must not contain more than ten servings or applications and must not exceed five hundred total milligrams of active THC.

(e) High THC compliant products must be labeled "Chapter 246-70 WAC Compliant - High THC" and must use the logo found in WAC 246-70-090 to indicate compliance with this chapter.

(f) High THC compliant products may be purchased only by qualifying patients age eighteen and older and designated providers who are entered into the data base and hold a valid recognition card.

(g) High THC compliant products may be sold only at retail outlets with a medical marijuana endorsement.

(3) High CBD.

(a) "High CBD compliant product" means any marijuana product, except usable marijuana or other plant material intended for smoking, allowed by the WSLCB, including edibles, meeting the requirements of this chapter and containing the following ratios:

(i) Marijuana extracts containing not more than two percent THC concentration and at least twenty-five times more CBD concentration by weight.

(ii) Marijuana-infused edible products containing not more than two milligrams of active THC and at least five times more CBD per serving by weight for solids or volume for liquids.

(iii) Marijuana-infused topical products containing at least five times more CBD concentration than THC concentration.

(b) High CBD compliant products must be labeled "Chapter 246-70 WAC Compliant - High CBD" and must use the logo found in WAC 246-70-090 to indicate compliance with this chapter.

(c) High CBD compliant products may be purchased by any adult age twenty-one or older, and qualifying patients between the ages of eighteen and twenty who are entered into the data base and hold a valid recognition card.

(d) High CBD compliant products may be sold at retail outlets and retail outlets with a medical marijuana endorsement.

NEW SECTION

WAC 246-70-050 Quality assurance testing. (1) Testing interval and sample size.

(a) The testing requirements of this section are in addition to the tests required under WAC 314-55-102 and shall be performed by a third-party testing lab certified by the WSLCB.

(b) Pesticide screening and heavy metal screening are required at the following time(s):

(i) For all marijuana flowers, trim, leaves, or other plant matter, intended for retail sale without extraction, at the time of harvest or when placed into lots.

(ii) For all products intended for retail sale as concentrates, extracts, or for use as an intermediate product, screening is required only after extraction and is not required according to (b)(i) of this subsection.

(iii) An imported cannabinoid must be screened prior to addition to any marijuana product.

(c) Minimum sample size for pesticide screening and heavy metal screening:

(i) For screening at harvest, three grams for every three pounds of harvested product. Harvest amounts will be rounded up to the next three-pound interval. For example, a harvest of less than three pounds requires at least three grams for testing; a harvest of three or more pounds but less than six pounds requires at least six grams for testing.

(ii) For screening a lot, three grams per lot.

(iii) For screening a batch of finished concentrates, extracts, or intermediate products, two grams per batch.

(iv) For screening imported cannabinoids, one percent of the product as packaged by the manufacturer of the imported cannabinoid but in no case shall the sample be less than two grams.

(d) Mycotoxin screening is required whenever microbial testing for any marijuana product is required by the WSLCB.

(e) Licensed marijuana producers, licensed marijuana processors, and certified third-party labs must follow the sampling protocols in chapter 314-55 WAC.

(f) At the request of the producer or processor, the WSLCB may authorize a retest to validate a failed test result on a case-by-case basis. All costs of the retest will be borne by the producer or processor.

(2) Pesticide screening.

(a) Only allowed pesticides shall be used in the production, processing, and handling of marijuana. Pesticide use must be consistent with the manufacturer's label requirements.

(b) Certified third-party labs must screen for any pesticides that are not allowed and are designated as having the potential for misuse on a list created, maintained, and periodically updated by the department in consultation with the Washington state department of agriculture and the WSLCB. Certified third-party labs must also screen for pyrethrins and piperonyl butoxide (PBO) in samples of concentrates, extracts, intermediate products, and imported cannabinoids. Certified third-party labs may also screen for additional pesticides.

(c) For purposes of the pesticide screening, a sample of any marijuana product shall be deemed to have failed if a pesticide that is not allowed is detected above the action level for that pesticide as determined by the WSLCB under chapter 314-55 WAC.

(d) A harvest, lot, or batch deemed to have failed pesticide screening must be destroyed according to chapter 314-55 WAC. Marijuana flowers, trim, leaves, or other plant matter deemed to have failed pesticide screening must not be used to create extracts or concentrates. Imported cannabinoids deemed to have failed pesticide screening must not be added to any marijuana product.

(e) Pesticides containing allowed pyrethrins or piperonyl butoxide (PBO) may not be applied less than seven days prior to harvest.

(f) All individuals applying pesticides shall adhere to the agricultural use requirements on the label. Pesticide applications that do not follow the pesticide product label may pose risks to public health and safety and are a violation of chapter 15.58 RCW.

(3) Heavy metal screening.

(a) For the purposes of heavy metal screening, a sample shall be deemed to have passed if it meets the following standards:

Metal	Limit, µg/daily dose (5 grams)
Inorganic arsenic	10.0
Cadmium	4.1
Lead	6.0
Mercury	2.0

(b) A harvest, lot, or batch deemed to have failed heavy metal screening must be destroyed according to chapter 314-55 WAC. Marijuana flowers, trim, leaves, or other plant matter deemed to have failed heavy metal screening must not be used to create extracts or concentrates. Imported cannabinoids deemed to have failed heavy metal screening must not be added to any marijuana product.

(4) For purposes of mycotoxin screening, a sample shall be deemed to have passed if it meets the following standards:

Test	Specification
The total of aflatoxin B1, aflatoxin B2, aflatoxin G1 and aflatoxin G2	<20 µG/kg of substance
Ochratoxin A	<20 µG/kg of substance

(5) Terpenes.

(a) Terpene analysis is not required. If terpene content is listed on product packaging or label, a terpene analysis from a certified third-party lab must be available for review by the consumer upon request.

(b) The addition of any terpene to useable marijuana is prohibited. Only the following terpenes may be added to a marijuana product other than useable marijuana.

(i) Terpenes naturally occurring in marijuana; or

(ii) Terpenes permitted or generally recognized as safe by, and used in accordance with, 21 C.F.R., Chapter I, subchapter B.

NEW SECTION

WAC 246-70-060 Compliant product labeling. (1) Products meeting the requirements of this chapter must be readily identifiable to the consumer by placement on the product's label of the appropriate logo found in WAC 246-70-090. A logo must be used in compliance with this chapter and any guidance for use developed by the department. A logo may not be used on any object or merchandise other than a compliant marijuana product. A logo used in accordance with this chapter must be printed in either black or dark blue.

(2) Labels for compliant products must not:

(a) Use any word(s), symbol, or image commonly used in or by medical or pharmaceutical professions including, but not limited to: Depiction of a caduceus, staff of Asclepius,

bowl of Hygieia, or mortar and pestle; or use of the word "prescription" or letters "RX";

(b) State or imply any specific medical or therapeutic benefit; or

(c) Mimic a brand of over-the-counter or legend drug.

(3) The label must prominently display the following statement: "This product is not approved by the FDA to treat, cure, or prevent any disease."

(4) Only marijuana products complying with this chapter may use a logo found in WAC 246-70-090. Marijuana products that use a logo but do not meet the requirements in this chapter will be reported to the WSLCB.

NEW SECTION

WAC 246-70-070 Compliant product safe handling. (1) Marijuana processors shall ensure all processing facilities that create or handle marijuana-infused products are constructed, kept, and maintained in a clean and sanitary condition in accordance with rules as prescribed by the Washington state department of agriculture under chapters 16-165 and 16-167 WAC.

(2) Marijuana processors that do not create or handle marijuana-infused products and all marijuana producers shall adopt and enforce policies and procedures to ensure that operations involving the growing, receiving, inspecting, transporting, segregating, preparing, production, packaging, and storing of marijuana or marijuana products are conducted in accordance with adequate sanitation principles including:

(a) Any person who, by medical examination or supervisory observation, is shown to have, or appears to have, an illness, open lesion, including boils, sores or infected wounds, or any other abnormal source of microbial contamination for whom there is a reasonable possibility of contact with marijuana, marijuana plants, or marijuana products shall be excluded from any operations that may be expected to result in microbial contamination until the condition is corrected.

(b) Hand-washing facilities must be available and furnished with running water. Hand-washing facilities shall be located in the permitted premises and where good sanitary practices require employees to wash or sanitize their hands, and provide effective hand-cleaning and sanitizing preparations and sanitary towel service or suitable drying devices.

(c) All persons working in direct contact with marijuana, marijuana plants, or marijuana products must conform to hygienic practices while on duty including, but not limited to:

(i) Maintaining personal cleanliness;

(ii) Washing hands thoroughly in hand-washing areas before starting work and at any other time when the hands may have become soiled or contaminated;

(iii) Refraining from having direct contact with marijuana, marijuana plants, or marijuana products if the person has or may have an illness, open lesion, including boils, sores or infected wounds, or any other abnormal source of microbial contamination, until the condition is corrected.

(d) Litter and waste are properly removed and the operating systems for waste disposal are maintained in a manner so that they do not constitute a source of contamination in areas where marijuana, marijuana plants, or marijuana products may be exposed.

(e) Floors, walls and ceilings are constructed in such a manner that they may be adequately cleaned and kept clean and in good repair.

(f) There is adequate lighting in all areas where marijuana, marijuana plants, or marijuana products are stored and where equipment or utensils are cleaned.

(g) There is adequate screening or other protection against the entry of pests. Rubbish must be disposed of so as to minimize the development of odor and minimize the potential for the waste becoming an attractant, harborage, or breeding place for pests.

(h) Any buildings, fixtures, and other facilities are maintained in a sanitary condition.

(i) Toxic cleaning compounds, sanitizing agents, and solvents used in the production of marijuana concentrates must be identified, held and stored in a manner that protects against contamination of marijuana, marijuana plants, and marijuana products, and in a manner that is in accordance with any applicable local, state, or federal law, rule, regulation, or ordinance.

(j) All contact surfaces, including utensils and equipment used for the preparation of marijuana, marijuana plants, or marijuana products must be cleaned and sanitized regularly to protect against contamination. Equipment and utensils must be designed and be of such material and workmanship as to be adequately cleanable, and must be properly maintained. Sanitizing agents must be used in accordance with labeled instructions.

(k) The water supply must be sufficient for the operations and capable of providing a safe, potable, and adequate supply of water to meet the facility's needs. Each facility must provide its employees with adequate and readily accessible toilet facilities that are maintained in a sanitary condition and good repair.

NEW SECTION

WAC 246-70-080 Employee training. (1) Marijuana producers, processors and retailers that create, handle, or sell compliant marijuana products shall adopt and enforce policies and procedures to ensure employees and volunteers receive training about the requirements of this chapter.

(2) Marijuana retailers holding a medical marijuana endorsement shall also adopt and enforce policies and procedures to ensure employees and volunteers receive training about:

(a) Procedures regarding the recognition of valid authorizations and the use of equipment to enter qualifying patients and designated providers into the medical marijuana authorization data base;

(b) Identification of valid recognition cards;

(c) Adherence to confidentiality requirements; and

(d) Science-based information about cannabinoids, strains, varieties, THC concentration, CBD concentration, and THC to CBD ratios of marijuana concentrates, usable marijuana, and marijuana-infused products available for sale when assisting qualifying patients and designated providers at the retail outlet.

(3) Nothing in subsection (2) of this section allows any owner, employee, or volunteer to:

(a) Perform the duties of a medical marijuana consultant or represent themselves as a medical marijuana consultant unless the person holds a valid certificate issued by the secretary under chapter 246-72 WAC;

(b) Offer or undertake to diagnose or cure any human or animal disease, ailment, injury, infirmity, deformity, pain, or other condition, physical or mental, real or imaginary, by use of marijuana products or any other means or instrumentality; or

(c) Recommend or suggest modification or elimination of any course of treatment that does not involve the medical use of marijuana or marijuana products.

NEW SECTION

WAC 246-70-090 Marijuana product compliant logos.

WSR 16-20-029

PERMANENT RULES

PUGET SOUND

CLEAN AIR AGENCY

[Filed September 27, 2016, 4:33 p.m., effective November 1, 2016]

Effective Date of Rule: November 1, 2016.

Purpose: **Section 3.11** - the agency's practice for many years has been to annually adjust the maximum civil penalty amount as allowed by law. The proposed adjustment to the maximum civil penalty amount accounts for inflation, as authorized by RCW 70.94.431 and as determined by the state office of the economic and revenue forecast council. Without this adjustment, the maximum penalty amount would effectively decrease each year. The CPI for the Seattle/Tacoma/Bremerton area increased by 2.25 percent for the 2015 calendar year, which amounts to an increase of $405 in the maximum civil penalty amount.

The proposed amendment does not affect the way the agency determines actual civil penalty amounts in individual cases. This continues to be done following civil penalty worksheets previously approved by the board.

Section 3.25 - this section currently provides that whenever federal rules are referenced in agency regulations, the effective date of the federal regulations referred to is July 1, 2015. This provides certainty so that persons affected by the regulations and agency staff know which version of a federal regulation to reference. For many years, the agency's practice has been to update this date annually to stay current with federal regulations. Following this practice, the proposed amendments would change the reference date to July 1, 2016.

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 16-16-119 on August 3, 2016.

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 22, 2016.

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 $((~~17,983.00~~)) 18,388.00, 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 $((~~17,983.00~~)) 18,388.00, 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, ((~~2015~~)) 2016.

WSR 16-20-030
PERMANENT RULES
PUGET SOUND CLEAN AIR AGENCY

[Filed September 27, 2016, 4:34 p.m., effective November 1, 2016]

Effective Date of Rule: November 1, 2016.

Purpose: This technical amendment for the registration program is being proposed to address interests regarding marijuana producers. The agency has been actively reaching out to marijuana producers to provide information regarding the requirement to submit notices of construction. As the agency has been working with the producers, we have gathered a great deal of information on emissions, equipment and activities that are used in the production process and have concluded that marijuana producers warrant registration. Most producers have control equipment that triggers the requirement to register the facility and the agency has been registering these sources as they are inspected and as they receive orders of approval. However, not all producers have equipment that triggers the current requirement to register. An example is outdoor producers that may not have equipment for odor control and do not trigger any other registration criteria. To fill this gap in agency regulations, we are proposing that the criteria for registration be amended to include all marijuana producers through a specific reference.

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 16-16-120 on August 3, 2016.

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 22, 2016.

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, the provisions of Subpart IIII pertaining to owners and operators of emergency stationary compression ignition internal combustion engines and the provisions of Subpart JJJJ pertaining to owners and operators of emergency stationary spark ignited 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 (≥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 (≥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 (≥27" diameter inlet);

(8) Sources with any of the following equipment or activities:

(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; or ((~~and~~))

(Q) Marijuana production; 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 16-20-031
PERMANENT RULES
PUGET SOUND CLEAN AIR AGENCY

[Filed September 27, 2016, 4:35 p.m., effective November 1, 2016]

Effective Date of Rule: November 1, 2016.

Purpose: The proposed technical amendment to the registration program will clarify civil penalties that may be issued for late registration fees and also to facilities that submitted incorrect or incomplete information used for determining registration fees. Section 5.07 of Regulation I outlines the due date for registration fees and includes an allowance for collecting a penalty of three times the registration fee under certain circumstances. These circumstances include situations when the fees are delinquent, or if incorrect or incomplete information was submitted such that fees could not be calculated properly. With various amendments (for other purposes) over time, the resulting language has become challenging to clearly interpret when registration fees were sufficiently delinquent to be eligible for enforcement action. The agency is proposing that the language in this section of the rule be clarified to clearly identify when a registration fee

is delinquent and the penalty associated with the delinquent fee can be applied.

Citation of Existing Rules Affected by this Order: Amending Regulation I, Section 5.07.

Statutory Authority for Adoption: Chapter 70.94 RCW.

Adopted under notice filed as WSR 16-16-121 on August 3, 2016.

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 22, 2016.

Craig Kenworthy
Executive Director

AMENDATORY SECTION

REGULATION I, SECTION 5.07 ANNUAL REGISTRATION FEES

(a) The Agency shall assess annual fees as set forth in Section 5.07(c) of this regulation for services provided in administering the registration program. Fees received under the registration program shall not exceed the cost of administering the program, which shall be defined as initial registration and annual or other periodic reports from the source owner providing information directly related to air pollution registration, on-site inspections necessary to verify compliance with registration requirements, data storage and retrieval systems necessary for support of the registration program, emission inventory reports and emission reduction credits computed from information provided by sources pursuant to registration program requirements, staff review, including engineering analysis for accuracy and currentness, of information provided by sources pursuant to registration program requirements, clerical and other office support provided in direct furtherance of the registration program, and administrative support provided in directly carrying out the registration program. Payment of these fees by the owner or operator of a source shall maintain its active registration status (even if it is not actively operating).

(b) Upon assessment by the Agency, registration fees are due and payable within 45 days of the date of the invoice. ((~~They~~)) Registration fees shall be deemed delinquent if not fully paid within 45 days of the date of the invoice. Persons or sources that ((~~knowingly~~)) under-report((~~ing~~)) emissions, fail to submit ((~~or~~)) other information used to set fees, or ((~~persons required~~)) fail to pay ((~~emission or permit~~)) required fees ((~~who are more than~~)) within 90 days of the date of the invoice, ((~~late with such payments~~)) may be subject to a penalty equal to 3 times the amount of the original fee owed (in addition to other penalties provided by chapter 70.94 RCW).

(c) Except as specified in Section 5.07 (d) and (e) of this regulation, registered sources shall be assessed a fee of $1,150, plus the following fees:

(1) Sources subject to a federal emission standard as specified in Section 5.03 (a)(1) of this regulation shall be assessed $2,100 per subpart of 40 CFR Parts 60-63;

(2) Sources subject to a federally enforceable emission limitation as specified in Section 5.03 (a)(2) or meeting the emission thresholds specified in Section 5.03 (a)(3) of this regulation shall be assessed $2,300;

(3) Sources subject to the emission reporting requirements under Section 5.05(b) of this regulation shall be assessed $30 for each ton of CO and $60 for each ton of NOx, PM10, SOx, HAP, and VOC, based on the emissions reported during the previous calendar year;

(4) Sources with more than one coffee roaster installed on-site that are approved under a Notice of Construction Order of Approval shall be assessed $2,300;

(5) Sources of commercial composting with raw materials from off-site and with an installed processing capacity of <100,000 tons per year shall be assessed $5,750; and

(6) Sources of commercial composting with raw materials from off-site and with an installed processing capacity of ≥100,000 tons per year shall be assessed $23,000.

(d) Gasoline dispensing facilities shall be assessed the following fees based on their gasoline throughput during the previous calendar year (as certified at the time of payment):

(1) More than 6,000,000 gallons. $4,085;

(2) 3,600,001 to 6,000,000 gallons $2,030;

(3) 1,200,001 to 3,600,000 gallons $1,350;

(4) 840,001 to 1,200,000 gallons $675;

(5) 200,001 to 840,000 gallons . . . . . .$340.

(e) The following registered sources shall be assessed an annual registration fee of $140, provided that they meet no other criteria listed in Section 5.03(a) of this regulation:

(1) Sources with spray-coating operations subject to Section 9.16 of this regulation that use no more than 4,000 gallons per year of total coatings and solvents;

(2) Gasoline dispensing facilities subject to Section 2.07 of Regulation II with gasoline annual throughput during the previous calendar year (as certified at the time of payment) of no more than 200,000 gallons;

(3) Motor vehicle and mobile equipment coating operations subject to Section 3.04 of Regulation II;

(4) Unvented dry cleaners using perchloroethylene; and

(5) Batch coffee roasters subject to notification under Section 6.03 (b)(11) of this regulation.

WSR 16-20-032
PERMANENT RULES
PUGET SOUND CLEAN AIR AGENCY

[Filed September 27, 2016, 4:35 p.m., effective November 1, 2016]

Effective Date of Rule: November 1, 2016.

Purpose: This is a technical amendment to remove subsection (c) of Regulation I, Section 14.05 in its entirety. This subsection was based upon RCW 43.105.280 which allowed the agency, if needed, to charge a fee to provide customized access to an electronic record to a requester. In 2015, the Washington state legislature deleted RCW 43.105.280, including the provision allowing the agency to charge a fee for customized access. Thus, the amendment would remove subsection (c), referring to RCW 43.105.280, in full from Section 14.05. In addition, to date the agency has not been in the position of needing to charge a fee for customized access in providing electronic records and the agency has been able to work with requesters to provide electronic records in formats that are easily or reasonably accessible to the agency and the requester.

Citation of Existing Rules Affected by this Order: Amending Regulation I, Section 14.05.

Statutory Authority for Adoption: Chapter 70.94 RCW.

Adopted under notice filed as WSR 16-16-122 on August 3, 2016.

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 22, 2016.

Craig Kenworthy
Executive Director

AMENDATORY SECTION

REGULATION I, SECTION 14.05 PROCESSING OF PUBLIC RECORDS REQUESTS—ELECTRONIC PUBLIC RECORDS

(a) **Requesting electronic public records.** The process for requesting electronic public records is the same as for requesting paper public records.

(b) **Providing electronic public records.** When a requester requests public records in an electronic format, the public records officer will provide the nonexempt public records or portions of such records that are reasonably locatable in an electronic format that is used by the Agency and is generally commercially available, or in a format that is reasonably translatable from the format in which the Agency keeps the public records.

(((c) ~~**Customized access to data bases.** With the consent of the requester, the Agency may provide customized access under RCW 43.105.280 if the public record is not reasonably locatable or not reasonably translatable into the format requested. The Agency may charge a fee consistent with RCW 43.105.280 for such customized access.~~))

WSR 16-20-050
PERMANENT RULES
OFFICE OF INSURANCE COMMISSIONER

[Insurance Commissioner Matter No. R 2016-12—Filed September 29, 2016, 11:45 a.m., effective October 30, 2016]

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

Purpose: The adopted rule amends WAC 284-30-330(16) to allow insurance companies to implement procedures for the processing and payment of claims to include, but not require, other forms of payment, including but not limited to, electronic funds transfer or a prepaid card.

Citation of Existing Rules Affected by this Order: Amending WAC 284-30-330.

Statutory Authority for Adoption: RCW 48.02.060 and 48.30.010.

Adopted under notice filed as WSR 16-17-125 on August 23, 2016.

A final cost-benefit analysis is available by contacting Jim Tompkins, P.O. [Box] 40260, Olympia, WA 98504-0260, phone (360) 725-7036, fax (360) 586-3109, e-mail rulescoordinator@oic.wa.gov.

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

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

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

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

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

Date Adopted: September 29, 2016.

Mike Kreidler
Insurance Commissioner

AMENDATORY SECTION (Amending WSR 09-11-129, filed 5/20/09, effective 8/21/09)

WAC 284-30-330 Specific unfair claims settlement practices defined. The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices of the insurer in the business of insurance, specifically applicable to the settlement of claims:

(1) Misrepresenting pertinent facts or insurance policy provisions.

(2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.

(3) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

(4) Refusing to pay claims without conducting a reasonable investigation.

(5) Failing to affirm or deny coverage of claims within a reasonable time after fully completed proof of loss documentation has been submitted.

(6) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. In particular, this includes an obligation to promptly pay property damage claims to innocent third parties in clear liability situations. If two or more insurers share liability, they should arrange to make appropriate payment, leaving to themselves the burden of apportioning liability.

(7) Compelling a first party claimant to initiate or submit to litigation, arbitration, or appraisal to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in such actions or proceedings.

(8) Attempting to settle a claim for less than the amount to which a reasonable person would have believed he or she was entitled by reference to written or printed advertising material accompanying or made part of an application.

(9) Making a claim payment to a first party claimant or beneficiary not accompanied by a statement setting forth the coverage under which the payment is made.

(10) Asserting to a first party claimant a policy of appealing arbitration awards in favor of insureds or first party claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(11) Delaying the investigation or payment of claims by requiring a first party claimant or his or her physician to submit a preliminary claim report and then requiring subsequent submissions which contain substantially the same information.

(12) Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

(13) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

(14) Unfairly discriminating against claimants because they are represented by a public adjuster.

(15) Failing to expeditiously honor drafts given in settlement of claims. A failure to honor a draft within three working days after notice of receipt by the payor bank will constitute a violation of this provision. Dishonor of a draft for valid reasons related to the settlement of the claim will not constitute a violation of this provision.

(16) Failing to adopt and implement reasonable standards for the processing and payment of claims after the obligation to pay has been established. Except as to those instances where the time for payment is governed by statute or rule or is set forth in an applicable contract, procedures which are not designed to deliver ((~~a~~)) payment, whether by check ((~~or~~)), draft, electronic funds transfer, prepaid card, or other method of electronic payment to the payee in payment of a settled claim within fifteen business days after receipt by the insurer or its attorney of properly executed releases or other settlement documents are not acceptable. Where the insurer is obligated to furnish an appropriate release or settlement document to a claimant, it must do so within twenty working days after a settlement has been reached.

(17) Delaying appraisals or adding to their cost under insurance policy appraisal provisions through the use of appraisers from outside of the loss area. The use of appraisers from outside the loss area is appropriate only where the unique nature of the loss or a lack of competent local appraisers make the use of out-of-area appraisers necessary.

(18) Failing to make a good faith effort to settle a claim before exercising a contract right to an appraisal.

(19) Negotiating or settling a claim directly with any claimant known to be represented by an attorney without the attorney's knowledge and consent. This does not prohibit routine inquiries to a first party claimant to identify the claimant or to obtain details concerning the claim.

WSR 16-20-055
PERMANENT RULES
SUPERINTENDENT OF PUBLIC INSTRUCTION

[Filed September 30, 2016, 10:13 a.m., effective October 31, 2016]

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

Purpose: Chapter 392-501 WAC had outdated language and processes related to the graduation alternatives available for students in Washington state and students transfering [transferring] to Washington state.

The incorporated edits are intended to address the following:

(1) Generalize all references to WASL as Washington's high school assessment.

(2) Align eligibility to alternatives in keeping with the intent of RCW 28A.655.061 (3)(d).

(3) Outline any additional content areas included in the already listed alternatives.

(4) Clean up language/provide clarifying language related to each alternative.

(5) Update submission processes for each alternative to align with current practice.

Citation of Existing Rules Affected by this Order: Amending chapter 392-501 WAC.

Statutory Authority for Adoption: RCW 28A.655.065, 28A.655.061.

Adopted under notice filed as WSR 16-16-123 on August 3, 2016.

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 27, 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 19, 2016.

Randy Dorn
State Superintendent
of Public Instruction

AMENDATORY SECTION (Amending WSR 07-13-035, filed 6/13/07, effective 7/22/07)

WAC 392-501-001 Authority. The authority for this chapter is RCW 28A.655.065 and 28A.655.061, which direct the superintendent of public instruction to:

(1) Develop and implement eligibility requirements and guidelines for objective alternative assessments for students to demonstrate achievement of state standards in content areas in which the student has not yet met the standard on ((~~the~~)) Washington's high school ((~~Washington~~)) assessment ((~~of student learning (WASL)~~)); and

(2) Develop guidelines and appeal processes for waiving specific requirements in RCW 28A.655.061 pertaining to the certificate of academic achievement and to the certificate of individual achievement for students who:

(a) Transfer to a Washington public school in their junior or senior year with the intent of obtaining a public high school diploma; and

(b) Have special, unavoidable circumstances.

((~~PSAT,~~)) SAT, ACT, IB AND AP COMPARISON OPTION

AMENDATORY SECTION (Amending WSR 07-13-035, filed 6/13/07, effective 7/22/07)

WAC 392-501-102 General description. The ((~~PSAT,~~)) SAT, ACT, IB and AP comparison option is an objective alternative assessment authorized in RCW 28A.655.061 (10)(b) that allows a student to use a score from the following tests to demonstrate that the student has met or exceeded the state standard for ((~~reading, writing,~~)) English language arts, science or mathematics on:

(1) ((~~The mathematics component of the PSAT;~~

~~(2)~~)) The ((~~reading or~~)) English((~~, writing,~~)) language arts, science or mathematics component as designated by superintendent, of the SAT (science not applicable) or ACT; or

(((~~3~~))) (2) International Baccalaureate or advanced placement examinations listed in WAC 392-501-104(2).

AMENDATORY SECTION (Amending WSR 07-13-035, filed 6/13/07, effective 7/22/07)

WAC 392-501-103 Eligibility. (1) A student is eligible for the ((~~PSAT,~~)) SAT, ACT, IB and AP comparison option if the student has taken the applicable component of ((~~the Washington~~)) Washington's high school assessment ((~~of student learning (WASL)~~)) at least once and has not met the standard for which the student is applying to use this option. To meet these criteria, a student must have ((~~sat for and generated a scale score during the administration of the WASL.~~

~~(2) To be eligible for the PSAT mathematics option, the student must have taken the PSAT prior to September 1, 2008.~~

~~(3)~~)) a recorded valid attempt of the general high school assessment.

(2) A student may use a score earned on the ((~~PSAT,~~)) SAT, ACT, IB or ((~~an~~)) advanced placement examination taken prior to or after ((~~taking the WASL once~~)) one valid attempt of the general high school assessment.

AMENDATORY SECTION (Amending WSR 07-13-035, filed 6/13/07, effective 7/22/07)

WAC 392-501-104 Required scores. (1) As required in RCW 28A.655.061 (10)(b), the state board of education shall identify the score students must achieve on the ((~~mathematics portion of the PSAT and the reading or~~)) English((~~, writing,~~)) language arts, science and mathematics components of the SAT (science not applicable) and ACT.

(2) A student who scores at least a three on the grading scale of one to five on the following advanced placement examinations shall meet the applicable high school standard:

(a) For meeting the mathematics standard, the calculus or statistics advanced placement examination;

(b) For meeting the ((~~writing standard, the English language and composition advanced placement examination; or~~

~~(c) For meeting the reading~~)) English language arts standard, the English language and composition advanced placement examination and one of the following additional examinations: English literature and composition, macroeconomics, microeconomics, psychology, United States history, world history, United States government and politics, or comparative government and politics ((~~advanced placement examination~~)).

(c) For meeting the science standard, biology, chemistry, physics or environmental science.

(3) A student who scores at least a four at the higher level on the following International Baccalaureate tests shall meet the applicable high school standard:

(a) For meeting the mathematics standard, the mathematics or further mathematics tests;

(b) For meeting the English language arts standard, the Language A: Literature; Language A: Language and literature, business and management, economics, geography, history, information technology is a global society, philosophy, psychology or social and cultural anthropology.

(c) For meeting the science standard, biology, chemistry, or physics.

AMENDATORY SECTION (Amending WSR 07-13-035, filed 6/13/07, effective 7/22/07)

WAC 392-501-105 Application process. (1) The superintendent of public instruction shall develop and make available to ((~~students and~~)) school district personnel ((~~a PSAT,~~)) an online application to capture SAT, ((~~and~~)) ACT ((~~mathematics~~)), IB and/or AP comparison applications for documenting that a student has met the eligibility requirements in WAC 392-501-103 and achieved the scores required in WAC 392-501-104.

(2) If the student is eligible, the student shall ((~~complete an application and submit the application to the school principal or designee~~)) work with school personnel to collect the SAT, ACT, IB and/or AP score reports to submit through the state provided graduation alternatives online application.

(3) If the school principal or designee agrees that the eligibility criteria have been met, the principal or designee shall ((~~transmit a facsimile or mail a copy of the application and the copy of the student's official PSAT, SAT, ACT, or AP score report that was sent to the school and to the office of superintendent of public instruction (OSPI).~~

~~(4) After the superintendent, or his or her designee, has received and verified the application to be complete and consistent with the requirements of this chapter, staff from the office of superintendent of public instruction shall notify the school principal or designee and the school district assessment coordinator once the application is verified.~~)) submit a copy of the student's official SAT, ACT, IB or AP score report via the graduation alternatives application for district assessment coordinator approval.

(4) If the district assessment coordinator, or their designee, agrees that the eligibility criteria have been met, the district assessment coordinator or designee shall approve the form (with accompanying score report(s)) present in the graduation alternatives online application for submission to the office of superintendent of public instruction.

(5) Upon approval of the submission, the school principal or designee shall notify the student of the ((~~verification~~)) approval. OSPI ((~~staff~~)) shall document in the ((~~student's state~~)) state's assessment records that the student met the applicable high school standard.

(((~~(5) The superintendent of public instruction shall act upon the student's application within thirty days of receiving the application.~~

~~(6) School staff shall include a copy of the application, the student's score report, and the verification in the student's cumulative folder.~~)) (6) Superintendent will conduct regular audits of district submissions to ensure accuracy and consistency in reported student status. Where irregularities are found, superintendent will notify the district for corrective action.

AMENDATORY SECTION (Amending WSR 07-13-035, filed 6/13/07, effective 7/22/07)

WAC 392-501-106 Notification requirements. The school principal or a designee shall notify students and their parents or guardians when students are in the eleventh and twelfth grade years of the availability of the ((~~PSAT,~~)) SAT, ACT, IB and AP comparison option.

((~~WASL/GRADES~~)) GRADES COMPARISON OPTION

AMENDATORY SECTION (Amending WSR 07-13-035, filed 6/13/07, effective 7/22/07)

WAC 392-501-200 General description. The ((~~WASL/grades~~)) grades comparison option is an objective alternative assessment authorized in RCW 28A.655.065 (3) and (4) that compares the applicant's grades in applicable courses with the grades of students who took the same courses and met or exceeded the assessment standard. This option may be used for meeting the high school ((~~reading, writing,~~)) English language arts, science and/or mathematics ((~~standard~~)) assessment requirement.

AMENDATORY SECTION (Amending WSR 11-19-042, filed 9/13/11, effective 10/14/11)

WAC 392-501-201 Eligibility. A student is eligible for the GPA comparison option if the student meets the following conditions:

(1) The student has taken the applicable component of the state high school assessment at least once and has not met the standard for which the student is applying to use this option. To meet these criteria, a student must have ((~~sat for and generated a valid scale score during the administration of the state~~)) a recorded valid attempt of the general high school assessment.

(2) The student is in the twelfth grade.

(3) The student has a cumulative grade point average of 3.2 or higher when the application is ((~~filed~~)) submitted.

AMENDATORY SECTION (Amending WSR 07-13-035, filed 6/13/07, effective 7/22/07)

WAC 392-501-202 Process for determining the comparison cohort and calculating the GPAs. (1) For the purpose of this section, "applicant" means an eligible student applying for the ((~~WASL/grades~~)) grades comparison option.

(2) A school district representative or designee shall ((~~determine the comparison cohort and complete the calculation in this subsection for all eligible students who apply to use this option~~)) utilize the grade comparison tool(s) provided by the office of superintendent of public instruction to calculate the grade comparison of the applicant against those identified as the cohort.

(3) To complete the ((~~WASL/grades~~)) grades comparison option for eligible students, the ((~~school district represen-~~

~~tative or designee shall complete the following steps~~)) grades comparison tool will:

(a) Identify the group of students in the same school as the applicant who took the same mathematics, science or English language arts high school courses, ((~~which ever~~)) whichever is applicable, in the same school year as the applicant. This group includes all of the students in the school who took courses with the same course title and course number (e.g., Algebra 1, Sophomore English) as the applicant, in the same school year, regardless of the grade level of the student. When selecting courses to be used, the following guidelines shall be followed:

(i) The credits generated by the courses must equal two annual high school credits and must include the most recent courses taken in which a comparison cohort of six or more students can be identified.

(ii) In order for applicants using the cohort comparison to meet the mathematics standard, the courses must be eligible for a mathematics graduation credit.

(iii) In order for applicants using the cohort comparison to meet the ((~~reading or writing~~)) English language arts standard, the courses must be eligible for an English/Language arts graduation credit.

(iv) In order for applicants using the cohort comparison to meet the science standard, the courses must be eligible for a science graduation credit.

(b) From the group of students identified in (a) of this subsection, the ((~~school district representative or designee~~)) grades comparison tool shall identify the "comparison cohort," which includes all students who met or slightly exceeded the state standard on the ((~~WASL~~)) high school assessment. For purposes of determining "who met or slightly exceeded the state standard," scores in Level 3 shall be used:

(i) Mathematics: ((~~400 - 433~~)) 2583 - 2681;

(ii) ((~~Reading: 400 - 426~~)) English language arts: 2583 - 2681; and

(iii) ((~~Writing: 17 - 20~~)) Science: 400 - 422.

(c) If there are fewer than six students in the comparison cohort, the cohort ((~~may~~)) will be expanded to also include students in Level 4. If there are still fewer than six students in the comparison cohort, the applicant is not eligible to use the ((~~WASL/grades~~)) grades comparison option.

(d) The ((~~school district representative or designee~~)) grades comparison tool shall compute the grade point average for the selected courses for the applicant and for each student in the comparison cohort. The following grade - number conversions shall be used:

A	= 4.0
A-	= 3.7
B+	= 3.3
B	= 3.0
B-	= 2.7
C+	= 2.3
C	= 2.0
C-	= 1.7
D+	= 1.3
D	= 1.0
E or F	= 0.0
Credit/No Credit	May not be used
Pass/Fail	May not be used

(e) The ((~~school district representative or designee~~)) grades comparison tool shall then calculate the mean comparison cohort grade point average of all the students in the comparison cohort.

(f) The ((~~school district representative or designee~~)) grades comparison tool shall then compare the applicant's grade point average in the relevant high school courses to the mean comparison cohort grade point average of the students in the comparison cohort.

(g) If the applicant's grade point average is below the mean comparison cohort grade point average, the student is not eligible to file the ((~~application~~)) grades comparison form and no further action is required.

(h) If the applicant's grade point average is equal to or higher than the mean comparison cohort grade point average, the ((~~principal or a designee shall transmit the application with the results of the calculation~~)) school district representative or designee shall submit the form with the results of the calculation via the graduation alternatives application for approval by their district assessment coordinator.

(i) If the district assessment coordinator, or their designee, agrees that the eligibility criteria have been met, the district assessment coordinator or designee shall approve the form(s), with the results of the calculation, in the graduation alternatives application for submission to the office of the superintendent of public instruction for approval.

AMENDATORY SECTION (Amending WSR 07-13-035, filed 6/13/07, effective 7/22/07)

WAC 392-501-204 Application timeline and approval criteria. (1) The ((~~superintendent of public instruction~~)) district assessment coordinator shall approve the ((~~application~~)) grades comparison form if:

(a) The student eligibility requirements are met; and

(b) ((~~The process for identifying the comparison cohort and for calculating the grade point averages and the mean grade point average was followed; and~~

~~(c)~~)) The applicant's grade point average is equal to or greater than the mean grade point average of the comparison cohort.

(2) ((~~If the application is approved,~~)) Upon approval of the submission, the school principal or designee shall notify the student of the approval, OSPI will document in the student's state assessment record that the student met the applicable high school assessment standard and the applicant will be deemed to have met the applicable content standard for purposes of obtaining a certificate of academic achievement or individual achievement.

(3) The superintendent of public instruction ((~~must act upon the student's application and notify the applicant's school principal or designee and the school district assessment coordinator whether the application was approved or~~

~~denied within thirty days of receiving the application. The school principal or designee shall notify the student.~~

~~(4) School staff shall include a copy of the application and approval notification in the student's cumulative folder~~)) will conduct regular audits of district submissions to ensure accuracy and consistency in reported student status. Where irregularities are found, superintendent will notify the district for corrective action.

AMENDATORY SECTION (Amending WSR 07-13-035, filed 6/13/07, effective 7/22/07)

WAC 392-501-206 Notification requirements. The school principal or a designee shall notify students and their parents or guardians when students are in the eleventh and twelfth grade years of the availability of the ((~~WASL/ grades~~)) grades comparison option.

AMENDATORY SECTION (Amending WSR 08-10-015, filed 4/25/08, effective 5/26/08)

WAC 392-501-300 General description. A collection of evidence (COE) is a high school graduation alternative assessment ((~~option~~)) authorized under RCW 28A.655.065 that evaluates a set of work samples in a specific content area (English language arts, science (biology/life science) and mathematics((~~, reading, and/or writing~~))) based on classroom work prepared by a student. Students may prepare a COE for one or more content areas.

AMENDATORY SECTION (Amending WSR 11-19-042, filed 9/13/11, effective 10/14/11)

WAC 392-501-310 Eligibility. A student who has taken the state high school assessment at least once and has not met standard in one or more of the content areas is eligible to submit a collection of evidence for each content area in which they have not met standard ((~~as an alternative assessment~~)) if: The student has ((~~sat for and generated a valid scale score during the administration of the state~~)) a recorded valid attempt of the general high school assessment.

AMENDATORY SECTION (Amending WSR 08-10-015, filed 4/25/08, effective 5/26/08)

WAC 392-501-320 Application process. (1) The superintendent of public instruction shall make available to students and school district personnel a COE submission ((~~application~~)) procedure for documenting that a student has met the eligibility requirements as set forth in WAC 392-501-310.

(2) It is the responsibility of the school district to determine whether the student is eligible for the COE option. If the student is eligible, the school district is required to inform the student of the COE alternative assessment option.

(3) If the student is eligible, the student, with the assistance of school district personnel, shall submit ((~~an application~~)) a collection of evidence to the superintendent of public instruction via the ((~~Washington assessment management system (WAMS)~~)) COE scoring center.

(4) The superintendent of public instruction will publish an annual calendar established before each school year setting forth the timelines for the twice yearly ((~~registration,~~)) submission, scoring, and student and district reporting ((~~for~~)) of the COE.

AMENDATORY SECTION (Amending WSR 08-10-015, filed 4/25/08, effective 5/26/08)

WAC 392-501-330 Guidelines and protocols. (1) Specific guidelines for types and numbers of work samples for English language arts, science and mathematics((~~, reading, or writing~~)) will be published and made available to students, guardians, schools, and districts. The guidelines will be published on the office of the superintendent of public instruction (OSPI) web site at((~~: http://www.k12.wa.us/assessment/default~~)) http://www.k12.wa.us/assessment/GraduationAlternatives/CollectionofEvidence.aspx as approved by the state board of education in an open and public process.

(2) ((~~Protocols for submission of work samples will include a Student Information Form, a Work Sample Documentation Form, and Work Sample Sign-Off Forms.~~)) Protocols for submission of work samples will be published on the OSPI web site at ((~~http://www.k12.wa.us/assessment/default~~)) http://www.k12.wa.us/assessment/GraduationAlternatives/CollectionofEvidence.aspx as approved by the state board of education in an open and public process.

AMENDATORY SECTION (Amending WSR 08-10-015, filed 4/25/08, effective 5/26/08)

WAC 392-501-340 Sufficiency process for all content areas. The following process will be utilized in determining sufficiency for a collection of evidence for one or more of the content areas submitted by a student. Upon receipt by OSPI, a collection of evidence will be reviewed to determine whether the protocols for submission have been met. OSPI will notify a school district of any missing ((~~paperwork or signatures~~)) materials. If the school district does not provide the missing ((~~paperwork or signatures~~)) materials within the time frame ((~~provided~~)) communicated, the collection of evidence will be returned without a score.

AMENDATORY SECTION (Amending WSR 08-10-015, filed 4/25/08, effective 5/26/08)

WAC 392-501-350 Scoring process for all content areas. The following process will be utilized to determine a score for a submitted collection ((~~for one or more of the content areas~~)).

(1) Collections shall be scored at the state level by ((~~a panel of educators~~)) professional scorers screened, selected, and trained by OSPI. To be selected as a scorer, a person must ((~~be a certificated educator in the content area, provide teacher leadership at the building and/or district level, and work with high school students in the content area in which they teach~~)) have a bachelor's degree.

(2) A submitted collection of evidence shall be scored in a rigorous process that aligns with state content standards and comparable ((~~WASL~~)) Washington state high school assessment performance.

(3) Uniform scoring criteria will be published on the OSPI web site at ((~~http://www.k12.wa.us/assessment/default~~)) http://www.k12.wa.us/assessment/GraduationAlternatives/CollectionofEvidence.aspx as approved by the state board of education in an open and public process.

AMENDATORY SECTION (Amending WSR 08-10-015, filed 4/25/08, effective 5/26/08)

WAC 392-501-360 Standard setting ((~~process~~)) for all content areas for the collection of evidence. (1) ((~~A neutral committee of educators, business people, and students will be trained on the state content standards in mathematics, reading, and writing. They will be led by an expert facilitator trained in standard setting processes. The facilitator assists the standard setting committees in order to determine the cut score which all collections must attain in order to meet standard in one or more of the content areas.~~

~~(2) The standard setting committee~~)) The superintendent of public instruction will recommend ((~~a~~)) cut scores for each content area to the state board of education for graduation purposes.

(((~~3~~))) (2) The state board of education shall have the responsibility of accepting or not accepting the recommended cut scores generated from the superintendent of public instruction's standard setting ((~~results~~)) process, using an open and public process.

AMENDATORY SECTION (Amending WSR 08-10-015, filed 4/25/08, effective 5/26/08)

WAC 392-501-380 Collection of evidence adherence to national standards. National Standards for Educational and Psychological Testing (AERA, NCME, APA, 1999) will be applied in all stages of the development and implementation of the collection of evidence in order to ensure reliability and validity of the COE as an alternative assessment ((~~option~~)). The National Technical Advisory Committee for the superintendent of public instruction shall also provide ongoing technical assistance for the COE.

AMENDATORY SECTION (Amending WSR 07-13-035, filed 6/13/07, effective 7/22/07)

WAC 392-501-502 Waivers for transfer students from other states who enroll in eleventh or twelfth grade. (1) The requirement that a student obtain a certificate of academic achievement or a certificate of individual achievement to graduate shall be waived for students who transfer to a Washington public school from another state in the ((~~eleventh or~~)) twelfth grade year if the student provides documentation that he or she has met standards in another state on a high school assessment ((~~or for students eligible to receive special education services, on an alternate assessment~~)), general or alternate. The assessment in the other state must be used for purposes of the high school assessment required in the federal Elementary and Secondary Education Act or be used for purposes of a high school graduation exit examination. Waivers shall be granted as follows:

(a) If the student met standards on ((~~both~~)) the mathematics, science, and ((~~reading or~~)) English language arts assessments in the other state, the applicable certificate shall be waived.

(b) If a student did not meet the standard on the mathematics assessment in the other state, then the student must meet the mathematics standard on the applicable Washington assessment for the certificate to be waived.

(c) If the student did not meet the standard on the ((~~reading assessment or~~)) English language arts assessment, then the student must meet the ((~~reading~~)) English language arts standard on the applicable Washington assessment for the certificate to be waived.

(d) ((~~If the student did not meet the standard on the writing or English language arts assessment, then the student must meet the writing standard on the applicable Washington assessment for the certificate to be waived.~~

~~(e) If the other state did not have a writing assessment, then the student must have met the standard on the English language arts assessment or other assessment used to meet the English/language arts assessment or other assessment used to meet the English/language arts requirement in the federal Elementary and Secondary Education Act for the certificate to be waived.~~

~~(2)~~)) If the student did not meet the standard on the science assessment, then the student must meet the science standard on the applicable Washington assessment for the certificate to be waived.

(e) If student was administered the consortium-generated assessment for mathematics and/or English language arts also administered by Washington, and did not meet the standards for graduation established by Washington, but did meet the standards for his or her former state, the student may apply for the associated waiver. In the event the student met or exceeded Washington's requirements with the administration in the former state, the student will be granted a certificate.

(2)(a) For eleventh grade transfer students, before using the process detailed in subsection (1) of this section, the student must be administered the Washington assessments for mathematics and English language arts. If the student does not meet standard on either the mathematics and/or English language arts assessment, the student may then apply his or her previous state assessment scores in pursuit of waiving the certificate requirement.

(b) Until the new next generation science standards assessment is administered in Washington eleventh grade students may apply for waiver from the science portion of the certificate per the process in subsection (1) of this section without administration of a Washington science assessment. The graduation alternative system will not allow student access to the science waiver until the student is in twelfth grade.

(3) The student waiver application must document passage of the assessment by one of the following options:

(a) The out-of-state school from which the student transferred must transmit ((~~directly~~)) to the student's new school a score report from the former school or school district where the student took the high school general assessment or alternate assessment. The score report must contain the student's assessment results (i.e., specific scores) by content area and whether or not the student met the state required standards. If the score report does not include whether or not the student

met the standards, then the former school or school district must provide information documenting that the standards were met. If the out-of-state school ((~~directly~~)) transmitted the score report when the student enrolled in the Washington school system, then the ((~~student need not provide~~)) the report need not be transmitted again; or

(b) The out-of-state school from which the student transferred must transmit ((~~directly~~)) to the student's new school, if it has not done so already, the student's transcript documenting the student's assessment results (i.e., specific scores). The transcript must contain the student's assessment results by content area and whether or not the student met the state required standards. If the transcript does not include whether or not the student met the standards, then the former school or school district must provide information documenting that the standards were met.

AMENDATORY SECTION (Amending WSR 07-13-035, filed 6/13/07, effective 7/22/07)

WAC 392-501-504 Application and approval process. (1) To obtain a waiver, ((~~the student or the student's parent or guardian must complete and submit to the student's principal or designee a waiver application developed by~~)) a waiver form must be submitted by the district to the superintendent of public instruction. The principal of the school or designee shall review the information and transmit through the district office the ((~~application~~)) wavier form and a copy of the student's assessment score report or transcript, if listing the state test scores, to the superintendent of public instruction ((~~for approval~~)) via the graduation alternatives online application.

(2) ((~~Applications must be received by the superintendent of public instruction by April 1 of the student's twelfth grade year to provide time for processing prior to graduation.~~

~~(3) The superintendent of public instruction must act upon the student's application and notify the applicant's school principal or designee, and the school district assessment coordinator whether the application was approved or denied within thirty days of receiving the application. The school principal or designee shall notify the student.~~

~~(4) If approved,~~)) Upon approval: The student's transcript shall indicate that the applicable certificate was waived.

(((~~(5) School staff shall include a copy of the application, the student's score report or transcript, and the approval notification in the student's cumulative folder.~~))

AMENDATORY SECTION (Amending WSR 10-01-055, filed 12/9/09, effective 1/9/10)

WAC 392-501-510 Access to alternative assessment. (1) Students who transfer into a public school from out-of-state ((~~or~~)), from out-of-country or into a public school from within the state from a nonpublic school setting in the ((~~eleventh or~~)) twelfth grade year may utilize an objective alternative assessment for purposes of meeting the high school standards as provided in RCW 28A.655.061 and 28A.655.065 without taking the state high school assessment.

(2) Students who transfer into a public school from out-of-state, from out-of-country or into a public school from within the state from a nonpublic school setting for their 11th ((~~or 12th~~)) grade year ((~~into a public school from within the state from a nonpublic school setting~~)) may utilize an objective alternative assessment for meeting the high school standards in science as provided in RCW 28A.655.061 and 28A.655.065 without taking the state high school assessment.

(3) Students who were exempted from the high school assessment in ((~~10th~~)) 11th grade due to their status as a new student with non-English proficiency, may utilize an objective alternative assessment after their ((~~10th~~)) 11th grade year, in the content areas originally exempted, for purposes of meeting the high school standards as provided in RCW 28A.655.061 and 28A.655.065 without taking the state high school assessment.

AMENDATORY SECTION (Amending WSR 15-04-083, filed 2/2/15, effective 3/5/15)

WAC 392-501-601 Eligibility and application requirements. (1) A student, or a student's parent or guardian may file an appeal to the superintendent of public instruction if the student has special, unavoidable circumstances that prevented the student, during the student's twelfth grade year (eleventh grade year under a specific circumstance where an educator has caused a testing irregularity), from ((~~successfully demonstrating~~)) participating in a testing opportunity that would allow demonstration of his or her skills and knowledge ((~~on the~~)), whether the general state high school assessment, ((~~on~~)) any of the objective alternative assessments authorized in RCW 28A.655.061 or 28A.655.065, or the alternate assessment or associated alternative assessments ((~~available~~)) applicable to students eligible for special education services. Appeals to the superintendent shall include a detailed description of the special, unavoidable circumstance that denied the student access to the testing opportunity, and will document a trend of continued improvement towards meeting standard (e.g., test scores, course grades, etc.) that demonstrates had the student participated in the state assessment, there was a reasonable probability the student would have met standard;

(2) Special, unavoidable circumstances shall include the following:

(a) Not being able to take or complete an assessment because of:

(i) The death of a parent, guardian, sibling or grandparent;

(ii) An unexpected and/or severe medical condition. The condition must be documented by a medical professional and included with the application, within the constraints of the Health Insurance Portability and Accountability Act (HIPAA); or

(iii) Another unavoidable event of a similarly compelling magnitude that district administrators determine prevented the student from sitting for or completing the assessment.

(b) A major irregularity in the administration of the assessment;

(c) Loss of the assessment material;

(d) Failure to receive an accommodation during administration of the assessment that was documented in the student's

individualized education program that is required in the federal Individuals with Disabilities Education Act, as amended, or in a plan required under Section 504 of the Rehabilitation Act of 1973;

(e) For students enrolled in the state transitional bilingual instructional program, failure to receive an accommodation during the administration of the assessment that was scheduled to be provided by the school district;

(f)(i) Students who transfer from an out-of-state, out-of-country, or nonpublic (including home-school environment) school to a Washington public school in the twelfth grade year after ((~~December 31st~~)) the end of the first term or February 15th whichever is first.

(ii) Application evidence must support a student's attempt of all available and feasible assessment opportunities and/or alternatives provided by Washington state before the application will be judged eligible for panel review.

(3) A school district superintendent may file an appeal to the superintendent of public instruction if the student has special, unavoidable circumstances that prevented the student, during the student's eleventh grade year, from successfully demonstrating his or her skills and knowledge on the state high school assessment, on an objective alternative assessment authorized in RCW 28A.655.061 or 28A.655.065, or alternate assessment or associated alternative assessments available to students eligible for special education services. For purposes of this subsection, a special, unavoidable circumstance is a major irregularity in the administration of the assessment that meets the following criteria:

(a) The major irregularity was caused by school district personnel;

(b) The student was not at fault for the irregularity; and

(c) The school district has taken documented disciplinary action against the school district personnel.

(4) To file an appeal, the student or the student's parent or guardian, with appropriate assistance from school staff, must complete and submit to the principal of the student's school an appeal application on a form developed by the superintendent of public instruction.

(5) The application shall require that the following materials be submitted: All available score reports from prior standardized assessments taken by the student during his or her high school years, the medical condition report (if applicable), IEP, 504 or transitional bilingual education program documentation pertinent to decisions about student access to available assessment type and/or testing accommodations (if applicable), enrollment/transfer information (if applicable), and the student's transcript. The principal of the school shall review the application and accompanying material and certify that, to the best of his or her knowledge, the information in the application is accurate and complete.

(6) Once the principal certifies that the application and accompanying material is accurate and complete, the principal shall transmit the application to the school district's assessment coordinator who will conduct an independent review for completeness prior to transmitting the application to the state superintendent of public instruction.

(7) Applications ((~~must~~)) are to be received by the superintendent of public instruction on or before May 1st or October 1st for processing and determinations.

AMENDATORY SECTION (Amending WSR 15-04-083, filed 2/2/15, effective 3/5/15)

WAC 392-501-602 Special, unavoidable circumstance appeal review board and approval criteria. (1) The special, unavoidable circumstance appeal review board shall be created to review and make recommendations to the superintendent of public instruction on all special, unavoidable circumstance appeal applications.

(2) The superintendent of public instruction shall appoint seven members total to the board, five voting members and two alternates (for cases of unanticipated absenteeism or potential conflict of interest on the part of a regular voting member). The board, where membership and panel experience allows, shall be chaired by a current or former high school principal and shall consist of current or former district administrators, teachers, school department heads, and/or school district assessment directors with experience and expertise with the Washington learning standards. Each member shall be appointed for a three-year term, provided that the initial terms may be staggered as the superintendent deems appropriate. As needed, the superintendent may elect to reappoint previous members if new candidates are not available to assume review board positions.

(3) The special, unavoidable circumstance appeals review board shall review applicable special, unavoidable circumstance appeal applications submitted to it by the superintendent of public instruction. The board shall:

(a) Review the written information submitted to determine whether sufficient evidence was presented that the student has the required knowledge and skills; and

(b) Make a recommendation to the superintendent, based on the criteria in subsection (6) of this section, regarding whether or not the appeal should be granted.

(4) Staff from the office of superintendent of public instruction (OSPI) shall coordinate and assist the work of the board. In this capacity, staff from OSPI shall prepare a preliminary analysis of each application and accompanying information that evaluates the extent in which the criteria in subsection (6) of this section have been met.

(5) If the board determines that additional information on a particular student is needed in order to fulfill its duties, the chair of the board shall contact the OSPI staff to request the information.

(6) The board shall recommend to the superintendent of public instruction that the appeal be granted if it finds that:

(a) The student, due to special, unavoidable circumstances as defined in WAC 392-501-601(2), was not able to successfully demonstrate his or her skills on a state high school assessment or on an objective alternative assessment;

(b) No other recourse or remedy exists to address the special, unavoidable circumstance prior to the student's expected graduation date;

(c) After considering the criteria below, in the board's best judgment, the student more likely than not possesses the skills and knowledge required to meet the state standard. The board shall consider the following criteria:

(i) Trends indicated by prior state high school assessment or alternative assessment results;

(ii) How near the student has been in achieving the standard;

(iii) Scores on other assessments, as available;

(iv) Participation and successful completion of remediation courses and other academic assistance opportunities;

(v) Cumulative grade point average;

(vi) Whether the student has taken advanced placement, honors, or other higher-level courses; and

(vii) Other available information deemed relevant by the board.

(7) Based upon the recommendation of the special, unavoidable circumstance appeals board and any other information that the superintendent deems relevant, the superintendent of public instruction shall decide, based on the criteria established in subsection (6) of this section, whether to:

(a) Grant the appeal and waive the requirement that a student earn a certificate to graduate;

(b) Deny the appeal and not waive the certificate; or

(c) Remand the appeal back to the appeals board for further information or deliberation.

(8) The superintendent of public instruction shall act upon the student's application and notify the student, the student's school principal or designee, and the school district assessment coordinator whether the application was approved or denied within thirty days of receiving the recommendation from the certificate appeals review board. The timeline for acting on the application recommendation may be extended if additional information is required from the student or the school district.

(9) If approved, the student's transcript shall indicate that the applicable content area assessment was waived.

(((10) School staff shall include a copy of the application, supporting information, and the superintendent's decision in the student's cumulative folder.))

AMENDATORY SECTION (Amending WSR 07-13-035, filed 6/13/07, effective 7/22/07)

WAC 392-501-604 Notification requirements. The school principal or a designee shall, as applicable, notify students and parents or guardians when student is in their ((eleventh and)) twelfth grade year((s)) of the availability of special, unavoidable circumstance appeals.

AMENDATORY SECTION (Amending WSR 10-01-054, filed 12/9/09, effective 1/9/10)

WAC 392-501-705 Eligibility and application requirements. (1) A student, ((or a student's parent or guardian, may initiate a waiver request to)) based on the decision of the student's IEP team, who participated in eleventh or twelfth grade Washington access to instruction and measurement (WA-AIM) using the engagement rubric process, will have his or her assessment graduation requirement for the content area automatically waived by the superintendent of public instruction ((if)). Assessment participation with the engagement rubric is appropriate if in the determination of the IEP team a student's cognitive development is identified at the awareness level. The automatic waiver ((request)) can cover one or all state assessed content areas of study. Students with cognitive development at the awareness level exhibit behaviors that include, but are not limited to, the following:

(a) Having limited intentionality and being unable to communicate using presymbolic strategies.

(b) Reactions to environmental stimuli are limited to crying, opening eyes, movement, etc.

(c) Behavior not under the student's control but reflects a general physical state (e.g., hungry, wet, sleepy).

(d) Being conscious (awake) during limited times each day.

(e) Requiring parents, teachers, or other adults to interpret the child's state from behaviors such as sounds, body movements, and facial expressions.

(f) Other criteria as defined by the superintendent of public instruction's guidelines posted to the agency web site.

(2) For ((a student requesting a)) the automatic waiver ((under this section)) to be processed, the student must have the following documented in his or her records:

(a) The student is in high school and is designated as being in the 11th or 12th grade.

(b) The individualized education program (IEP) team as identified under WAC 392-172A-03095, through an evaluation of the student's behaviors and educational history, determines that the student is functioning at the awareness level (as defined in subsection (1) of this section).

(((3) Filing a waiver request requires the use of a specific form developed by the superintendent of public instruction. Completing the waiver request requires:

(a) The special education teacher responsible for the IEP of the student to complete and sign the awareness waiver application and document the student's nonparticipation in the state assessment system in the student's IEP.

(b) The waiver application is submitted to the district's special education director for review, verification, and signature.

(c) Upon verification, the district special education director files the waiver application form with the district assessment coordinator.

(d) The district assessment coordinator reviews, signs, and transmits the waiver application to the superintendent of public instruction per instruction listed on the form.

(e) Staff from the office of)) (c) The superintendent of public instruction shall record a status of "waived" in the state graduation data base((, then transmit a confirmation e-mail to the student's high school principal and the district assessment coordinator.

(f))).

(d) The school shall complete all necessary school and district documentation, including but not limited to, IEP documentation.

WSR 16-20-056
PERMANENT RULES
SUPERINTENDENT OF PUBLIC INSTRUCTION

[Filed September 30, 2016, 10:14 a.m., effective October 31, 2016]

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

Purpose: These new rules, codified at chapter 392-900 WAC, will implement sections 5026 and 5028, chapter 3,

Laws of 2015, which create two pilot school construction grant programs for class size reduction and STEM facilities. The rules define the procedures that school districts must follow to receive funding under these new pilot programs.

Statutory Authority for Adoption: RCW 28A.525.020.

Adopted under notice filed as WSR 16-16-079 on July 29, 2016.

Changes Other than Editing from Proposed to Adopted Version: Language was added to clarify the WAC and make the processes easier to understand.

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 9, 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, 2016.

Randy Dorn
Superintendent of
Public Instruction

Chapter 392-900 WAC

PILOT GRANT PROGRAMS

STEM AND K-3 CLASS SIZE REDUCTION PILOT GRANT PROGRAMS ESTABLISHED IN THE 2015-17 WASHINGTON STATE CAPITAL BUDGET 2EHB 115.SL.

NEW SECTION

WAC 392-900-010 Authority. This chapter is adopted pursuant to RCW 28A.525.020, which authorizes the superintendent of public instruction to prescribe rules and regulations governing the administration, control, terms, conditions, and disbursements of state funding assistance to school districts to assist them in providing school facilities. In accordance with RCW 28A.525.200, the only provisions of chapter 28A.525 RCW currently applicable to state funding assistance for school facilities are RCW 28A.525.030, 28A.525.040, 28A.525.050, 28A.525.162 through 28A.525.178.

NEW SECTION

WAC 392-900-020 Purpose. The purpose of this chapter is to set forth provisions applicable to approval of STEM pilot project grants and K-3 class size reduction grants as provided for in sections 5026 and 5028, chapter 3, Laws of 2015 3rd sp. sess. (2EHB 1115 (2015)).

NEW SECTION

WAC 392-900-030 Eligibility. Eligibility for school construction assistance program funding through the STEM grant program will be based on a school district's ability to demonstrate a lack of sufficient space for science classrooms and labs to enable students to meet Washington state graduation requirements. The STEM grant award will constitute the district's local funding for purposes of eligibility for the school construction assistance program under RCW 28A.525.166.

Eligibility for the K-3 class size reduction grant program will be based on a school district's ability to demonstrate a need for additional K-3 classrooms as outlined in chapter 41, Laws of 2015, 3rd sp. sess. (2ESSB 6080 (2015)), with consideration of planned schools approved at the D-6 stage of the school construction assistance program. The K-3 class size reduction grant award may not constitute local funding in the school construction assistance program under RCW 28A.525.166.

NEW SECTION

WAC 392-900-040 Funding assistance percentage. (1) The state funding assistance percentage for the STEM pilot program is the computed state ratio defined in RCW 28A.525.166 plus twenty percent of the percent of district head count eligible and enrolled in the district's free and reduced school meal program, plus the following additional percentage points:

(a) Ten for second class school districts;

(b) Ten for school districts with funding assistance percentages of more than fifty percent.

(2) The enhanced funding assistance percentage for the K-3 class size reduction grant program is the computed state ratio defined in RCW 28A.525.166 plus twenty percent of the percent of district head count eligible and enrolled in the free and reduced school meal program.

NEW SECTION

WAC 392-900-050 Construction cost allocation (CCA). The eligible construction cost in the STEM grant program shall be calculated by multiplying the approved square foot area of the projects as set forth in WAC 392-900-040 by the construction cost allocation as set forth in WAC 392-343-060.

NEW SECTION

WAC 392-900-060 Eligible square footage. (1) Eligible area for STEM pilot projects is one thousand four hundred forty square feet per science lab or classroom combination, or both; and one thousand forty square feet per science classroom. The total eligible area per STEM project must not exceed fifteen thousand eight hundred forty.

(2) Additional square footage funded through the STEM grant program will be excluded from the school district's inventory of instructional space as defined in WAC 392-343-019 for determining eligibility for state assistance until the date of the final review of the latest study and survey of the

affected school district following acceptance of the project by the school district board of directors, or for a period of five years, whichever is earliest.

(3) Permanent additional square footage funded through the K-3 class size reduction grant program becomes part of a school district's inventory of instructional space for determining eligibility as defined in WAC 392-343-019 and shall be ineligible for state funding assistance for modernization for thirty years as described in WAC 392-347-015(4).

(4) Districts receiving funding through K-3 class size reduction grants may modernize facilities that were previously closed pursuant to WAC 392-347-042. Upon board acceptance of completion of the modernization project, the facility will be returned to the district's instructional inventory.

NEW SECTION

WAC 392-900-070 Process requirements. (1) Prior to STEM grant award finalization, the following documents and information will be required to be submitted to the office of the superintendent of public instruction:

(a) School board resolution for new-in-lieu facilities, as provided in WAC XXX-XX-XXX (if applicable);

(b) Intent to construct school board resolution;

(c) Five-year use/thirty-year life board resolution per WAC 392-347-030 and 392-347-015; and

(d) Certification letter from school district that any excess project costs above STEM grant award and enhanced state assistance funding will be expended from local sources.

(2) Upon completion of all STEM projects, the following shall be submitted to the office of the superintendent of public instruction:

(a) Certified letter from architect verifying final gross square footage of project; and

(b) Final acceptance of completion of the project or facility school board resolution.

(3) Prior to K-3 grant awards being finalized, the following documents and information will be required to be submitted to the superintendent of public instruction:

(a) Five-year use/thirty-year life board resolution per WAC 392-347-030 and 392-347-015;

(b) School board resolution certifying that the district will submit the required documentation of subsection (4) of this section;

(c) Certification that the school district has authorized local funds to complete the project(s);

(d) Certification that the school district has an available site(s) for the project(s) if the total project cost exceeds the state grant amount;

(e) Certification that additional classrooms will achieve progress towards the reduction of the average class size objectives provided for in the 2017-18 school year and enumerated in RCW 28A.150.260, and all-day kindergarten as funded pursuant to RCW 28A.150.315.

(4) Upon completion of each K-3 class size reduction grant project, the following shall be submitted to the superintendent of public instruction:

(a) Name of school facility;

(b) Number of classrooms added, renovated or modernized;

(c) Gross square footage added, renovated or modernized;

(d) Total project budget amount (construction and other related direct project costs);

(e) Final construction contract amount;

(f) Site plan;

(g) Floor plan(s);

(h) Area analysis per WAC 392-343-040;

(i) If applicable, high-performance scorecard and credit cost analysis (chapter 39.35D RCW);

(j) If applicable, high-performance ELCCA executive summary (chapter 39.35D RCW);

(k) If applicable, apprenticeship reporting documentation (RCW 39.04.320); and

(l) Final acceptance of completion school board resolution.

NEW SECTION

WAC 392-900-080 State funded combination projects. Eligible STEM grant projects that are undertaken in conjunction with another school construction assistance program project must follow all applicable requirements defined in chapters 392-342 through 392-347 WAC. State construction assistance funding and STEM grant awards for eligible area within the STEM grant project will be calculated separately in accordance with this chapter.

NEW SECTION

WAC 392-900-090 Waiver of rules to facilitate pilot grant programs. Subject to factual determinations by the superintendent of public instruction, the provisions of chapters 392-341 through 392-347 WAC which supplement statutory requirements are hereby deemed waived to the extent any provision would prevent or delay the implementation of legislative allocations, grant programs or pilot grant programs.

WSR 16-20-078
PERMANENT RULES
DEPARTMENT OF LABOR AND INDUSTRIES

[Filed October 4, 2016, 10:39 a.m., effective November 15, 2016]

Effective Date of Rule: November 15, 2016.

Purpose: This rule change will allow for the elimination of the existing differential payment for advanced registered nurse practitioners (ARNP). The anticipated effect is a maintenance or increase in the number of ARNPs who could treat injured workers. The department of labor and industries has a perpetual interest in maintaining or increasing access of care for injured workers so they can get quality and timely treatment from licensed and qualified providers.

Citation of Existing Rules Affected by this Order: Amending WAC 296-23-245.

Statutory Authority for Adoption: RCW 51.04.020(1) and 51.04.030.

Adopted under notice filed as WSR 16-15-076 on July 19, 2016.

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 1, Repealed 0.

Date Adopted: October 4, 2016.

Joel Sacks
Director

AMENDATORY SECTION (Amending WSR 01-18-041, filed 8/29/01, effective 10/1/01)

WAC 296-23-245 Licensed nursing billing instructions. (1) Registered nurses may be required to obtain provider account numbers from the department as outlined by department policy.

(2) Advanced registered nurse practitioners must obtain provider account numbers from the department.

(3) Refer to WAC 296-20-132 and 296-20-135 for information regarding the conversion factors.

(4) Refer to the department's billing instructions for additional information.

(5) Services performed by advanced registered nurse practitioners must be billed using the appropriate procedure code number listed in the fee schedules preceded by a Type of Service Code "N." ((~~The rate of reimbursement for the services billed by advanced registered nurse practitioners will be ninety percent of the value listed in the fee schedules.~~))

(6) Refer to WAC 296-20-303 for rules regarding home attendant services.

WSR 16-20-080
PERMANENT RULES
HEALTH CARE AUTHORITY
(Public Employees Benefits Board)

[Admin. # 2016-01—Filed October 4, 2016, 10:58 a.m., effective January 1, 2017]

Effective Date of Rule: January 1, 2017.

Purpose: Amends existing rules in Title 182 WAC specific to the public employees benefits board (PEBB) program with the following effect:

1. Implement PEBB policy resolutions to amend the definition of tobacco products and amend domestic partner eligibility requirements.

2. Makes technical amendments to:

- Amend WAC 182-08-180 to specifically state that failure to pay premiums will result in termination of PEBB benefits.
- Amend WAC 182-08-197 to state that elections not submitted in a timely manner will result in default elections; add clarity to describe when optional life and long-term disability insurance begins for an employee who regains eligibility, and changing the number of days for an employee to submit a life insurance form from sixty to thirty-one days.
- Amend WAC 182-08-199 (3)(a)(xi) to state "or enrolls in or terminates enrollment in a medicare Part D plan."
- Amend WAC 182-08-220 (1)(c) to replace the word "employees" with the word "enrollees."
- Amend rules in chapters 182-08 and 182-12 WAC to more clearly distinguish school districts and educational service districts from all the other employer groups that may contract with the PEBB program. Clarify that applications submitted by employer groups must clearly identify all bargaining units within their organization and which bargaining units are applying for PEBB benefits. Clarify when enrollment will begin following approval of an application.
- Clarify within WAC 182-08-237 that a local government or tribal government must make the decision to include or not include existing retirees at the time the entity submits an application for the bargaining unit to participate in PEBB benefits.
- Amend WAC 182-08-240 to clarify what data is used to evaluate employer group applications.
- Amend WAC 182-12-131(3) to ensure that the references to WAC 182-12-114 are clear.
- Amend WAC 182-12-133(2) to say employees may continue medical, dental, or both for the remaining months allowed under COBRA.
- Amend WAC 182-12-148 to state that premiums must be paid or coverage will be terminated.
- Amend chapters 182-08, 182-12, 182-16 WAC to clarify the meaning of employer-paid coverage versus employer-based coverage.
- Amend references to RCW 41.05.011, to include medical only employer groups in which an employee has waived PEBB program medical coverage.
- Amend chapters 182-08 and 182-12 WAC to address underpayment of premiums.
- Amend WAC 182-12-260(3) to say "Children are eligible through the last day of the month in which their twenty-sixth birthday occurred."
- Amend WAC 182-16-010 to state that the definitions within WAC 182-16-020 apply throughout this chapter.
- Amend WAC 182-16-020 to add new definitions for "appellant," "filling," ["filing"] and "service" and to amend definitions for "PEBB program," "denial or denial notice," "documents," and "hearing."

- Amend all sections within chapter 182-16 WAC to account for the new and amended definitions contained within WAC 182-16-020.
- Clarify within WAC 182-16-050(2) that a written request must be received within thirty calendar days after the date of the written decision letter from the PEBB appeals committee.
- Amend WAC 182-16-052 so that an appellant may act on their own behalf or have someone else represent them.
- Clarify within WAC 182-16-061(3) that a petition request can also be denied.
- Add new sections to chapter 182-16 WAC regarding how to serve documents and the use of subpoenas within the appeals process.
- Clarify within WAC 182-16-071 that a presiding officer's office must serve notice twenty-one calendar days before a hearing, not fourteen calendar days.
- Clarify within WAC 182-16-081 (4)(d) that a schedule will be established for the exchange and filling [filing] of briefs, providing a proposed witnesses list, and providing exhibit lists prior to the hearing.
- Amend WAC 182-16-105(1) to include a timeline when a reconsideration request may be made to the presiding officer.
- Global change across chapters 182-08, 182-12, 182-16 WAC to incorporate the correct use of "PEBB insurance coverage" vs. "insurance coverage."
- Global change across chapters 182-08, 182-12, 182-16 WAC to incorporate the correct use of "employer" as used in RCW 41.05.011.
- Amend WAC 182-12-205 to require a request to terminate coverage to be made in writing and to allow coverage to be terminate[d] the last day of the previous month if a written request to voluntary [voluntarily] terminate coverage is received on the first day of the month.
- Global change across chapters 182-08, 182-12, 182-16 WAC to include "and regulations" along with every reference to Internal Revenue Code.
- Amend WAC 182-12-114 so that employee's eligibility for benefits is in alignment with RCW 41.05.065.
- Amend the special open enrollment provision for a "change in employment status" to add clarity.

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

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Other Authority: SB 6475 (2016 regular session) and PEBB policy resolutions.

Adopted under notice filed as WSR 16-17-115 on August 22, 2016.

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 14, 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 2, Amended 50, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 2, Amended 64, Repealed 0.

Date Adopted: October 4, 2016.

Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 15-22-099, filed 11/4/15, effective 1/1/16)

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

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

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

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

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

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

"Continuation coverage" means the temporary continuation of PEBB health plan coverage available to enrollees after a qualifying event occurs as administered under Title XXII of the Public Health Service (PHS) Act, 42 U.S.C. Secs. 300bb-1 through 300bb-8.

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

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

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

"Dependent care assistance program" or "DCAP" means a benefit plan whereby 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 authority.

"Documents" means papers, letters, writings, ((~~e-mails~~)) electronic mail, electronic files, or other printed or written items.

"Employee" includes all employees of the state, whether or not covered by civil service; elected and appointed officials of the executive branch of government, including full-time members of boards, commissions, or committees; justices of the supreme court and judges of the court of appeals and the superior courts; and members of the state legislature. Pursuant to contractual agreement with the authority, "employee" may also include: (a) Employees of a county, municipality, or other political subdivision of the state and members of the legislative authority of any county, city, or town who are elected to office after February 20, 1970, if the legislative authority of the county, municipality, or other political subdivision of the state ((~~seeks and receives the approval of~~)) submits application materials to the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.04.205 and 41.05.021 (1)(g); (b) employees of employee organizations representing state civil service employees, at the option of each such employee organization, and, effective October 1, 1995, employees of employee organizations currently pooled with employees of school districts for the purpose of purchasing insurance benefits, at the option of each such employee organization; (c) employees of a school district if the authority agrees to provide any of the school districts' insurance programs by contract with the authority as provided in RCW 28A.400.350; (d) employees of a tribal government, if the governing body of the tribal government seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(f) and (g); (e) employees of the Washington health benefit exchange if the governing board of the exchange established in RCW 43.71.020 seeks and receives approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(g) and (n); and (f) employees of a charter school established under chapter 28A.710 RCW. "Employee" does not include: Adult family home providers; unpaid volunteers; patients of state hospitals; inmates; employees of the Washington state convention and trade center as provided in RCW 41.05.110; students of institutions of higher education as determined by their institution; and any others not expressly defined as employees under this chapter or by the authority under this chapter.

"Employer" means the state of Washington as defined in RCW 41.05.011.

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

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

"Employer contribution" means the funding amount paid to the authority by a state agency, employer group, or charter school for its eligible employees as described in WAC 182-12-114 and 182-12-131, and the employee's eligible dependents as described in WAC 182-12-260.

"Employer group" means those counties, municipalities, political subdivisions, the Washington health benefit exchange, tribal governments, school districts, educational service districts, and employee organizations representing state civil service employees, obtaining employee benefits through a contractual agreement with the authority as described in WAC 182-08-245.

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

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

"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; charter school; 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.

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

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

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

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

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

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

((~~"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.~~))

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

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

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

"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.

((~~"Mail" or "mailing" means placing a document in the United States Postal system, commercial delivery service, or Washington state consolidated mail services properly addressed.~~))

"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.

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

"PEBB" means the public employees benefits board.

"PEBB 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 health care authority.

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

"PEBB program" means the program within the HCA that administers insurance and other benefits for eligible employees (as described in WAC 182-12-114), eligible retired employees (as described in WAC 182-12-171), eligible dependents (as described 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.

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

• Premiums are less than ninety-five percent of Uniform Medical Plan (UMP) Classic premiums; and

• The actuarial value of benefits is at least ninety-five percent of the actuarial value of UMP Classic benefits.

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

"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.

((~~"School district" means public schools as defined in RCW 28A.150.010 which includes charter schools established under chapter 28A.710 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.~~))

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

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

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

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

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

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

AMENDATORY SECTION (Amending WSR 13-22-019, filed 10/28/13, effective 1/1/14)

WAC 182-08-120 Employer contribution. The employer contribution must be used to provide public employees benefits board (PEBB) 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 WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-08-180 Premium payments and premium refunds. Premiums are due as described in this section, except when an employing agency is correcting its enrollment error as described in WAC 182-08-187 (2) or (3).

(1) **Premium payments.** Public employees benefits board (PEBB) insurance coverage premiums become due the first of the month in which insurance coverage is effective.

Premium is due from the subscriber for the entire month of insurance coverage and will not be prorated during any month.

(a) If an employee elects optional coverage as described in WAC 182-08-197 (1)(a) or (3)(a), the employee is responsible for payment of premiums from the month that the optional coverage begins.

(b) Unpaid or underpaid ((~~accounts~~)) premiums must be paid, and are due from the employing agency, subscriber, or ((~~beneficiary~~)) a subscriber's legal representative to the health care authority (HCA). ((~~If a subscriber's account is past due and~~)) A subscriber's monthly premium or premium surcharge that remains unpaid for thirty days will be considered delinquent. A subscriber is allowed a grace period of thirty days from the date the monthly premium or premium surcharge becomes delinquent to pay the unpaid premium balance or surcharge. If a subscriber's monthly premium or premium surcharge remains unpaid for sixty days, the subscriber's PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and any premium surcharge was paid. If it is determined by the authority that ((~~full~~)) payment of the unpaid balance in a lump sum would be considered a hardship, the authority may develop a reasonable repayment plan with the subscriber or ((~~beneficiary~~)) the subscriber's legal representative upon request.

(c) A monthly premium due from a subscriber who is not eligible for the employer contribution will be considered unpaid if one of the following occurs:

(i) No payment of premium or premium surcharge is received by the authority and the monthly premium remains unpaid for thirty days; or

(ii) A premium payment or premium surcharge received by the authority is underpaid by an amount greater than an insignificant shortfall and the monthly premium remains underpaid for thirty days past the date the monthly premium was due.

(2) **Premium refunds.** PEBB premiums will be refunded using the following method:

(a) When a subscriber submits an enrollment change affecting subscriber or dependent eligibility, HCA may allow up to three months of accounting adjustments. HCA will refund to the individual or the employing agency any excess premium paid during the three month adjustment period, except as indicated in WAC 182-12-148(((~~(4)~~))) (5).

(b) If a PEBB subscriber, dependent, or beneficiary submits a written appeal as described in WAC 182-16-025, showing proof of extraordinary circumstances beyond his or her control such that it was effectively impossible to submit the necessary information to accomplish an enrollment change within sixty days after the event that created a change of premium occurred, the PEBB ((~~deputy~~)) division director, designee, or the PEBB appeals committee may approve a refund which does not exceed twelve months of premium.

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

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

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

AMENDATORY SECTION (Amending WSR 15-22-099, filed 11/4/15, effective 1/1/16)

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

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

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

(ii) If there is a change in the tobacco use status of any enrollee, thirteen years and older on the subscriber's PEBB medical, the subscriber must update his or her attestation on the required form. An employee must submit the updated attestation to his or her employing agency. Any other subscriber must submit his or her updated attestation to the PEBB program.

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

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

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

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

(v) An employee or retiree who enrolls in PEBB medical as described in WAC 182-12-171 (1)(a), 182-12-200 (3)(a) and (b), or 182-12-205 (6)(a), (b), (c), (d), and (e), must provide an attestation on the required form if he or she has not previously attested as described in (a) of this subsection. The employee or retiree must submit his or her updated attestation to the PEBB program. An attestation that results in a premium surcharge will take effect the same date as PEBB medical begins.

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

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

Exception: (1) A subscriber enrolled in both medicare parts A and B and in the medicare risk pool is not required to provide an attestation and no premium surcharge will be imposed on the subscriber's account.

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

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

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

(i) An enrollee who is eighteen years and older and uses tobacco products has access to a free tobacco cessation program through his or her PEBB medical.

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

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

(2) A subscriber will incur a premium surcharge if an enrolled spouse or state registered domestic partner elected not to enroll in employer-based group medical ((~~insurance~~)) that has premiums less than ninety-five percent of the Uniform Medical Plan (UMP) Classic's premiums and benefits with an actuarial value of at least ninety-five percent of the actuarial value of the UMP Classic's benefits.

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

(i) When a subscriber becomes eligible to enroll a spouse or state registered domestic partner in PEBB medical as described in WAC 182-12-262 (1)(a). A subscriber must complete the required form to enroll his or her spouse or state registered domestic partner. The subscriber must include his or her attestation on that form. The employee must submit the attestation to his or her employing agency. Any other subscriber must submit an attestation to the PEBB program. If the subscriber's attestation results in a premium surcharge it will take effect the same date as PEBB medical begins;

(ii) When a special open enrollment (SOE) event occurs as described in WAC 182-12-262 (1)(c). A subscriber must submit the required form to enroll a spouse or state registered domestic partner in PEBB medical. The subscriber must include his or her updated attestation on that form. An employee must submit an updated attestation to his or her employing agency. Any other subscriber must submit an updated attestation to the PEBB program. If the subscriber's attestation results in a premium surcharge it will take effect the first day of the month following receipt of the attestation. If that day is the first day of the month, the change to the surcharge begins on that day;

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

• Incurring the surcharge;

• Not incurring the surcharge because the spouse's or state registered domestic partner's share of the medical premium through his or her employer-based group medical ((~~insurance~~)) was more than ninety-five percent of the UMP Classic's premiums; or

• Not incurring the surcharge because the actuarial value of benefits provided through the spouse's or state registered domestic partner's employer-based group medical ((~~insur-~~

~~ance~~)) was less than ninety-five percent of the UMP Classic's actuarial value.

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

(iv) When there is a change in the spouse's or state registered domestic partner's employer-based group medical ((~~insurance~~)). An employee must submit an updated attestation to his or her employing agency within sixty days of when the spouse's or state registered domestic partner's employer-based group medical ((~~insurance~~)) status changes. Any other subscriber must submit an updated attestation to the PEBB program no later than sixty days after the spouse's or state registered domestic partner's employer-based group medical ((~~insurance~~)) changes.

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

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

Exception:
(1) A subscriber enrolled in both medicare parts A and B and in the medicare risk pool is not required to provide an attestation and no premium surcharge will be imposed on the subscriber's account.
(2) An employee who waives PEBB medical according to WAC 182-12-128 is not required to provide an attestation and no premium surcharge will be applied to his or her account as long as the employee remains in waived status.
(3) An employee who covers his or her spouse or state registered domestic partner who has waived his or her own PEBB medical must attest, but a premium surcharge will not be applied.
(4) A subscriber who covers his or her spouse or state registered domestic partner who elected not to enroll in TRICARE must attest, but a premium surcharge will not be applied.

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

AMENDATORY SECTION (Amending WSR 15-22-099, filed 11/4/15, effective 1/1/16)

WAC 182-08-187 How do employing agencies correct enrollment errors and is there a limit on retroactive enrollment? An employing agency that fails to timely enroll an employee, or his or her dependent, in public employees benefits board (PEBB) benefits must correct the error as described in this section. An agency must correct a failure to notify an employee timely of his or her eligibility for PEBB benefits and the employer contribution; or a failure to accurately enroll PEBB insurance coverage; or a failure to accurately enroll PEBB insurance coverage as ((~~required by~~)) described in WAC 182-08-197 (1)(b); or a failure to accurately reflect premium surcharge status.

The employing agency or the PEBB program's designee must enroll the employee and the employee's dependent, as elected, in PEBB benefits as described in subsection (1) of this section, reconcile premium payments and premium surcharges as described in subsection (2) of this section, and provide recourse as described in subsection (3) of this section.

Note: If the employing agency failed to provide the notice required in WAC 182-12-113 or the employer group contract before the end of the employee's thirty-one day enrollment period described in WAC 182-08-197 (1)(a), the employing agency must provide the employee a written notice of eligibility for PEBB benefits and offer a new enrollment period. Employees who do not return the required enrollment forms default to enrollment according to WAC 182-08-197 (1)(b).

(1) **Enrollment.**

(a) PEBB medical and dental enrollment is effective the first day of the month following the date the enrollment error is identified, unless the authority determines additional recourse is warranted, as described in subsection (3) of this section. If the enrollment error is identified on the first day of the month, the enrollment correction is effective that day;

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

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

(i) Optional life and optional LTD insurance ((~~coverage~~)) is enrolled the first day of the month the employee regained eligibility, at the same level of coverage the employee continued during the period of leave, without evidence of insurability.

(ii) If the employee was not eligible to continue optional LTD insurance ((~~coverage~~)) during the period of leave, optional LTD insurance ((~~coverage~~)) is reinstated the first day of the month the employee regained eligibility, to the level of coverage the employee was enrolled in prior to the period of leave, without evidence of insurability.

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

(d) If the employee is eligible and elects (or elected) to enroll in the medical flexible spending arrangement (FSA) or

dependent care assistance program (DCAP), enrollment is limited to three months prior to the date enrollment is processed, but not earlier than the current plan year. If an employee was not enrolled in an FSA or DCAP as elected, the employee may adjust his or her election. The employee may either participate at the amount originally elected with a corresponding increase in contributions for the balance of the plan year, or participate at a reduced amount for the plan year by maintaining the per-pay period contribution in effect.

(2) **Premium payments.**

(a) The employing agency must remit to the authority the employer contribution and the employee contribution for health plan premiums, premium surcharges, basic life, and basic LTD from the date insurance coverage begins as described in subsections (1) and (3)(a)(i) of this section. If a state agency failed to notify a newly eligible employee of his or her eligibility for PEBB benefits, the state agency may only collect the employee contribution for health plan premiums and premium surcharges for coverage for months following notification of a new enrollment period.

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

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

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

(3) **Recourse.**

(a) Employee eligibility for PEBB benefits begins on the first day of the month following the date eligibility is established as described in WAC 182-12-114. Dependent eligibility is described in WAC 182-12-260, and dependent enrollment is described in WAC 182-12-262. When retroactive correction of an enrollment error is limited as described in subsection (1) of this section, the employing agency must work with the employee, and the authority, to implement retroactive PEBB insurance coverage within the following parameters:

(i) Retroactive enrollment in a PEBB health plan;

(ii) Reimbursement of claims paid;

(iii) Reimbursement of amounts paid for medical and dental premiums; or

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

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

AMENDATORY SECTION (Amending WSR 15-22-099, filed 11/4/15, effective 1/1/16)

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

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

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

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

(4) Employees of employer groups and charter schools eligible under criteria stipulated under contract with the HCA are eligible for the employer contribution. The entire employer contribution is due and payable to the HCA even if PEBB medical is waived as described in WAC 182-12-128.

(5) Washington state patrol officers disabled while performing their duties as determined by the chief of the Washington state patrol are eligible for the employer contribution for PEBB medical as authorized in RCW 43.43.040. No other retiree or disabled employee is eligible for the employer contribution for PEBB benefits unless they are an eligible employee as described in WAC 182-12-114 or 182-12-131.

(6) The terms of payment to HCA for employer groups and charter schools shall be stipulated under contract with the HCA.

AMENDATORY SECTION (Amending WSR 11-22-036, filed 10/26/11, effective 1/1/12)

WAC 182-08-196 What happens if my health plan becomes unavailable? (1) Subscribers must select a new health plan within sixty days of their chosen health plan becoming unavailable due to a change in contracting service area or the subscriber or subscriber's dependent ceasing to be eligible because of his or her enrollment in medicare.

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

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

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

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

(a) Employees who fail to select a new health plan within the required time period will be enrolled in a successor plan

if one is available or will be enrolled in a plan designated by the director.

(b) All other subscribers who fail to select a new health plan within the required time period will be enrolled in a successor plan if one is available or a plan designated by the director.

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

AMENDATORY SECTION (Amending WSR 15-22-099, filed 11/4/15, effective 1/1/16)

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

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

(a) An employee must complete the required forms indicating his or her enrollment elections, including an election to waive PEBB medical if the employee chooses to waive PEBB medical as described in WAC 182-12-128. The required forms must be returned to the employee's employing agency. Forms must be received by his or her employing agency no later than thirty-one days (((~~(sixty days for life insurance)~~))) after the employee becomes eligible for PEBB benefits under WAC 182-12-114.

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

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

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

(b) If a newly eligible employee's employing agency does not receive the employee's required forms indicating medical, dental, life insurance, and LTD insurance elections, and the employee's tobacco use status attestation within thirty-one days ((~~and life insurance elections within sixty days~~)) of the employee becoming eligible, his or her enrollment will be as follows for those elections not received within thirty-one days:

(i) Uniform Medical Plan Classic;

(ii) Uniform Dental Plan;

(iii) Basic life insurance;

(iv) Basic long-term disability insurance;

(v) Dependents will not be enrolled; and

(vi) A tobacco use surcharge will be incurred as described in WAC 182-08-185 (1)(b).

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

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

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

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

(ii) An employee who was eligible to continue optional life under continuation coverage but discontinued that insurance coverage must submit evidence of insurability;

(iii) An employee who was eligible to continue optional LTD under continuation coverage but discontinued that insurance coverage must submit evidence of insurability for optional LTD insurance to the PEBB designee when he or she regains eligibility for the employer contribution.

(b) An employee in any of the following circumstances does not have to return a form indicating optional LTD insurance elections. His or her optional LTD insurance will be automatically reinstated effective the first day of the month he or she is in pay status eight or more hours:

(i) The employee continued to self-pay for his or her optional LTD insurance after losing eligibility for the employer contribution;

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

(c) If an employee's employing agency does not receive the required forms within thirty-one days of the employee

regaining eligibility, medical, dental, life insurance, tobacco use surcharge, and LTD insurance enrollment will be as described in subsection (1)(b) of this section, except as described in (b) of this subsection.

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

(4) If an employee who is eligible to participate in the state's salary reduction plan (see WAC 182-12-116) is hired into a new position that is eligible for PEBB benefits in the same year, the employee may not resume participation in DCAP or medical FSA until the beginning of the next plan year, unless the time between employments is 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.

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

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

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 public employees benefits board (PEBB) annual open enrollment period. The subscriber must submit the required enrollment forms to change his or her health plan. An employee((~~s~~)) submits the enrollment forms to ((~~their~~)) his or her employing agency. All other subscribers submit the enrollment forms to the PEBB program. The required enrollment forms must be received no later than the last day of the annual open enrollment. Enrollment in the new health plan will begin January 1st of the following year.

(2) **During a special open enrollment:** 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 Treasury regulations, and correspond to and be consistent with the event that creates the special open enrollment for the subscriber, the subscriber's dependent, or both. To make a health plan change, the subscriber must submit the required enrollment forms (and a completed disenrollment form, if required). The forms must be received no later than sixty days after the event occurs. An employee((~~s~~)) submits the enrollment forms to ((~~their~~)) his or her employing agency. All other subscribers submit the enrollment forms to the PEBB program. Subscribers must provide evidence of the event that created the special open enrollment. New health plan coverage will begin the first day of the month following the later of the event date or the date the form is received. If that day is the first of the month, the change in enrollment begins on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, health plan coverage will begin the month in which the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption occurs. Any one of the following events may create a special open enrollment:

(a) Subscriber acquires a new dependent due to:

(i) Marriage or registering a domestic partnership;

(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 ((~~their~~)) his or her employer contribution toward his or her employer-based group health ((~~insurance~~)) plan;

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

Exception: For the purposes of special open enrollment "employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 54.9801-6.

(e) Subscriber or a subscriber's dependent has a change in residence that affects health plan availability. If the subscriber moves and the subscriber's current health plan is not available in the new location the subscriber must select a new health plan. 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(2);

(((~~e~~))) (f) A court order or national medical support 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 state registered domestic partner is not an eligible dependent);

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

(((~~g~~))) (h) Subscriber or a subscriber's dependent becomes eligible for state premium assistance subsidy for

PEBB health plan coverage from medicaid or a state children's health insurance program (CHIP);

(((~~h~~))) (i) Subscriber or a subscriber's dependent becomes entitled to coverage under medicare, or the subscriber or a subscriber's dependent loses eligibility for coverage under medicare, or enrolls in or ((~~cancels~~)) terminates enrollment in a medicare Part D plan. If the subscriber's current health plan becomes unavailable due to the subscriber's or a subscriber's dependent's entitlement to medicare, the subscriber must select a new health plan as described in WAC 182-08-196(1);

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

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

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

(ii) 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 postoperative period of up to eight weeks; or

(v) Third trimester of pregnancy.

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 WSR 15-22-099, filed 11/4/15, effective 1/1/16)

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 employee who is eligible to participate in the state's salary reduction plan 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 newly eligible under WAC 182-12-114, as described in WAC 182-08-197(1).

(2) **During annual open enrollment:** An eligible employee may enroll in or change his or her election under the state's premium payment plan, medical FSA, or DCAP during the annual open enrollment. For the state's premium payment plan, the required form must be submitted to his or her employing agency. To enroll or reenroll in medical FSA or DCAP the employee must submit the required form to his or her employing agency or the public employees benefits board (PEBB) program's designee. All required forms must be received no later than the last day of the annual open enrollment. The enrollment or new election ((~~will be~~)) becomes effective January 1st of the following year.

(3) **During a special open enrollment:** An employee may enroll or change his or her 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 election must be allowable under Internal Revenue Code (IRC) and Treasury regulations, and correspond to and be consistent with the event that creates the special open enrollment. To make a change or enroll, the employee must submit the required forms as instructed on the forms. The required forms must be received no later than sixty days after the event occurs. The employee must provide evidence of the event that created the special open enrollment.

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 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. The enrollment or change in election will be effective the first day of the month following the later of the event date or the date the required form is received. If that day is the first of the month, the enrollment or change in election begins on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, the enrollment or change in election will begin the first of the month in which the event occurs.

(i) Employee acquires a new dependent due to:

• Marriage;

• Registering a 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 PEBB eligibility criteria because:

• Employee has a change in marital status;

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

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

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

• An eligible dependent dies.

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

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

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

Exception: For the purposes of special open enrollment "employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 54.9801-6.

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

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

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

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

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

(((~~x~~))) (xi) Employee or an employee's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from medicaid or a state children's health insurance program (CHIP);

(((~~xi~~))) (xii) Employee or an employee's dependent becomes entitled to coverage under medicare((~~,~~)) or the employee or an employee's dependent loses eligibility for coverage under medicare((~~, or enrolls in or terminates enrollment in a medicare Part D plan~~));

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

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

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

• Transplant within the last twelve months; or

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

• Recent major surgery still within the postoperative period of up to eight weeks; or

• Third trimester of pregnancy.

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

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

(b) **Medical flexible spending arrangement (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. The enrollment or change in election will be effective the first day of the month following the later of the event date or the date the required form is received. If that day is the first of the month, the enrollment or change in election begins on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, the enrollment or change in election will begin the first of the month in which the event occurs.

(i) Employee acquires a new dependent due to:

• Marriage;

• Registering a 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 state registered domestic partner who qualifies as a tax dependent is dissolved or terminated;

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

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

• An eligible dependent dies.

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

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

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

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

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

(c) **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. The enrollment or change in election will be effective the first day of the month following the later of the event date or the date the required form is received. If that day is the first of the month, the enrollment or change in election begins on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, the enrollment or change in election will begin the first of the month in which the event occurs.

(i) Employee acquires a new dependent due to:

• Marriage;

• Registering a 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~~)) an employer-based group health ((~~insurance~~)) 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;

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

(vi) Employee's dependent care provider imposes a change in the cost of dependent care; employee may make a change in the DCAP to reflect the new cost if the dependent care provider is not a qualifying relative of the employee as defined in Internal Revenue Code Section 152.

AMENDATORY SECTION (Amending WSR 15-22-099, filed 11/4/15, effective 1/1/16)

WAC 182-08-220 Advertising or promotion of public employees benefits board (PEBB) benefit plans. (1) In order to assure equal and unbiased representation of public employees benefits board (PEBB) benefits, contracted vendors must comply with all of the following:

(a) All materials describing PEBB benefits must be prepared by or approved by the health care authority (HCA) before use.

(b) Distribution or mailing of all benefit descriptions must be performed by or under the direction of the HCA.

(c) All media announcements or advertising by a contracted vendor which includes any mention of the "public employees benefits board," "PEBB," "health care authority," "HCA," any reference to benefits for "state employees," or "retirees," or any group of ((~~employees~~)) enrollees covered by PEBB benefits, must receive the advance written approval of the HCA.

(2) Failure to comply with any or all of these requirements by a PEBB contracted vendor or subcontractor may result in contract termination by the HCA, refusal to continue or renew a contract with the noncomplying party, or both.

AMENDATORY SECTION (Amending WSR 15-22-099, filed 11/4/15, effective 1/1/16)

WAC 182-08-235 Employer group and charter school application process. This section applies to employer groups as defined in WAC 182-08-015 and to charter schools. An employer group or charter school may apply to obtain public employees benefits board (PEBB) insurance coverage through a contract with the health care authority (HCA). ((~~With the exception of school districts and educational service districts, the authority will approve or deny applications through the evaluation criteria described in WAC 182-08-240. To apply, employer groups must submit the documents and information described in this rule to the public employees benefits board (PEBB) program~~))

(1) Employer groups and charter schools with less than five thousand employees must apply at least sixty days before the requested coverage effective date. ((~~School districts and educational service districts are only~~)) Employer groups and charter schools with five thousand or more employees must apply at least one hundred twenty days before the requested coverage effective date. To apply, employer groups and charter schools must submit the documents and information described in subsection (2) of this section to the PEBB program as follows:

(a) School districts, educational service districts, and charter schools are required to provide the documents described in subsections ((~~(1), (2), and (3)~~)) (2)(a) through (c) of this section((~~. If school districts or educational service districts are required by the superintendent of public instruction to purchase insurance coverage provided by the authority, they are required to submit documents and information described in subsections (1)(c), (2), and (3) of this section.~~

~~(1)~~));

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

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

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

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

(2) Documents and information required with application:

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

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

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

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

(((~~d~~))) (iv) A statement of whether the ((~~employer~~)) group is ((~~requesting only medical or medical, dental, life, and long-term disability (LTD) insurance~~)) applying to obtain only medical or all available PEBB insurance coverages. School districts and educational service districts must purchase medical, dental, life, and LTD insurance.

(((~~2~~))) (b) A resolution from the ((~~employer~~)) group's governing body authorizing the purchase of PEBB insurance coverage.

(((~~3~~))) (c) 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~~))) (d) 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~~))) (i) Employee ID (any identifier which uniquely identifies the employee; for dependents the employee's unique identifier must be used);

(((~~b~~))) (ii) Age;

(((~~c~~))) (iii) Gender;

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

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

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

(((~~5~~))) (e) Historical claims and cost information that include the following:

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

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

(iii) Summary of historical plan costs; and

(iv) The director or designee may make an exception to the claims and cost information requirements based on the size of the group.

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

(f) 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 (d) of this subsection (((~~(4) of this section~~))). This includes retired employees participating under the ((~~employer~~)) group's current health plan. 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 three hundred one to two thousand 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)~~)) (g) Employer groups ((~~with greater than two thousand five hundred eligible employees~~)) described in subsection (1)(c) and (d) of this section must submit to an actuarial evaluation of the group provided by an actuary designated by the PEBB program. The ((~~employer~~)) group must pay for the cost of the evaluation. This cost is nonrefundable. ((~~An employer~~)) A group that is approved will not have to pay for an additional actuarial evaluation if it applies to add another bargaining unit within two years of the evaluation. Employer groups of this size must provide the following:

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

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

(iii) Executive summary of benefits;

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

(v) Summary of historical plan costs.

~~(((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.~~))

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

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

AMENDATORY SECTION (Amending WSR 12-20-022, filed 9/25/12, effective 11/1/12)

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

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

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

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

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

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

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

((~~(3)~~)) (4) Employees eligible for retirement subsequent to the local government or tribal government transferring to PEBB health plan coverage must meet retiree eligibility as outlined in chapter 182-12 WAC.

((~~(4)~~)) (5) To protect the integrity of the risk pool, if total local government or tribal government retiree enrollment exceeds ten percent of the total PEBB retiree population, the PEBB program may:

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

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

AMENDATORY SECTION (Amending WSR 15-22-099, filed 11/4/15, effective 1/1/16)

WAC 182-08-240 How will the health care authority (HCA) decide to approve or deny ((~~an employer~~)) a group application? ((~~Employer~~)) This section only applies to employee organizations representing state civil service employees and the Washington health benefit exchange, regardless of the number of employees, counties, municipalities, political subdivisions, and tribal governments with five thousand or more employees. Group applications for participation in public employees benefits board (PEBB) 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 a census file, as described in WAC 182-08-235 ((~~(1) through (5)~~)) (2)(d), and additional information as described in WAC 182-08-235((~~(6)~~)) (2)(g) for all employees eligible to participate under the ((~~employer~~)) group's current health plan. If the ((~~employer~~)) group's application is for both employees and retirees, the census file data and additional information for retired employees participating under the ((~~employer~~)) group's current health plan must also be included.

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

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

(2) ((~~An employer~~)) A group must pass the EGE criteria or the actuarial evaluation required in subsection (3) of this section as a single unit before the application can be approved. For purposes of this section a single unit includes all employees eligible under the ((~~employer~~)) group's current health plan. If the application is only for a bargaining unit, then the bargaining unit must be evaluated using the EGE criteria in addition to all eligible employees of ((~~employer~~)) the 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 as determined by the authority for the like population within the nonmedicare PEBB risk pool as described in subsection (1) of this section.~~

~~(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 as determined by the authority for the like population within the nonmedicare PEBB risk pool as described in subsection (1) of this section.~~

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

~~(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 like population within the nonmedicare population as described in subsection (1) of this section; 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 like population within the nonmedicare population as described in subsection (1) of this section.~~

~~(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)~~)) use the following criteria to evaluate the group.

(a) The member level census file demographic data must indicate a relative underwriting factor that is equal to or better than the relative underwriting factor as determined by the authority for the like population within the nonmedicare PEBB risk pool as described in subsection (1) of this section;

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

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

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

((~~(iii)~~)) (c) Provide an executive summary of benefits;

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

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

((~~(vi)~~)) (f) The evaluation of criteria in ((~~(d)(iii), (iv) and (v)~~)) (c), (d), and (e) 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 like population within the nonmedicare population as described in subsection (1) of this section for a comparable plan design.

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

(5) An entity whose ((~~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.

AMENDATORY SECTION (Amending WSR 15-22-099, filed 11/4/15, effective 1/1/16)

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

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

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

(b) Sign a contract with the authority;

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

(d) Determine eligibility in order to ensure the PEBB program's continued status as a governmental plan under Section 3(32) of the Employee Retirement Income Security Act

of 1974 (ERISA) as amended. This means the employer group or charter school may only consider employees whose services are substantially all in the performance of essential governmental functions, but not in the performance of commercial activities, whether or not those activities qualify as essential governmental functions to be eligible; and

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

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

(a) The premium rate structure for school districts ((~~and~~)), educational service districts, and charter schools will be a composite rate equal to the rate charged to state agencies plus an amount equal to the employee premium based on health plan election and family enrollment. School districts and educational service districts must collect an amount equal to the premium ((~~surcharge(s)~~)) surcharges applied to an employee's account by the authority from their employees and include the funds in their payment to the authority.

Exception: The authority will allow 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 and charter schools described in (a) of this subsection will be a tiered rate based on health plan election and family enrollment. Employer groups must collect an amount equal to the premium ((~~surcharge(s)~~)) surcharges applied to an employee's account by the authority from their employees and include the funds in their payment to the authority.

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

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

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

(((~~(4)~~))) (5) The employer group or charter school must maintain participation in PEBB insurance coverage for at least one full year. An employer group or charter school may only end participation at the end of a plan year unless the authority approves a mid-year termination. To end participation, an employer group or charter school must provide written notice to the PEBB program at least sixty days before the requested termination date.

(((~~(5)~~))) (6) Upon approval to purchase insurance through a contract with the authority, the employer group or charter school must provide a list of employees and dependents that are enrolled in Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage and the remaining number of months available to them based on their qualifying event. These employees and dependents may enroll in a PEBB ((~~medical and dental~~)) health plan as COBRA ((~~enrollees~~)) subscribers for the remainder of the months available to them based on their qualifying event.

(((~~(6)~~))) (7) Enrollees in PEBB insurance coverage under one of the continuation of coverage provisions allowed under chapter 182-12 WAC or retirees included in the transfer unit as allowed under WAC 182-08-237 cease to be eligible as of the last day of the contract and may not continue enrollment beyond the end of the month in which the contract is terminated.

Exception: If an employer group, other than 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 coverage cease to be eligible under WAC 182-12-171, but may continue health plan enrollment under COBRA (see WAC 182-12-146).

AMENDATORY SECTION (Amending WSR 15-22-099, filed 11/4/15, effective 1/1/16)

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

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

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

"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).

"Blind vendor" means a "licensee" as defined in RCW 74.18.200.

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

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

"Continuation coverage" means the temporary continuation of PEBB health plan coverage available to enrollees after a qualifying event occurs as administered under Title XXII of the Public Health Service (PHS) Act, 42 U.S.C. Secs. 300bb-1 through 300bb-8.

"Creditable coverage" means coverage that meets the definition of "creditable coverage" under RCW 48.66.020

(13)(a) and includes payment of medical and hospital benefits.

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

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

"Dependent care assistance program" or "DCAP" means a benefit plan whereby 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 authority.

"Documents" means papers, letters, writings, ((~~e-mails~~)) electronic mail, electronic files, or other printed or written items.

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

"Employee" includes all employees of the state, whether or not covered by civil service; elected and appointed officials of the executive branch of government, including full-time members of boards, commissions, or committees; justices of the supreme court and judges of the court of appeals and the superior courts; and members of the state legislature. Pursuant to contractual agreement with the authority, "employee" may also include: (a) Employees of a county, municipality, or other political subdivision of the state and members of the legislative authority of any county, city, or town who are elected to office after February 20, 1970, if the legislative authority of the county, municipality, or other political subdivision of the state ((~~seeks and receives the approval of~~)) submits application materials to the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.04.205 and 41.05.021 (1)(g); (b) employees of employee organizations representing state civil service employees, at the option of each such employee organization, and, effective October 1, 1995, employees of employee organizations currently pooled with employees of school districts for the purpose of purchasing insurance benefits, at the option of each such employee organization; (c) employees of a school district if the authority agrees to provide any of the school districts' insurance programs by contract with the authority as provided in RCW 28A.400.350; (d) employees of a tribal government, if the governing body of the tribal government seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(f) and (g); (e) employees of the Washington health benefit exchange if the governing board of the exchange established in RCW 43.71.020 seeks and receives approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(g) and (n); and (f) employees of a charter school established under chapter 28A.710 RCW. "Employee" does not include: Adult family home providers; unpaid volunteers; patients of state hospitals; inmates; employees of the Washington state convention and trade center as provided in RCW 41.05.110; students of institutions of higher education as determined by their institution; and any others not expressly defined as employees under this chapter or by the authority under this chapter.

"Employer" means the state of Washington as defined by RCW 41.05.011.

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

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

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

"Employer contribution" means the funding amount paid to the authority by a state agency, employer group, or charter school for its eligible employees as described under WAC 182-12-114 and 182-12-131 and the employee's eligible dependents as described in WAC 182-12-260.

"Employer group" means those counties, municipalities, political subdivisions, the Washington health benefit exchange, tribal governments, school districts, educational service districts, and employee organizations representing state civil service employees, obtaining employee benefits through a contractual agreement with the authority as described in WAC 182-08-245.

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

"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; charter school; 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.

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

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

"Faculty" means an academic employee of an institution of higher education whose workload is not defined by work

hours but whose appointment, workload, and duties directly serve the institution's academic mission, as determined under the authority of its enabling statutes, its governing body, and any applicable collective bargaining agreement.

"Federal retiree medical plan" means the Federal Employees Health Benefits program (FEHB) or TRICARE which are not employer-based group medical ((~~insurance~~)).

"Health plan" means a plan offering medical or dental, or both, 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.~~))

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

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

"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.

((~~"Mail" or "mailing" means placing a document in the United States Postal system, commercial delivery service, or Washington state consolidated mail services properly addressed.~~))

"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.

"Pay status" means all hours for which an employee receives pay.

"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 health care authority.

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

"PEBB program" means the program within the HCA that administers insurance and other benefits for eligible employees (as described in WAC 182-12-114), eligible retired employees (as described in WAC 182-12-171), eligible dependents (as described 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.

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

• Premiums are less than ninety-five percent of Uniform Medical Plan (UMP) Classic premiums; and

• The actuarial value of benefits is at least ninety-five percent of the actuarial value of UMP Classic benefits.

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

"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.

((~~"School district" means public schools as defined in RCW 28A.150.010 which includes charter schools established under chapter 28A.710 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.

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

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

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

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

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

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

AMENDATORY SECTION (Amending WSR 15-22-099, filed 11/4/15, effective 1/1/16)

WAC 182-12-111 Which entities and individuals are eligible for public employees benefits board (PEBB) benefits? The following entities and individuals shall be eligible for public employees benefits board (PEBB) benefits 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.

(2) **Employer groups.** Employer groups may apply to participate in PEBB insurance coverage for groups of employees described in (a)(i) of this subsection and for members of the group's governing authority as described in (a)(i), (ii), and (iii) of this subsection at the option of each employer group:

(a) All eligible employees of the entity must transfer as a unit with the following exceptions:

(i) Bargaining units may elect to participate separately from the whole group;

(ii) Nonrepresented employees may elect to participate separately from the whole group provided all nonrepresented employees join as a group; and

(iii) Members of the employer group's governing authority may participate as described in the employer group's governing statutes and RCW 41.04.205.

(b) Employer groups must apply through the process described in WAC 182-08-235. ((~~School district and educational service district applications must provide the documents described in WAC 182-08-235 (1), (2), and (3). If a school district or educational service district is required by the superintendent of public instruction to purchase insurance coverage provided by the authority, the school district or educational service district is required to submit documents and information described in WAC 182-08-235 (1)(c), (2), and (3). Employer group~~)) Applications from employees of employee organizations representing state civil service employees, the Washington health benefit exchange, and employer groups with five thousand or more employees, except for school districts and educational service districts are subject to review and approval by the health care authority (HCA)((~~. With the exception of a school district or educational service district, the authority will approve or deny an employer group's application~~)) based on the employer group evaluation criteria described in WAC 182-08-240.

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

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

(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 and an amount equal to any applicable premium surcharge as would be charged to state employees for each participating school district ((~~or~~)), educational service district, or charter school.

(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) Employees of the Washington health benefit exchange are subject to the same rules as employees of an employing agency in chapters 182-08, 182-12 and 182-16 WAC.

(5) **Eligible nonemployees.**

(a) Blind vendors actively operating a business enterprise program facility in the state of Washington and deemed eligible by the department of services for the blind (DSB) may voluntarily participate in PEBB medical. Dependents of blind vendors are eligible as described in WAC 182-12-260. Eligible blind vendors and their dependents may enroll during the following times:

(i) When newly eligible: The DSB will notify eligible blind vendors of their eligibility in advance of the date they are eligible for enrollment in PEBB medical.

To enroll, blind vendors must submit the required forms to the DSB. The forms must be received by the DSB no later than thirty-one days after the blind vendor becomes eligible for PEBB medical.

(ii) During the annual open enrollment: Blind vendors may enroll during the annual open enrollment. The required form must be received by the DSB before the end of the annual open enrollment. Enrollment will begin January 1st of the following year.

(iii) Following loss of other medical insurance coverage: Blind vendors may enroll following loss of other medical insurance coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA). To enroll, blind vendors must submit the required forms to the DSB. The forms must be received by the DSB no later than sixty days after the loss of other medical insurance coverage. In addition to the required forms, the DSB will require blind vendors to provide evidence of loss of other medical insurance coverage.

(iv) Blind vendors who cease to actively operate a facility become ineligible to participate in PEBB medical as described in (a) of this subsection. Enrollees who lose eligibility for coverage may continue enrollment in PEBB medical on a self-pay basis under COBRA coverage as described in WAC 182-12-146(5).

(v) Blind vendors are not eligible for PEBB retiree insurance coverage.

(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.

(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 and entities not eligible as employees include:**

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

(b) Unpaid volunteers;

(c) Patients of state hospitals;

(d) Inmates in work programs offered by the Washington state department of corrections as described in RCW 72.09.100 or an equivalent program administered by a local government;

(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 an employee.

AMENDATORY SECTION (Amending WSR 12-20-022, filed 9/25/12, effective 11/1/12)

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 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~~)) as described in 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 PEBB 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 WSR 13-22-019, filed 10/28/13, effective 1/1/14)

WAC 182-12-114 How do employees establish eligibility for public employees benefits board (PEBB) benefits? Eligibility for an employee whose work circumstances are described by more than one of the eligibility categories in subsections (1) through (5) of this section shall be determined solely by the criteria of the category that most closely describes the employee's work circumstances.

Hours that are excluded in determining eligibility include standby hours and any temporary increases in work hours, of six months or less, caused by training or emergencies that have not been or are not anticipated to be part of the employee's regular work schedule or pattern. Employing agencies must request the public employees benefits board (PEBB) program's approval to include temporary training or emergency hours in determining eligibility.

For how the employer contribution toward PEBB insurance coverage is maintained after eligibility is established under this section, see WAC 182-12-131.

(1) Employees are eligible for PEBB benefits as follows, except as ((~~provided~~)) described in subsections (2) through (5) of this section:

(a) **Eligibility.** An employee is eligible if he or she ((~~works~~)) is anticipated to work an average of at least eighty hours per month and ((~~works~~)) is anticipated to work for at least eight hours in each month for more than six consecutive months.

(b) **Determining eligibility.**

(i) **Upon employment:** An employee is eligible from the date of employment if the employing agency anticipates the

employee will work according to the criteria in (a) of this subsection.

(ii) **Upon revision of anticipated work pattern:** If an employing agency revises an employee's anticipated work hours or anticipated duration of employment such that the employee meets the eligibility criteria in (a) of this subsection, the employee becomes eligible when the revision is made.

(iii) **Based on work pattern:** An employee who is determined to be ineligible, but later meets the eligibility criteria in (a) of this subsection, becomes eligible the first of the month following the six-month averaging period.

(c) **Stacking of hours.** As long as the work is within one state agency, employees may "stack" or combine hours worked in more than one position or job to establish eligibility and maintain the employer contribution toward PEBB insurance coverage. Employees must notify their employing agency if they believe they are eligible through stacking. Stacking includes work situations in which:

(i) The employee works two or more positions or jobs at the same time (concurrent stacking);

(ii) The employee moves from one position or job to another (consecutive stacking); or

(iii) The employee combines hours from a seasonal position ((~~to~~)) with hours from a nonseasonal position or job. An employee who establishes eligibility by stacking hours from a seasonal position or job with hours from a nonseasonal position or job shall maintain the employer contribution toward PEBB insurance coverage ((~~under~~)) as described in WAC 182-12-131(1).

(d) **When PEBB insurance coverage begins.** Medical ((~~and~~)), dental ((~~insurance coverage~~)), basic life insurance, and basic long-term disability insurance ((~~coverage~~)) begin on the first day of the month following the date an employee becomes eligible. If the employee becomes eligible on the first working day of a month, then PEBB insurance coverage begins on that date.

(2) **Seasonal employees,** as defined in WAC 182-12-109, are eligible as follows:

(a) **Eligibility.** A seasonal employee is eligible if he or she ((~~works~~)) is anticipated to work an average of at least eighty hours per month and ((~~works~~)) is anticipated to work for at least eight hours in each month of at least three consecutive months of the season. A season is any recurring, cyclical period of work at a specific time of year that lasts three to eleven months.

(b) **Determining eligibility.**

(i) **Upon employment:** A seasonal employee is eligible from the date of employment if the employing agency anticipates that he or she will work according to the criteria in (a) of this subsection.

(ii) **Upon revision of anticipated work pattern.** If an employing agency revises an employee's anticipated work hours such that the employee meets the eligibility criteria in (a) of this subsection, the employee becomes eligible when the revision is made.

(iii) **Based on work pattern.** An employee who is determined to be ineligible for benefits, but later works an average of at least eighty hours per month and works for at least eight hours in each month and works for more than six consecutive months, becomes eligible the first of the month following a six-month averaging period.

(c) **Stacking of hours.** As long as the work is within one state agency, employees may "stack" or combine hours worked in more than one position or job to establish eligibility and maintain the employer contribution toward PEBB insurance coverage. Employees must notify their employing agency if they believe they are eligible through stacking. Stacking includes work situations in which:

(i) The employee works two or more positions or jobs at the same time (concurrent stacking);

(ii) The employee moves from one position or job to another (consecutive stacking); or

(iii) The employee combines hours from a seasonal position or job ((~~to~~)) with hours from a nonseasonal position or job. An employee who establishes eligibility by stacking hours from a seasonal position or job with hours from a nonseasonal position or job shall maintain the employer contribution toward PEBB insurance coverage ((~~under~~)) as described in WAC 182-12-131(1).

(d) **When PEBB insurance coverage begins.** Medical ((~~and~~)), dental ((~~insurance coverage and~~)), basic life insurance, and basic long-term disability insurance ((~~coverage~~)) begin on the first day of the month following the day the employee becomes eligible. If the employee becomes eligible on the first working day of a month, then PEBB insurance coverage begins on that date.

(3) **Faculty** are eligible as follows:

(a) **Determining eligibility.** "Half-time" means one-half of the full-time academic workload as determined by each institution, except that half-time for community and technical college faculty employees is governed by RCW 28B.50.489.

(i) **Upon employment:** Faculty who the employing agency anticipates will work half-time or more for the entire instructional year, or equivalent nine-month period, are eligible from the date of employment.

(ii) **For faculty hired on quarter/semester to quarter/semester basis:** Faculty who the employing agency anticipates will not work for the entire instructional year, or equivalent nine-month period, are eligible at the beginning of the second consecutive quarter or semester of employment in which he or she is anticipated to work, or has actually worked, half-time or more. Spring and fall are considered consecutive quarters/semesters when first establishing eligibility for faculty that work less than half-time during the summer quarter/semester.

(iii) **Upon revision of anticipated work pattern:** Faculty who receive additional workload after the beginning of the anticipated work period (quarter, semester, or instructional year), such that their workload meets the eligibility criteria ((~~of~~)) as described in (a)(i) or (ii) of this subsection become eligible when the revision is made.

(b) **Stacking.** Faculty may establish eligibility and maintain the employer contribution toward PEBB insurance coverage by working as faculty for more than one institution of higher education. Faculty workloads may only be stacked with other faculty workloads to establish eligibility under this section or maintain eligibility ((~~under~~)) as described in WAC 182-12-131(3). When a faculty works for more than one institution of higher education, the faculty must notify his or

her employing agencies that he or she works at more than one institution and may be eligible through stacking.

(c) **When PEBB insurance coverage begins.**

(i) Medical ((~~and~~)), dental ((~~insurance coverage and~~)), basic life insurance, and basic long-term disability insurance ((~~coverage~~)) begin on the first day of the month following the day the faculty becomes eligible. If the faculty becomes eligible on the first working day of a month, then PEBB insurance coverage begins on that date.

(ii) For faculty hired on a quarter/semester to quarter/semester basis under (a)(ii) of this subsection, medical ((~~and~~)), dental ((~~insurance coverage and~~)), basic life insurance, and basic long-term disability insurance ((~~coverage~~)) begin the first day of the month following the beginning of the second consecutive quarter/semester of half-time or more employment. If the first day of the second consecutive quarter/semester is the first working day of the month, then PEBB insurance coverage begins at the beginning of the second consecutive quarter/semester.

(4) **Elected and full-time appointed officials of the legislative and executive branches of state government** are eligible as follows:

(a) **Eligibility.** A legislator is eligible for PEBB benefits on the date his or her term begins. All other elected and full-time appointed officials of the legislative and executive branches of state government are eligible on the date their terms begin or the date they take the oath of office, whichever occurs first.

(b) **When PEBB insurance coverage begins.** Medical ((~~and~~)), dental ((~~insurance coverage and~~)), basic life insurance, and basic long-term disability insurance ((~~coverage for an eligible employee~~)) begin on the first day of the month following the day ((~~he or she~~)) the employee becomes eligible. If the employee becomes eligible on the first working day of a month, then PEBB insurance coverage begins on that date.

(5) **Justices and judges** are eligible as follows:

(a) **Eligibility.** A justice of the supreme court and judges of the court of appeals and the superior courts become eligible for PEBB benefits on the date they take the oath of office.

(b) **When PEBB insurance coverage begins.** Medical ((~~and~~)), dental ((~~insurance coverage and~~)), basic life insurance, and basic long-term disability insurance ((~~coverage for an eligible employee~~)) begin on the first day of the month following the day ((~~he or she~~)) the employee becomes eligible. If the employee becomes eligible on the first working day of a month, then PEBB insurance coverage begins on that date.

AMENDATORY SECTION (Amending WSR 13-22-019, filed 10/28/13, effective 1/1/14)

WAC 182-12-116 Who is eligible to participate in the state's salary reduction plan? (1) Employees of state agencies are eligible to participate in the state's salary reduction plan provided they are eligible for PEBB benefits as described in WAC 182-12-114 and they elect to participate within the time frames described in WAC 182-08-197, 182-08-187, or 182-08-199.

(2) Employees of employer groups, as defined in WAC 182-12-109, and charter schools are not eligible to participate in the state's salary reduction plan.

AMENDATORY SECTION (Amending WSR 15-22-099, filed 11/4/15, effective 1/1/16)

WAC 182-12-123 Is 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,~~)) An individual who has more than one source of eligibility for enrollment in PEBB health plan coverage (called "dual eligibility") is limited to one enrollment.

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

(3) A dependent enrolled in a PEBB health plan who becomes eligible for PEBB benefits as an employee must elect to enroll in PEBB benefits as described in WAC 182-08-197 (1) or (3). This includes making an election to enroll in or waive enrollment in PEBB medical as described in WAC 182-12-128 (1)(a).

(a) If the employee does not waive enrollment in PEBB medical, the employee is not eligible to remain enrolled in his or her spouse's, state registered domestic partner's, or parent's PEBB health plan as a dependent. If the employee's spouse, state registered domestic partner, or parent does not remove the employee (who is enrolled as a dependent) from his or her subscriber account, the PEBB program will terminate the employee's enrollment as a dependent the last day of the month before the employee's employer-paid coverage begins.

Exception: An enrolled dependent who becomes newly eligible for PEBB benefits as an employee may be dual-enrolled in PEBB coverage for one month. This exception is only allowed for the first month the dependent is enrolled as an employee, and only if the dependent becomes enrolled as an employee on the first working day of a month that is not the first day of the month.

(b) If the employee elects to waive his or her enrollment in PEBB medical, the employee will remain enrolled in PEBB medical under his or her spouse's, state registered domestic partner's, or parent's PEBB health plan as a dependent.

(4) A child who is eligible for medical and dental under two subscribers may be enrolled as a dependent under the health plan of only one subscriber.

(5) When an employee is eligible for the employer contribution towards PEBB insurance coverage due to employment in more than one PEBB-participating employing agency the following provisions apply:

(a) The employee must choose to enroll under only one employing agency.

Exception: Faculty who stack to establish or maintain eligibility ((~~under~~)) as described in 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).

(b) If the employee loses eligibility under the employing agency he or she chose to enroll under as described in ((~~subsection (5)~~)) (a) of this ((~~section~~)) subsection, the employee must notify his or her other employing agency no later than sixty days from the date PEBB coverage ends through the

employing agency described in (a) of this subsection to transfer coverage.

(c) The employee's PEBB insurance coverage elections remain the same when an employee transfers from enrollment under one employing agency to another employing agency without a break in PEBB insurance coverage, as described in (b) of this subsection.

(6) A retiree who defers enrollment in a PEBB health plan as described in WAC 182-12-200 by enrolling as an eligible dependent in a health plan sponsored by PEBB, a Washington state school district, ((~~or~~)) a Washington state education service district, or a Washington state charter school and who loses the employer contribution for such coverage must enroll in PEBB retiree insurance coverage as described in WAC 182-12-171 or defer enrollment as described in WAC 182-12-205.

AMENDATORY SECTION (Amending WSR 15-22-099, filed 11/4/15, effective 1/1/16)

WAC 182-12-128 When may an employee waive enrollment in public employees benefits board (PEBB) medical and when may he or she enroll in PEBB medical after having waived enrollment? An employee may waive enrollment in public employees benefits board (PEBB) medical if he or she is enrolled in other employer-based group medical ((~~insurance~~)), TRICARE, or medicare. An employee who waives enrollment in PEBB medical must enroll in dental, basic life insurance, and basic long-term disability insurance (unless the employing agency does not participate in these PEBB insurance coverages).

(1) To waive enrollment in PEBB medical, the employee must submit the required form to his or her employing agency at one of the following times:

(a) **When the employee becomes eligible:** An employee may waive PEBB medical when he or she becomes eligible for PEBB benefits. The employee must indicate his or her election to waive enrollment in PEBB medical on the required form and submit the form to his or her employing agency. The form must be received by the employing agency no later than thirty-one days after the date the employee becomes eligible (see WAC 182-08-197). PEBB medical will be waived as of the date the employee becomes eligible for PEBB benefits.

(b) **During the annual open enrollment:** An employee may waive PEBB medical during the annual open enrollment. The required form must be received by the employee's employing agency before the end of the annual open enrollment. PEBB medical will be waived beginning January 1st of the following year.

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

The employee must submit the required form to his or her employing agency. The form must be received no later than sixty days after the event that creates the special open enrollment. In addition to the required form, the employee must provide evidence of the event that creates the special open enrollment.

PEBB medical will be waived the last day of the month following the later of the event date or the date the required form is received. If that day is the first of the month, PEBB medical will be waived the last day of the previous month. 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, PEBB medical will be waived the last day of the previous month.

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

(3) Once PEBB medical is waived, the employee is only allowed to enroll in PEBB medical at the following times:

(a) During the annual open enrollment. The required form must be received by the employee's employing agency before the end of the annual open enrollment. PEBB medical will begin January 1st of the following year.

(b) During a special open enrollment. A special open enrollment allows an employee to change his or her enrollment outside of the annual open enrollment. A special open enrollment may be created when one of the events described in subsection (4) of this section occurs.

The employee must submit the required form to his or her employing agency. The form must be received no later than sixty days after the event that creates the special open enrollment. In addition to the required form, the employee must provide evidence of the event that creates the special open enrollment.

PEBB medical will begin the first day of the month following the later of the event date or the date the required form is received. If that day is the first of the month, coverage is effective on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, PEBB medical will begin the first of the month in which the event occurs.

(4) **Special open enrollment:** Any one of the events in (a) through ((~~(j)~~)) (k) of this subsection may create a special open enrollment. The change in enrollment must be allowable under the Internal Revenue Code (IRC) and Treasury regulations, and correspond to and be consistent with the event that creates the special open enrollment for the employee, the employee's dependent, or both.

(a) Employee acquires a new dependent due to:

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

(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 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);

(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 ((~~their~~)) his or her

employer contribution toward his or her employer-based group medical ((~~insurance~~));

(d) The employee's dependent has a change in his or her own employment status that affects his or her eligibility for the employer contribution under his or her employer-based group medical;

Exception: For the purposes of special open enrollment "employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 54.9801-6.

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

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

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

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

(((~~(h)~~))) (i) Employee or an employee's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from medicaid or a state children's health insurance program (CHIP);

(((~~(i)~~))) (j) Employee or employee's dependent becomes eligible and enrolls in TRICARE, or loses eligibility for TRICARE;

(((~~(j)~~))) (k) Employee becomes eligible and enrolls in medicare, or loses eligibility for medicare.

AMENDATORY SECTION (Amending WSR 13-22-019, filed 10/28/13, effective 1/1/14)

WAC 182-12-129 What happens when an employee moves from an eligible to an otherwise ineligible position or job due to a layoff? This section applies to employees employed by state agencies (as defined in this chapter), including benefits-eligible seasonal employees, and is intended to address situations where an employee moves from one position or job to another due to a layoff, as described in WAC 182-12-109. This section does not apply to employees with an anticipated end date.

If an employee moves from an eligible to an otherwise ineligible position due to layoff, the employee may retain his or her eligibility for the employer contribution toward public employees benefits board (PEBB) insurance coverage for each month that the employee is in pay status for at least eight hours. To maintain eligibility using this section the employee must:

• Be hired into a position with a state agency within twenty-four months of the original eligible position ending; and

• Upon hire, notify the employing state agency that he or she is potentially eligible to use this section.

This section ceases to apply if the employee is employed in a position eligible for ((~~public employees benefits board (~~))PEBB((~~)~~)) benefits under WAC 182-12-114 within twenty-four months of leaving the original position.

After the twenty-fourth month, the employee must reestablish eligibility ((~~under~~)) as described in WAC 182-12-114.

AMENDATORY SECTION (Amending WSR 15-22-099, filed 11/4/15, effective 1/1/16)

WAC 182-12-131 How do eligible employees maintain the employer contribution toward public employees benefits board (PEBB) insurance coverage? The employer contribution toward public employees benefits board (PEBB) insurance coverage begins on the day that ((~~public employees benefits board (~~))PEBB((~~)~~)) benefits begin ((~~under~~)) as described in WAC 182-12-114. This section describes under what circumstances employees maintain eligibility for the employer contribution toward PEBB insurance coverage.

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

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

(a) Benefits-eligible seasonal employees (eligible ((~~under~~)) as described in WAC 182-12-114(2)) who work a season of less than nine months are eligible for the employer contribution in any month of the season in which they are in pay status eight or more hours during that month. The employer contribution toward PEBB insurance coverage 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) Benefits-eligible seasonal employees (eligible ((~~under~~)) as described in WAC 182-12-114(2)) who work a season of nine months or more are eligible for the employer contribution:

(i) In any month of the season in which they are in pay status eight or more hours during that month; and

(ii) Through the off season following each season worked, but the eligibility may not exceed a total of twelve consecutive calendar months for the combined season and off season.

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

(a) Benefits-eligible faculty anticipated to work half time or more the entire instructional year or equivalent nine-month period (eligible ((~~under~~)) as described in 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~~)) as described in WAC 182-12-114 (3)(a)(ii)) are eligible for the employer contribution each quarter or semester in which employees work half-time or more.

(c) Summer or off-quarter/semester coverage: All benefits-eligible faculty (eligible ((~~under~~)) as described in WAC 182-12-114 (3)(a) and (b)) 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 PEBB 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~~)) as described in WAC 182-12-114 (3)(a) and (b)) 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~~)) toward PEBB insurance coverage. "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~~)) as described in WAC 182-12-114 (3)(a) and (b)) 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 PEBB insurance coverage ((~~under the criteria~~)) as described 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 employees are not in pay status for at least eight hours, employees:

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

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

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

(a) When employees fail 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 employees move to a position that is not anticipated to be eligible for PEBB benefits ((~~under~~)) as described in WAC 182-12-114, not including changes in position due to a layoff.

The employer contribution toward PEBB benefits cease for employees and their enrolled dependents the last day of the month in which employees are eligible for the employer contribution under this section.

Exception: If the employing agency deducted the employee's premium for PEBB insurance coverage after the employee was no longer eligible for the employer contribution, PEBB 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 PEBB 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~~)) as described in WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, and 182-12-270.

AMENDATORY SECTION (Amending WSR 15-22-099, filed 11/4/15, effective 1/1/16)

WAC 182-12-133 What options for continuation coverage are available to employees and their dependents during certain types of leave or when employment ends due to a layoff? Employees who have established eligibility for public employees benefits board (PEBB) benefits ((~~under~~)) as described in WAC 182-12-114 may continue coverage for themselves and their dependents during certain types of leave or when their employment ends due to a layoff.

(1) Employees who are no longer eligible for the employer contribution toward PEBB insurance coverage due to an event described in (c)(i) through (vi) of this subsection may continue PEBB insurance coverage by self-paying the ((~~full~~)) premium set by the health care authority (HCA) from the date the employer contribution is lost:

(a) Employees may self-pay for a maximum of twenty-nine months. The employee must pay the premium amounts for PEBB insurance coverage as premiums become due. If the monthly premium((~~s are more than~~)) or premium surcharge remains unpaid for sixty days ((~~delinquent~~)), PEBB insurance coverage will ((~~end as of~~)) be terminated retroactive to the last day of the month for which ((~~a full~~)) the monthly premium and premium surcharge was paid as described in WAC 182-08-180 (1)(b).

(b) 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.

(c) Employees in the following circumstances qualify to continue coverage under this subsection:

(i) Employees who are on authorized leave without pay;

(ii) Employees who are on approved educational leave;

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

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

(v) Employees whose employment ends due to a layoff as defined in WAC 182-12-109; or

(vi) Employees who are applying for disability retirement.

(2) The number of months that employees self-pay the premium while eligible as described in subsection (1) of this section will count toward the total months of continuation coverage allowed under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). Employees who are no longer eligible for continuation coverage as described in subsection (1) of this section but who have not used the maximum number of months allowed under COBRA coverage may continue medical ((~~and~~)), dental, or both for the remaining difference in months by self-paying the premium as described in WAC 182-12-146.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-12-136 May employees on approved educational leave waive continuation coverage? In order to avoid duplication of group health plan coverage, the following shall apply to employees during any period of approved educational leave. Employees eligible for continuation coverage provided in WAC 182-12-133 who obtain other employer-based group medical or dental ((~~insurance~~)), or both, may waive continuation of such coverage for each full calendar month in which they maintain coverage under the other ((~~insurance~~)) employer-based medical or dental. These employees have the right to reenroll in a public employees benefits board (PEBB) health plan effective the first day of the month after the date the other employer-based group medical or dental ((~~insurance~~)) ends, provided evidence of such other coverage is provided to the PEBB program upon application for reenrollment.

AMENDATORY SECTION (Amending WSR 15-22-099, filed 11/4/15, effective 1/1/16)

WAC 182-12-138 What options are available if an employee is approved for the federal Family and Medical Leave Act (FMLA)? (1) An employee on approved leave under the federal Family and Medical Leave Act (FMLA) may continue to receive the employer contribution toward public employees benefits board (PEBB) insurance coverage in accordance with the federal FMLA. The employee 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.

(2) If an employee's contribution toward premiums is more than sixty days delinquent, PEBB insurance coverage will end as of the last day of the month for which a ((~~full~~)) premium was paid.

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

AMENDATORY SECTION (Amending WSR 11-22-036, filed 10/26/11, effective 1/1/12)

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

premium or premium surcharge remains unpaid for sixty days, PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and premium surcharge was paid as described in WAC 182-08-180 (1)(b).

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

AMENDATORY SECTION (Amending WSR 10-20-147, filed 10/6/10, effective 1/1/11)

WAC 182-12-142 What options for continuation coverage are available to faculty and seasonal employees who are between periods of eligibility? (1) **Faculty** may continue any combination of medical, dental and life insurance ((~~coverage~~)) by self-paying the ((~~full~~)) premium set by the HCA, with no contribution from the employer, for a maximum of twelve months between periods of eligibility. The employee must pay the premium amounts associated with public employees benefits board (PEBB) insurance coverage as premiums become due. If the monthly premium((~~s are more than~~)) or premium surcharge remains unpaid for sixty days ((~~delinquent~~)), PEBB insurance coverage will ((~~end as of~~)) be terminated retroactive to the last day of the month for which ((~~a full~~)) the monthly premium or premium surcharge was paid as described in WAC 182-08-180 (1)(b).

(2) **Benefits-eligible seasonal employees** may continue any combination of medical, dental, and life insurance ((~~coverage~~)) by self-paying the ((~~full~~)) premium set by the health care authority (HCA), with no contribution from the employer, for a maximum of twelve months between periods of eligibility. The employee must pay the premium amounts associated with PEBB insurance coverage as premiums become due. If the monthly premium((~~s are more than~~)) or premium surcharge remains unpaid for sixty days ((~~delinquent~~)), PEBB insurance coverage will ((~~end as of~~)) be terminated retroactive to the last day of the month for which ((~~a full~~)) the monthly premium and premium surcharge was paid as described in WAC 182-08-180 (1)(b).

(3) **COBRA.** An employee who is no longer eligible for continuation coverage as described in subsections (1) and (2) of this section, but who has not used the maximum number of months allowed under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), may continue medical and dental for the remaining difference in months by self-paying the ((~~full~~)) premium set by the HCA under COBRA as described in WAC 182-12-146. The number of months that a faculty or seasonal employee self-pays premiums under the criteria in subsection (1) or (2) of this section will count toward the total months of continuation coverage allowed under COBRA.

AMENDATORY SECTION (Amending WSR 15-22-099, filed 11/4/15, effective 1/1/16)

WAC 182-12-146 When is an enrollee eligible to continue public employee's benefits board (PEBB) health plan coverage under Consolidated Omnibus Budget Reconciliation Act (COBRA)? An enrollee may continue public employee's benefits board (PEBB) health plan coverage under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) by self-paying the ((~~full~~)) premium set by the health care authority (HCA). Premiums must be paid as described in WAC 182-08-180 (1)(b).

(1) An employee or an employee's dependent who loses eligibility for the employer contribution toward PEBB insurance coverage and who qualifies for continuation coverage under COBRA may continue medical, dental, or both.

(2) An employee or an employee's dependent who loses eligibility for continuation coverage 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, dental, or both for the remaining difference in months.

(3) A retired employee who loses eligibility for PEBB retiree insurance because an employer group, with the exception of school districts ((~~and~~)), educational service districts, and charter schools ceases participation in PEBB insurance coverage may continue medical, dental, or both.

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

(5) A blind vendor who ceases to actively operate a facility as described in WAC 182-12-111 (5)(a) may continue enrollment in ((~~public employees benefits board~~))PEBB((~~,~~)) medical for the maximum number of months allowed under COBRA as described in this section.

A blind vendor is not eligible for PEBB retiree insurance coverage.

AMENDATORY SECTION (Amending WSR 12-20-022, filed 9/25/12, effective 11/1/12)

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 public employees benefits board (PEBB) 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) The employee must pay premium amounts and premium surcharges associated with PEBB insurance coverage as premiums and surcharges become due. If the monthly premium or premium surcharge remains unpaid for sixty days, PEBB insurance coverage will be terminated retroactive to

the last day of the month for which the monthly premium and premium surcharge was paid as described in WAC 182-08-180 (1)(b).

(3) If the dismissal is upheld, all PEBB 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 later, with the exception described in subsection (((~~(3)~~)) (4) of this section.

(((~~(3)~~)) (4) 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)~~)) (5) If the board, arbitrator, committee, or court sustains the employee in the appeal and directs reinstatement of employer paid PEBB insurance coverage retroactively, the employing agency must forward to HCA the full employer contribution for the period directed by the board, arbitrator, committee, or court and collect from the employee the employee's share of premiums due, if any.

(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 PEBB 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 WSR 15-22-099, filed 11/4/15, effective 1/1/16)

WAC 182-12-171 When is a retiring employee eligible to enroll in public employees benefits board (PEBB) retiree insurance coverage? A retiring employee is eligible to continue enrollment or defer enrollment in public employees benefits board (PEBB) insurance coverage as a retiree if he or she meets procedural and substantive eligibility requirements as described in subsections (1) and (2) of this section.

(1) **Procedural requirements.** A retiring employee must enroll or defer enrollment in PEBB retiree insurance coverage as described in (a) and (b) of this subsection:

(a) To enroll in PEBB retiree insurance coverage, the required form must be received by the PEBB program no later than sixty days after the employee's employer-paid coverage, Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage, or continuation coverage ends. The effective date of PEBB retiree insurance coverage is the first day of the month after the employee's employer-paid coverage, COBRA coverage, or continuation coverage ends.

(b) To defer enrollment in a PEBB health plan, the employee must defer enrollment as described in WAC 182-12-200 or 182-12-205.

(c) A retiring employee and his or her 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 a retiree or an enrolled dependent becomes entitled to medicare after enrollment in PEBB retiree insurance coverage, he or she must enroll and maintain enrollment in medicare parts A and B to remain enrolled in PEBB retiree insurance coverage.

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 coverage. The enrollee may continue PEBB health plan enrollment as described in WAC 182-12-146.

(2) **Substantive eligibility requirements.**

(a) An employee as defined in WAC 182-12-109 who is ((~~enrolled in~~)) eligible for PEBB benefits or an employee who is enrolled in basic benefits through a Washington state school district ((~~or~~)), educational service district as defined in RCW 28A.400.270, or a charter school and ends public employment after becoming vested in a Washington state-sponsored retirement plan may enroll or defer enrollment in PEBB retiree insurance coverage if he or she meets procedural and substantive eligibility requirements.

(i) To be eligible to continue enrollment or defer enrollment in 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 coverage, COBRA coverage, or continuation coverage ends.

(ii) A retiring employee who does not meet his or her Washington state-sponsored retirement plan's age requirement when his or her employer-paid coverage or COBRA coverage, or continuation coverage ends, but who meets the age requirement within sixty days of coverage ending, may request an appeal as described in WAC 182-16-032. His or her eligibility will be reviewed by the PEBB appeals committee. An employee must meet PEBB retiree insurance coverage procedural requirements as described in subsection (1) of this section.

(b) A retiring employee of a state agency must immediately begin to receive a monthly retirement plan payment, with exceptions described below:

(i) A retiring employee who receives a lump-sum payment instead of a monthly retirement plan payment is only eligible if the department of retirement systems offered the employee the choice between a lump sum actuarially equivalent payment and the ongoing monthly payment, as allowed by the plan; or

(ii) A retiring employee who is a member of a Plan 3 retirement plan, also called a separated employee (defined in RCW 41.05.011(((~~20~~))) (21)), must meet his or her Plan 3 retirement eligibility criteria. The employee does not have to receive a retirement plan payment to enroll in retiree insurance coverage;

(c) A retiring employee of a Washington higher education institution who is a member of a higher education retire-

ment plan (HERP) must immediately begin to receive a monthly retirement plan payment, or meet his or her HERP plan's retirement eligibility criteria, or be at least age fifty-five with ten years of state service;

(d) A retiring employee of an employer group participating in PEBB insurance coverage under contractual agreement with the authority must be eligible to retire as described in (i) or (ii) of this subsection to be eligible to continue PEBB insurance coverage as a retiree, except for a school district ((~~or~~)), educational service district, or charter school employee who must meet the requirements as described in subsection (2)(e) of this section.

(i) A retiring employee who is eligible to retire under a retirement plan sponsored by an employer group or tribal government that is not a Washington state-sponsored retirement plan must meet the same age and years of service requirements as if he or she was a member of public employees retirement system Plan 1 or Plan 2 during his or her employment.

(ii) A retiring employee who is eligible to retire under a Washington state-sponsored retirement plan must immediately begin to receive a monthly retirement plan payment, with exceptions described in subsection (2)(b)(i) and (ii) of this section.

(iii) A retired employee of an employer group, except a Washington state school district or educational service district, that ends participation in PEBB insurance coverage is no longer eligible to continue enrollment in PEBB retiree insurance coverage if he or she enrolled after September 15, 1991. Any retiree who loses eligibility for this reason may continue health plan enrollment as described in WAC 182-12-146.

(iv) A retired employee of a tribal government employer that ends participation in PEBB insurance coverage is no longer eligible to continue enrollment in PEBB retiree insurance coverage. Any retiree who loses eligibility for this reason may continue health plan enrollment as described in WAC 182-12-146.

(e) A retiring employee of a Washington state school district ((~~or~~)), Washington state educational service district, or a Washington state charter school must immediately begin to receive a monthly retirement plan payment, with exceptions described below:

(i) A retiring employee who ends employment before October 1, 1993; or

(ii) A retiring employee who receives a lump-sum payment instead of a monthly retirement plan payment is only eligible if the department of retirement systems offered the employee the choice between a lump sum actuarially equivalent payment and the ongoing monthly payment, as allowed by the plan, or the employee enrolled before 1995; or

(iii) A retiring employee who is a member of a Plan 3 retirement system, also called a separated employee (defined in RCW 41.05.011((~~(20)~~)) (21)), must meet his or her Plan 3 retirement eligibility criteria; or

(iv) An employee who retired as of September 30, 1993, and began receiving a monthly retirement plan payment from a Washington state-sponsored retirement system (as defined in chapters 41.32, 41.35 or 41.40 RCW) is eligible if he or she enrolled in a PEBB health plan no later than the health care authority's (HCA's) annual open enrollment period for the year beginning January 1, 1995.

(3) An elected or a full-time appointed state official of the legislative or executive branch of state government who voluntarily or involuntarily leaves public office is eligible to continue PEBB insurance coverage as a retiree if he or she meets procedural requirements of subsection (1) of this section.

(4) Washington state-sponsored retirement plans include:

(a) Higher education retirement plans;

(b) Law enforcement officers' and firefighters' retirement system;

(c) Public employees' retirement system;

(d) Public safety employees' retirement system;

(e) School employees' retirement system;

(f) State judges/judicial retirement system;

(g) Teachers' retirement system; and

(h) State patrol retirement system.

(i) The two federal retirement systems, Civil Service Retirement System and Federal Employees' Retirement System, are considered Washington state-sponsored retirement systems for Washington State University Extension for an employee covered under PEBB insurance coverage at the time of retirement.

AMENDATORY SECTION (Amending WSR 15-22-099, filed 11/4/15, effective 1/1/16)

WAC 182-12-200 How does a retiree who is enrolled as a dependent in a health plan sponsored by public employees benefits board (PEBB), a Washington state school district, ((~~or~~)) a Washington state educational service district, or a Washington state charter school defer enrollment under PEBB retiree insurance coverage? (1) A retiree may defer enrollment in a public employees benefits board (PEBB) health plan during the period of time he or she is enrolled as a dependent in a health plan sponsored by PEBB, a Washington state school district, ((~~or~~)) a Washington state education service district, or a Washington state charter school, including such coverage under Consolidated Omnibus Budget Reconciliation Act (COBRA) or continuation coverage.

(2) A retiree who defers enrollment in medical must defer enrollment in dental. Retirees must be enrolled in medical to enroll in dental.

(3) A retiree who defers coverage may later enroll in a PEBB health plan if he or she provides evidence of continuous enrollment in a health plan sponsored by PEBB, a Washington state school district, ((~~or~~)) a Washington state educational service district, or a Washington state charter school and submits the required form as described in (a) and (b) of this subsection:

(a) During the PEBB annual open enrollment period. The required form must be received by the PEBB program no later than the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or

(b) When enrollment in a health plan sponsored by PEBB, a Washington state school district, ((~~or~~)) a Washing-

ton state educational service district, or a Washington state charter school ends, or such coverage under COBRA or continuation coverage ends. The retiree must submit the required form to enroll or defer enrollment as described in WAC 182-12-171 (1)(a). The required form must be received by the PEBB program no later than sixty days after coverage ends. PEBB health plan coverage begins the first day of the month following the date the other coverage ends.

AMENDATORY SECTION (Amending WSR 15-22-099, filed 11/4/15, effective 1/1/16)

WAC 182-12-205 May retirees defer or voluntarily terminate enrollment under public employees benefits board (PEBB) retiree insurance coverage at or after retirement? The following provisions apply when retirees defer or voluntarily terminate enrollment under public employees benefits board (PEBB) retiree insurance coverage when enrolled in other coverage:

(1) Retirees who defer enrollment in a PEBB health plan also defer enrollment for all eligible dependents, except as described in subsection (2)(c) of this section.

(2) Retirees may defer enrollment in a PEBB health plan at or after retirement if continuously enrolled in other medical as described in this section or WAC 182-12-200. Retirees who defer enrollment in medical must defer enrollment in dental. Retirees must be enrolled in medical to enroll in dental.

(a) Beginning January 1, 2001, retirees may defer enrollment in a PEBB health plan if they are enrolled in employer-based group medical ((~~insurance~~)) as an employee or the dependent of an employee, or such medical insurance continued under Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage or continuation coverage.

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

(c) Beginning January 1, 2006, retirees may defer enrollment in a PEBB health plan if they are enrolled in medicare Parts A and B and a medicaid program that provides creditable coverage as described 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.

(d) Beginning January 1, 2014, retirees who are not eligible for Parts A and B of medicare may defer enrollment in a PEBB health plan if they are enrolled in exchange coverage.

(3) To defer PEBB health plan enrollment, retiring employees or enrolled subscribers must submit the required forms to the PEBB program.

(a) If retiring employees submit the required forms to defer enrollment in a PEBB health plan after their employer-paid coverage, COBRA coverage, or continuation coverage ends as described in WAC 182-12-171 (1)(b), enrollment will be deferred the first of the month following the date their employer-paid coverage, COBRA coverage, or continuation coverage ends. The forms must be received by the PEBB program no later than sixty days after the employer-paid coverage, COBRA coverage, or continuation coverage ends.

(b) If enrolled subscribers submit the required forms to defer enrollment in a PEBB health plan, enrollment will be deferred effective the first of the month following the date the required form is received by the PEBB program. If the form is received on the first day of the month, coverage will end on the last day of the previous month.

(4) Retirees who defer enrollment while enrolled in coverage as described in subsection (2)(a) through (d) of this section and lose such coverage must enroll in a PEBB retiree health plan as described in WAC 182-12-171 or defer enrollment as described in this section or WAC 182-12-200.

(5) Retirees who meet substantive eligibility requirements in WAC 182-12-171(2) and whose employer-paid coverage, COBRA coverage, or continuation coverage ended between January 1, 2001, and December 31, 2001, was not required to submit the deferral form at that time, but must have met all procedural requirements as stated in this section, WAC 182-12-171, and 182-12-200.

(6) Retirees who defer may later enroll themselves and their dependents in a PEBB health plan as follows:

(a) Retirees who defer enrollment while enrolled in employer-based group medical ((~~insurance,~~)) or such medical insurance continued under COBRA coverage or continuation coverage may enroll in a PEBB health plan by submitting the required forms and evidence of continuous enrollment in such coverage to the PEBB program:

(i) During the PEBB annual open enrollment period. The required form must be received by the PEBB program no later than the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or

(ii) When their employer-based group medical ((~~insurance~~)) or such coverage under COBRA coverage or continuation coverage ends. The required form and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after such coverage ends. PEBB health plan coverage begins the first day of the month after the employer-based group medical ((~~insurance~~)) coverage, COBRA coverage, or continuation coverage 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 required forms and evidence of continuous enrollment in such coverage to the PEBB program:

(i) During the PEBB annual open enrollment period. The required form must be received by the PEBB program no later than the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or

(ii) When the federal retiree medical plan coverage ends. The required form and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after such coverage ends. PEBB health plan coverage begins the first day of the month after coverage under the federal retiree medical plan ends.

(c) Retirees who defer enrollment while enrolled in medicare Parts A and B and a medicaid program that provides creditable coverage as described in this chapter may enroll in a PEBB health plan by submitting the required

forms and evidence of continuous enrollment in such coverage to the PEBB program:

(i) During the PEBB annual open enrollment period. The required form must be received by the PEBB program no later than the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or

(ii) When their medicaid coverage ends. The required form and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after such coverage ends. PEBB health plan 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. The required form must be received by the PEBB program no later than the last day of the calendar year in which the retiree's medicaid coverage ends.

(d) Retirees who defer enrollment while enrolled in exchange coverage will have a one-time opportunity to enroll or reenroll in a PEBB health plan by submitting the required forms and evidence of continuous enrollment in such coverage to the PEBB program:

(i) During the PEBB annual open enrollment period. The required form must be received by the PEBB program no later than the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or

(ii) When exchange coverage ends. The required form and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after such coverage ends. PEBB health plan coverage begins the first day of the month after exchange coverage ends.

(e) Retirees who defer enrollment may enroll in a PEBB health plan if the retiree receives formal notice that the authority has determined it is more cost-effective to enroll the retiree or the retiree's eligible dependents in PEBB medical than a medical assistance program.

(7) Retirees who request to voluntarily terminate their PEBB retiree insurance coverage must do so in writing. The written termination request must be received by the PEBB program. Retirees who voluntarily terminate their enrollment in PEBB retiree insurance coverage also terminate enrollment for all eligible dependents. PEBB insurance coverage will end on the last day of the month in which the PEBB program receives the termination request. If the termination request is received on the first day of the month, PEBB insurance coverage will end on the last day of the previous month.

Exception: When a member is enrolled in a medicare advantage plan then PEBB insurance coverage will end on the last day of the month when the medicare advantage form is received.

AMENDATORY SECTION (Amending WSR 09-23-102, filed 11/17/09, effective 1/1/10)

WAC 182-12-207 When can a retiree or eligible dependent's public employees benefits board (PEBB) insurance coverage be canceled by the health care authority (HCA)? A retiree or eligible dependent's public employees benefits board (PEBB) insurance coverage can be ((~~canceled by~~)) terminated by the health care authority (HCA) for the following reasons:

(1) Failure to comply with the PEBB program's procedural requirements, including failure to provide information or documentation requested by the due date in written requests from the PEBB program;

(2) Knowingly providing false information;

(3) Failure to pay the monthly premium or premium surcharge when due ((~~or an underpayment of premium~~)) as described in WAC 182-08-180 (1)(b);

(4) Misconduct. If a retiree's PEBB insurance coverage is ((~~canceled~~)) terminated for misconduct, PEBB insurance coverage will not be reinstated at a later date. Examples of such termination include, but are not limited to the following:

(a) Fraud, intentional misrepresentation or withholding of information the subscriber knew or should have known was material or necessary to accurately determine eligibility or the correct premium; or

(b) Abusive or threatening conduct repeatedly directed to an HCA employee, a health plan or other HCA contracted vendor providing insurance coverage on behalf of the HCA, its employees, or other persons.

If a retiree's PEBB insurance coverage is ((~~canceled~~)) terminated by HCA for the above reasons, PEBB insurance coverage for all of the retiree's eligible dependents is also ((~~canceled~~)) terminated.

AMENDATORY SECTION (Amending WSR 15-22-099, filed 11/4/15, effective 1/1/16)

WAC 182-12-208 What are the requirements regarding enrollment in dental under public employees benefits board (PEBB) retiree insurance coverage? The following provisions apply to a subscriber and his or her dependents enrolled under public employees benefits board (PEBB) retiree insurance coverage:

(1) A subscriber and his or her dependents enrolling in dental must meet procedural requirements (as described in WAC 182-12-171(1) and 182-12-262) and eligibility requirements (as described in WAC 182-12-171(2) and 182-12-260).

(2) A subscriber and his or her dependents must be enrolled in medical to enroll in dental.

(3) A subscriber enrolling in dental must stay enrolled for at least two years before dental can be dropped unless he or she defers medical and dental coverage as described in WAC 182-12-200 or 182-12-205, or drops dental as described in subsection (4) of this section.

(4) A subscriber enrolled in PEBB dental who becomes eligible for, and enrolls in, employer-based group dental ((~~insurance~~)) as an employee or the dependent of an employee, or such coverage under Consolidated Omnibus Budget Reconciliation Act (COBRA), or continuation coverage may drop PEBB dental, before completing the two-year enrollment requirement. Coverage will end on the last day of the month in which the required form is received by the PEBB program. If that day is the first of the month, the

change in enrollment will be made the last day of the previous month.

(a) A subscriber may enroll in PEBB dental during the PEBB annual open enrollment period. The required form must be received by the PEBB program no later than the last day of the open enrollment period. PEBB dental begins January 1st of the following year.

(b) A subscriber may enroll in PEBB dental after his or her employer-based group dental ((~~insurance~~)) or such coverage under COBRA coverage or continuation coverage ends. The required form must be received by the PEBB program no later than sixty days after such coverage ends. PEBB dental begins the first day of the month after the employer-based group dental ((~~insurance~~)) or coverage under COBRA ends.

AMENDATORY SECTION (Amending WSR 15-22-099, filed 11/4/15, effective 1/1/16)

WAC 182-12-250 Public employees benefits board (PEBB) insurance coverage eligibility for survivors of emergency service personnel killed in the line of duty. Surviving spouses, state registered domestic partners, and dependent children of emergency service personnel who are killed in the line of duty are eligible to enroll in public employees benefits board (PEBB) retiree insurance coverage.

(1) This section applies to the surviving spouse, the surviving 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, 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 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(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 state registered domestic partner;

(iii) Legally adopted children;

(iv) Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child;

(v) Children specified in a court order or divorce decree; or

(vi) Children as defined in RCW 26.26.101.

(4) Surviving spouses, 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 his or her behalf) must submit the required forms to the PEBB program to either enroll or defer enrollment in retiree insurance coverage as described in subsection (7) of this section. The forms must be received by the PEBB program no later than one hundred eighty days after the 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, 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, 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 retiree insurance coverage may choose among the following options for when their enrollment in a PEBB health plan will begin:

(a) June 1, 2006, for survivors whose required 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 required forms (for example, if the PEBB program receives the required forms on August 29, the survivor may request health plan enrollment to begin on July 1st); or

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

For surviving spouses, state registered domestic partners, and children who enroll, monthly health plan premiums and premium surcharges must be paid by the survivor as described in WAC 182-08-180 (1)(b) 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 retiree 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 for at least two years before dental can be dropped, unless they defer medical and dental coverage as described in WAC 182-12-205, or drop dental as described in WAC 182-12-208(4).

(iv) Dental only is not an option.

(b) Defer enrollment:

(i) Survivors may defer enrollment in a PEBB health plan if continuously enrolled in other coverage as described in WAC 182-12-205 (2).

(ii) Survivors may enroll in a PEBB health plan as described in WAC 182-12-205(4) when they lose other coverage. Survivors must provide evidence that they were continuously enrolled in other such coverage when enrolling in a PEBB health plan. The required form and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after such coverage ends.

(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 retiree insurance coverage if they:

(a) Do not apply to enroll or defer PEBB health plan enrollment within the timelines as described in subsection (5) of this section; or

(b) Do not maintain continuous enrollment in other coverage during the deferral period, as described in subsection (7)(b)(i) of this section.

AMENDATORY SECTION (Amending WSR 15-22-099, filed 11/4/15, effective 1/1/16)

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 will 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, when his or her dependent is not eligible under this section. The notification must be received by the PEBB program 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 PEBB insurance coverage.

The following are eligible as dependents:

(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) State registered domestic partner. State registered domestic partner ((~~is defined to include the following:~~

~~(a) Effective January 1, 2010, a state registered domestic partner, 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; and~~

~~(c)~~)) as defined in RCW 26.60.020(1) and substantially equivalent legal unions from other jurisdictions as defined in RCW 26.60.090. Former 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 eligible ((~~up to~~)) through the last day of the month in which their twenty-sixth birthday occurred except as described in (i) of this subsection. Children are defined as the subscriber's:

(a) Children ((~~as defined~~)) based on establishment of a parent-child relationship as described in RCW 26.26.101 ((~~establishment of parent-child relationship~~));

(b) Biological children, where parental rights have not been terminated;

(c) Stepchildren. The stepchild's relationship to a subscriber (and eligibility as a PEBB dependent) ends, for purposes of this rule, on the same date the subscriber's legal relationship with the spouse or state registered domestic partner ends through divorce, annulment, dissolution, termination, or death;

(d) Legally adopted children;

(e) Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child;

(f) Children of the subscriber's state registered domestic partner;

(g) Children specified in a court order or divorce decree;

(h) Extended dependents in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or subscriber's 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; and

(i) Children of any age with a developmental disability or physical handicap that renders the child incapable of self-sustaining employment and chiefly dependent upon the subscriber for support and maintenance provided such condition occurs before the 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, when his or her dependent is not eligible under this section. The notification must be received by the PEBB program no later than sixty days after the date that a child age twenty-six or older no longer qualifies under this subsection;

(iii) A child with a developmental disability or physical handicap who becomes self-supporting is not eligible under this subsection as of the last day of the month in which he or she becomes capable of self-support;

(iv) A child with a developmental disability or physical handicap age twenty-six and older who becomes capable of self-support does not regain eligibility under (i) of this subsection if he or she later becomes incapable of self-support;

(v) The PEBB program will periodically certify the eligibility of a dependent child with a disability beginning at age twenty-six, but no more frequently than annually after the two-year period following the child's twenty-sixth birthday.

(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 PEBB insurance coverage.

AMENDATORY SECTION (Amending WSR 15-22-099, filed 11/4/15, effective 1/1/16)

WAC 182-12-262 When may subscribers enroll or remove eligible dependents? (1) **Enrolling dependents in public employees benefits board (PEBB) benefits.** 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 (2)(c). Subscribers may enroll eligible dependents at the following times:

(a) **When the subscriber becomes eligible** and enrolls in public employees benefits board (PEBB) benefits. 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) **A dependent's eligibility for enrollment in health plan coverage ends the last day of the month the dependent** meets the eligibility criteria as described in WAC 182-12-250 or 182-12-260. Employees must notify their employing agency when a dependent is no longer eligible. All other subscribers must notify the PEBB program when a dependent is no longer eligible. Consequences for not submitting notice within sixty days of the last day of the month the dependent loses eligibility for health plan coverage 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~~)) as described in WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, or 182-12-148 may remove dependents** from their PEBB insurance 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 PEBB insurance coverage prospectively. PEBB insurance coverage will end on the last day of the month in which the written notice is received by the PEBB program. If the written notice is received on the first day of the month, coverage will end on the last day of the previous month.

(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 be allowable under the Internal Revenue Code (IRC) and Treasury regulations, and correspond to and be consistent with the event that creates the special open enrollment for the subscriber, 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 required form is received. If that day is the first of the month, the change in enrollment begins on that day.

• Enrollment of an extended dependent or a dependent with a disability will be the first day of the month following eligibility certification.

• The dependent 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 required form is received. If that day is the first of the month, the change in enrollment will be made the last day of the previous month.

• 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 for a state domestic partnership;

(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 ((~~their~~)) his or her

employer contribution toward his or her employer-based group health ((~~insurance~~)) plan;

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

Exception: For the purposes of special open enrollment "employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 54.9801-6.

(e) Subscriber or a subscriber's dependent has a change in enrollment under ((~~another~~)) an employer-based group health ((~~insurance~~)) plan during its annual open enrollment that does not align with the PEBB program's annual open enrollment;

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

(((~~f~~))) (g) A court order or national medical support 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 state registered domestic partner is not an eligible dependent);

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

(((~~h~~))) (i) Subscriber or a subscriber's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from medicaid or a state children's health insurance program (CHIP).

(4) **Enrollment requirements. A subscriber must submit the required forms within the time frames described in this subsection.** Employees submit the required forms to their employing agency. All other subscribers submit the required forms to the PEBB program. In addition to the required 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 his or her eligible dependents when the subscriber becomes eligible to enroll in PEBB benefits, the subscriber must include the dependent's enrollment information on the required forms that the subscriber submits within the relevant time frame described in WAC 182-08-197, 182-08-187, 182-12-171, or 182-12-250.

(b) If a subscriber wants to enroll eligible dependents during the PEBB annual open enrollment period, the required forms must be received no later than the last day of the annual open enrollment.

(c) If a subscriber wants to enroll newly eligible dependents, the required forms must be received 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 the required form as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the required form must be received 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 a disability, the required forms must be received 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, required forms must be received no later than sixty days after the event that creates the special open enrollment.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

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 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 as a survivor under public employees benefits board (PEBB) retiree insurance coverage. An eligible survivor must submit the ((~~appropriate~~)) required forms to enroll or defer enrollment in retiree insurance coverage. The forms must be received by the PEBB program no later than sixty days after the date of the employee's or retiree's death.

(1) An employee's spouse, state registered domestic partner, or child who loses eligibility due to the death of an eligible employee may 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 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~~)) as described in WAC 182-12-260.

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) A retiree's spouse, state registered domestic partner, or child who loses eligibility due to the death of an eligible retiree may enroll or defer enrollment as a survivor under retiree insurance coverage.

(a) The retiree's spouse or 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~~)) as described in WAC 182-12-260.

(c) 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, the dependent is eligible to enroll or defer enrollment as a survivor under retiree insurance coverage. The dependent must submit the ((~~appropriate~~)) required form(s) to enroll or defer PEBB health plan enrollment. The forms must be received by the PEBB program no later than sixty days after the retiree's death. To enroll in a PEBB health plan, the dependent must provide evidence of continuous enrollment in medical coverage from the most recent open enrollment for which the dependent was not enrolled in a PEBB medical plan prior to the retiree's death.

(3) The spouse, state registered domestic partner, or child of a deceased school district ((~~or~~)), educational service district employee, or a charter school is eligible to enroll or defer enrollment as a survivor under PEBB retiree insurance coverage at the time of the employee's death provided the employee died on or after October 1, 1993. The dependent must immediately begin receiving a retirement benefit allowance under chapter 41.32, 41.35 or 41.40 RCW and submit the ((~~appropriate~~)) required form to enroll or defer enrollment in PEBB retiree insurance coverage. The form must be received by the PEBB program no later than sixty days after the date of the employee's death.

(a) The employee's spouse or 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~~)) as described in WAC 182-12-260.

(4) If a premium or surcharge payment received by the authority is sufficient as described in WAC 180-08-180 (1)(c)(ii) to maintain PEBB health plan enrollment 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 the dependent's enrollment ended due to the death of the employee or retiree, the PEBB program will reinstate 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~~)) as described in WAC 182-12-200 and 182-12-205.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-12-270 What options for continuation coverage are available to dependents who cease to meet the eligibility criteria as described 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 dependent must pay premium and premium surcharge amounts associated with PEBB insurance coverage as premiums and premium surcharges become due. If the monthly premium or premium surcharge remain unpaid for sixty days, PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and premium surcharge was paid as described in WAC 182-08-180 (1)(b). The public employees benefits board (PEBB) program must receive the ((~~appropriate~~)) required 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, 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~~)) as described in WAC 182-12-250 or 182-12-265; or

(2) Dependents who lose eligibility because they no longer meet the eligibility criteria as described 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 dependent who loses eligibility because a state registered 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*.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-16-010 Appeals—Purpose and scope. (1) For WAC 182-16-025 through 182-16-040, the model rules of procedure adopted by the chief administrative law judge pursuant to RCW 34.05.250, as now or hereafter amended, are hereby adopted for use by the authority in public employees benefits board (PEBB) benefits related proceedings. The model rules of procedure may be found in chapter 10-08 WAC. Other procedural rules adopted in chapters 182-08, 182-12, and 182-16 WAC 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 WAC 182-16-025 through 182-16-040, the procedural rules adopted shall govern.

(2) WAC 182-16-050 through 182-16-110 describes the general rules and procedures that apply to an administrative hearing, requested under WAC 182-16-050, of a PEBB appeals committee decision.

(a) WAC 182-16-050 through 182-16-110 supplements the Administrative Procedure Act (APA), chapter 34.05 RCW, and the model rules of procedure in chapter 10-08 WAC. The model rules of procedure adopted by the chief administrative law judge pursuant to RCW 34.05.250, as now or hereafter amended are adopted for use in a hearing. In the case of a conflict between the model rules of procedure and the rules adopted in WAC 182-16-050 through 182-16-110,

the rules adopted in WAC 182-16-050 through 182-16-110 shall prevail.

(b) If there is a conflict between WAC 182-16-050 through 182-16-110 and specific PEBB program rules, the specific PEBB program rules prevail. PEBB program rules are found in chapters 182-08, 182-12, and 182-16 WAC.

(c) Nothing in WAC 182-16-050 through 182-16-110 is intended to affect the constitutional rights of any person or to limit or change additional requirements imposed by statute or other rule. Other laws or rules determine if a hearing right exists, including the APA and program rules or laws.

(d) The hearing rules for the PEBB program in WAC 182-16-050 through 182-16-110 do not apply to any other health care authority program.

(3) The definitions in WAC 182-16-020 apply throughout this chapter.

AMENDATORY SECTION (Amending WSR 15-22-099, filed 11/4/15, effective 1/1/16)

WAC 182-16-020 Definitions. ((~~As used in~~)) The following definitions apply throughout this chapter ((~~the term~~)):

"Appellant" means a person or entity who requests a review by the PEBB appeals committee or an administrative hearing about the action of the HCA or its designee.

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

"Business days" means all days except Saturdays, Sundays, and all legal holidays as set forth in RCW 1.16.050.

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

"Continuance" means a change in the date or time of a hearing.

"Denial" or "denial notice" means an action by, or communication from, either an employing agency, or the PEBB program that aggrieves ((~~an employee, or his or her dependent~~)) a subscriber, a dependent, or an applicant, with regard to PEBB benefits including, but not limited to, actions or communications expressly designated as a "denial," "denial notice," or "cancellation notice."

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

"Dependent care assistance program" or "DCAP" means a benefit plan whereby 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 authority.

"Documents" means papers, letters, writings, ((~~e-mails~~)) electronic mail, electronic files, or other printed or written items.

"Employee" includes all employees of the state, whether or not covered by civil service; elected and appointed officials of the executive branch of government, including full-time members of boards, commissions, or committees; justices of the supreme court and judges of the court of appeals and the superior courts; and members of the state legislature. Pursuant to contractual agreement with the authority, "employee" may also include: (a) Employees of a county, municipality, or other political subdivision of the state and members of the legislative authority of any county, city, or town who are elected to office after February 20, 1970, if the legislative authority of the county, municipality, or other political subdivision of the state ((~~seeks and receives the approval of~~)) submits application materials to the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.04.205 and 41.05.021 (1)(g); (b) employees of employee organizations representing state civil service employees, at the option of each such employee organization, and, effective October 1, 1995, employees of employee organizations currently pooled with employees of school districts for the purpose of purchasing insurance benefits, at the option of each such employee organization; (c) employees of a school district if the authority agrees to provide any of the school districts' insurance programs by contract with the authority as provided in RCW 28A.400.350; (d) employees of a tribal government, if the governing body of the tribal government seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(f) and (g); (e) employees of the Washington health benefit exchange if the governing board of the exchange established in RCW 43.71.020 seeks and receives approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(g) and (n); and (f) employees of a charter school established under chapter 28A.710 RCW. "Employee" does not include: Adult family home providers; unpaid volunteers; patients of state hospitals; inmates; employees of the Washington state convention and trade center as provided in RCW 41.05.110; students of institutions of higher education as determined by their institution; and any others not expressly defined as employees under this chapter or by the authority under this chapter.

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

"Employer group" means those counties, municipalities, political subdivisions, the Washington health benefit exchange, tribal governments, school districts, educational service districts, and employee organizations representing state civil service employees, obtaining employee benefits through a contractual agreement with the authority as described in WAC 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; charter school; 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.

"File" or "filing" means the act of delivering documents to the presiding officer's office.

"Final order" means an order that is the final PEBB program decision.

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

"Hearing" means a proceeding before a presiding officer that gives ((~~a party~~)) an appellant an opportunity to be heard in a dispute about a decision made by the PEBB appeals committee, including prehearing conferences, dispositive motion hearings, status conferences, and evidentiary hearings.

"Hearing representative" means a person who is authorized to represent the PEBB program in an administrative hearing. The person may be an assistant attorney general, a licensed attorney, or authorized HCA employee.

"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.

((~~"Mail" or "mailing" means placing a document in the United States Postal system, commercial delivery service, or Washington state consolidated mail services properly addressed.~~))

"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 health care authority.

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

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

"Prehearing conference" means a proceeding scheduled and conducted by a presiding officer to address issues in preparation for a hearing.

"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.

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

• Premiums are less than ninety-five percent of Uniform Medical Plan (UMP) Classic premiums; and

• The actuarial value of benefits is at least ninety-five percent of the actuarial value of UMP Classic benefits.

"Presiding officer" means an impartial decision maker who is an attorney, presides at an administrative hearing, and is either a director designated HCA employee or an administrative law judge employed by the office of administrative hearings.

"Record" means the official documentation of the hearing process. The record includes recordings or transcripts, admitted exhibits, decisions, briefs, notices, orders, and other filed documents.

"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.

"Service" or "serve" means the delivery of documents as described in WAC 182-16-067.

"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.

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

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

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

agency or instrumentality of the tribal government, that has government offices principally located in this state.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-16-025 Where do members appeal decisions regarding eligibility, enrollment, premium payments, premium surcharges, a public employees benefits board (PEBB) wellness incentive, or the administration of benefits? (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 employees benefits board (PEBB) eligibility, enrollment, or premium surcharge may appeal that decision to the employing state agency by the process outlined in WAC 182-16-030.

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.

(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, enrollment, or premium surcharge may appeal that decision to the employer group through the process established by the employer group.

Exception: Any employee of an employer group aggrieved by a decision regarding life insurance, LTD insurance, eligibility to participate in the PEBB wellness incentive program, or eligibility to receive a PEBB wellness incentive may appeal that decision 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 PEBB eligibility, enrollment, premium payments, premium surcharge, eligibility to participate in the PEBB wellness incentive program, or eligibility to receive a PEBB wellness incentive, 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~~)) health plan, life insurance, or LTD insurance may appeal that decision by following the appeal provisions of those plans, with the exception of eligibility, enrollment, and premium payment determinations.

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

(6) Any PEBB employee aggrieved by a decision regarding the administration of a benefit offered under the state's salary reduction plan may appeal that decision by the process described in WAC 182-16-036.

(7) Any subscriber aggrieved by a decision made by the third-party administrator contracted to administer the PEBB wellness incentive program regarding the completion of the PEBB wellness incentive program requirements, or a request for a reasonable alternative to a wellness incentive program requirement, may appeal that decision by the process described in WAC 182-16-035.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-16-030 How can an employee or an employee's dependent appeal a decision made by a state agency about eligibility, premium surcharge, or enrollment in benefits? (1) An eligibility, premium surcharge, 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 no later than thirty days after the date of the initial denial notice. The contents of the request for review are to be provided ((~~in accordance with~~)) as described in 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~~)) employee or employee's dependent who submitted the request for review.

(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, premium surcharge, 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 no later than thirty days after 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~~)) as described in WAC 182-16-040.

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

(b) The PEBB appeals committee shall render a written decision to the appellant within thirty days of receiving the notice of appeal. The committee may extend the thirty-day time requirement for rendering a decision upon issuing a written finding of a good reason 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 WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-16-038 How can an entity or organization appeal a decision of the health care authority to deny an employer group application? An entity or organization whose employer group application is denied by the authority may appeal the decision to the public employees benefits board (PEBB) appeals committee. For rules regarding eligible entities, see WAC 182-12-111. The PEBB appeals manager must receive the notice of appeal no later than thirty days after the date of the denial notice. The contents of the notice of appeal are to be provided ((~~in accordance with~~)) as described in WAC 182-16-040.

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

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

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

AMENDATORY SECTION (Amending WSR 15-22-099, filed 11/4/15, effective 1/1/16)

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

(1) The name and mailing address of the ((~~appealing~~)) party submitting the request for review or notice of appeal;

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

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

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

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

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

(7) The type of relief sought;

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

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

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-16-050 How can an ((~~enrollee or entity request an administrative hearing if~~)) appellant aggrieved by a written decision made by the public employees benefits board (PEBB) appeals committee request an administrative hearing? (1) Any ((~~party~~)) appellant aggrieved by a written 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 written request for an administrative hearing no later than thirty calendar days ((~~of~~)) after the date ((~~after~~)) of the written decision ((~~by~~)) letter from the PEBB appeals committee.

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

(4) All hearings must be conducted in compliance with WAC 182-16-050 through 182-16-110, chapter 34.05 RCW, and chapter 10-08 WAC, as described in WAC 182-16-010(2).

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-16-052 Requirements to appear and represent a party in the administrative hearing process. (1) All parties must provide the presiding officer and all other parties with their name, address, and telephone number.

(2) The appellant may act as his or her own representative or have anyone represent him or her, except employees of the health care authority (HCA) or HCA's authorized agents.

(3) If the ((~~party who requested a hearing~~)) appellant is represented by a ((~~party~~)) person who is not an attorney admitted to practice in Washington state, the representative must provide the presiding officer and other parties with the representative's name, address, and telephone number. In cases involving confidential information, the nonattorney representative must provide the hearing representative with a signed, written consent permitting release to the nonattorney representative of personal health information protected by state or federal law.

(((~~(3)~~))) (4) An attorney admitted to practice law in Washington state, who wishes to represent the ((~~party who requested a hearing~~)) appellant, must file a written notice of appearance containing the attorney's name, address, and telephone number with the presiding officer's office and serve all parties with the notice. The attorney must file a written notice of withdrawal of representation with the presiding officer's office and serve all parties with the notice.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-16-055 Mailing address changes. (1) The ((~~party who requested the hearing must tell~~)) appellant must notify the hearing representative and the presiding officer as

soon as possible, when the ((~~party's~~)) appellant's mailing address changes.

(2) If ((~~that party~~)) the appellant does not notify the hearing representative and the presiding officer of a change in the ((~~party's~~)) appellant's mailing address and the presiding officer and hearing representative continue to ((~~mail~~)) serve notices and other important documents to the last known mailing address, the documents will be deemed ((~~received by the party~~)) served on the appellant.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-16-061 Presiding officers—Assignment, motions of prejudice, and disqualification. (1) **Assignment:** A presiding officer will be assigned at least five business days before a hearing. A party may ask which presiding officer is assigned to a hearing by contacting the presiding officer's office listed on the notice of hearing. If requested by a party, the presiding officer's office must send the name of the assigned presiding officer to all parties, by ((~~e-mail~~)) electronic mail or in writing, at least five business days before the scheduled hearing date.

(2) **Motion of prejudice:** Any party requesting a different presiding officer may file a written motion of prejudice against the presiding officer assigned to the matter before the presiding officer rules on a discretionary issue in the case, admits evidence, or takes testimony.

(a) A motion of prejudice must include a declaration stating that a party does not believe the presiding officer can hear the case fairly. Service of copies of the motion must also be ((~~mailed~~)) made to all parties listed on the notice of hearing.

(b) Any party's first motion of prejudice will be automatically granted. Any subsequent motion of prejudice made by a party may be granted or denied at the discretion of the presiding officer no later than seven days after receiving the motion.

(c) A party may make an oral motion of prejudice at the beginning of a hearing before the presiding officer rules on a discretionary issue in the matter, admits evidence, or takes testimony if:

(i) The presiding officer was not assigned at least five business days before the date of the hearing; or

(ii) The presiding officer was changed within five business days of the date of the hearing.

(3) **Disqualification:** A presiding officer may be disqualified from presiding over a hearing for bias, prejudice, conflict of interest, or ex parte contact with a party to the hearing.

(a) Any party may file a petition to disqualify a presiding officer ((~~pursuant to~~)) as described in RCW 34.05.425. A petition to disqualify must be in writing and service promptly ((~~mailed~~)) made to all parties and the presiding officer upon discovering facts of possible grounds for disqualification.

(b) The presiding officer whose disqualification is requested will determine whether to grant or deny the petition in a written order, stating facts and reasons for the determination. The presiding officer must ((~~mail~~)) serve the order no later than seven days after receiving the petition for disqualification.

NEW SECTION

WAC 182-16-067 Service of documents on another party. (1) When the rules in this chapter or in other PEBB program rules or statutes require a party to serve copies of documents on other parties, a party must send copies of the documents to all other parties or their representatives in accordance with this section.

(2) Unless otherwise stated in applicable law, documents may be sent only as identified in this section to accomplish service. A party may serve someone by:

(a) Personal service (hand delivery);

(b) First class, registered, or certified mail sent via the United States Postal Service or Washington state consolidated mail services;

(c) Fax;

(d) Commercial delivery service; or

(e) Legal messenger service.

(3) A party must serve all other parties or their representatives whenever the party files a motion, pleading, brief, or other document with the presiding officer's office, or when required by law.

(4) Service is complete when:

(a) Personal service is made;

(b) Mail is properly stamped, addressed, and deposited in the United States Postal Service;

(c) Mail is properly addressed, and deposited in the Washington state consolidated mail services;

(d) Fax produces proof of transmission;

(e) A parcel is delivered to a commercial delivery service with charges prepaid; or

(f) A parcel is delivered to a legal messenger service with charges prepaid.

(5) A party may prove service by providing any of the following:

(a) A signed affidavit or certificate of mailing;

(b) The certified mail receipt signed by the person who received the parcel;

(c) A signed receipt from the person who accepted the commercial delivery service or legal messenger service parcel;

(d) Proof of fax transmission.

(6) Service cannot be made by electronic mail unless mutually agreed to in advance and in writing by the parties.

(7) If the document is a subpoena, follow the compliance procedure as described in WAC 182-16-085.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-16-070 Calculating when a hearing deadline ends. (1) When counting days to calculate when a hearing deadline ends ((~~under~~)) as described in WAC 182-16-050 through 182-16-110:

(a) Do not include the day of the action, notice, or order. For example, if service of a hearing decision is ((~~mailed~~)) made on Tuesday and the party has twenty-one calendar days to request a review, start counting the days with Wednesday.

(b) If the last day of the period is a Saturday, Sunday, or legal holiday, the deadline is the next business day.

(2) The deadline is 5:00 p.m. on the last day.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-16-071 Time requirements for service of notices ((~~mailed~~)) made by the presiding officer. (1) The presiding ((~~officer must mail~~)) officer's office must serve a notice of a hearing to all parties and their representatives at least ((~~fourteen~~)) twenty-one calendar days before the hearing date. The parties may agree to, but the presiding officer cannot impose, a shorter notice period.

(2) If a prehearing conference or dispositive motion hearing is scheduled, the presiding officer must ((~~mail~~)) serve a notice of the prehearing conference or dispositive motion hearing to the parties and their representatives at least seven business days before the date of the prehearing conference or dispositive motion hearing except:

(a) The presiding officer may change any scheduled hearing into a prehearing conference or dispositive motion hearing and provide less than seven business days' notice of the prehearing conference or dispositive motion hearing; and

(b) The presiding officer may give less than seven business days' notice if the only purpose of the prehearing conference is to consider whether to grant a continuance.

(3) The presiding officer must reschedule a hearing if necessary to comply with the notice requirements in this section.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-16-072 Hearing location. (1) A presiding officer must be present at all hearings. Hearings may be held either in person or telephonically.

(a) A telephonic hearing is where all parties and the presiding officer are present by telephone.

(b) An in-person hearing is where the ((~~party that requested the hearing~~)) appellant appears face-to-face with the presiding officer. The other parties can choose to appear either in person or by telephone, but cannot be ordered to appear in person.

(2) Whether a hearing is held in person or telephonically, the parties have the right to see all documents, hear all testimony, and question all witnesses.

(3) If a hearing is originally scheduled to be held in-person, the ((~~party that requested the hearing~~)) appellant may ask the presiding officer to change the in-person hearing to a telephonic hearing. Once a telephonic hearing begins, the presiding officer may stop, reschedule, and change the telephonic hearing to an in-person hearing if any party makes such a request.

AMENDATORY SECTION (Amending WSR 15-22-099, filed 11/4/15, effective 1/1/16)

WAC 182-16-073 Rescheduling and continuances. (1) Any party may request the presiding officer to reschedule a hearing if a rule requires notice of a hearing and the amount of notice required was not provided.

(a) The presiding officer must reschedule the hearing under circumstances identified in this subsection (1) if requested by any party.

(b) The parties may agree to shorten the amount of notice required by any rule.

(2) Any party may request a continuance of a hearing either orally or in writing.

(a) In each administrative hearing, the presiding officer must grant each party's first request for a continuance. The continuance may be up to thirty calendar days.

(b) The presiding officer may grant each party up to one additional continuance of up to thirty calendar days because of extraordinary circumstances established at a proceeding.

(c) After granting a continuance, the presiding officer's office must:

(i) Immediately telephone all other parties to inform them the hearing was continued; and

(ii) Serve an order of continuance on the parties no later than fourteen days before the new hearing date. All orders of continuance must provide a new deadline ((~~for mailing documents to~~)) for filing documents with the presiding officer. The new ((~~mailing~~)) filing deadline can be no less than ten calendar days prior to the new hearing date. If the continuance is granted pursuant to (b) of this subsection, then the order of continuance must also include findings of fact that state with specificity the extraordinary circumstances for which the presiding officer granted the continuance.

(3) Regardless of whether a party has been granted a continuance as described in subsection (1) of this section, the presiding officer must grant a continuance if a new issue is raised during the hearing and a party requests a continuance.

AMENDATORY SECTION (Amending WSR 15-22-099, filed 11/4/15, effective 1/1/16)

WAC 182-16-080 Determining if an administrative hearing right exists. (1) ((~~A party~~)) An appellant has a right to a hearing only if a law or program rule gives that right. If the ((~~party~~)) appellant is not sure whether a hearing right exists, they may request a hearing to protect their rights.

(2) The right to a hearing does not exist unless:

(a) The public employees benefits board (PEBB) appeals committee has issued a written decision ((~~under~~)) as described in WAC 182-16-030 (2)(b), 182-16-032(7), 182-16-035(4), 182-16-036 (1)(f), (2)(b), (3)(b), or 182-16-038(2); and

(b) A hearing of the PEBB appeals committee's written decision has been ((~~timely~~)) requested ((~~pursuant to~~)) timely as described in WAC 182-16-050.

(3) If the hearing representative or the presiding officer questions the right to a hearing, the presiding officer must decide whether a hearing right exists, in a written ruling, prior to reviewing and ruling on any other issues.

(4) If the presiding officer decides a person or entity does not have a right to a hearing, the matter must be dismissed.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-16-081 Prehearing conferences. (1) A prehearing conference is a formal proceeding conducted on the record by a presiding officer to prepare for a hearing.

(a) The presiding officer must record a prehearing conference using audio recording equipment.

(b) The presiding officer may conduct a prehearing conference in person, by telephone conference call, or in any other manner acceptable to the parties.

(2) Any party can request a prehearing conference. The presiding officer must grant each party's first request for a prehearing conference if it is filed with the presiding officer at least seven business days before the next scheduled hearing date. The presiding officer may grant requests for additional prehearing conferences.

(3) The ((~~party requesting the hearing~~)) appellant must attend or participate in any scheduled prehearing conference. If the ((~~party requesting the hearing~~)) appellant does not attend or participate in a scheduled prehearing conference, the presiding officer will enter an order of default dismissing the matter.

(4) During a prehearing conference the parties and the presiding officer may:

(a) Identify the issue(s) to be decided;

(b) Agree to the date, time, and place of any requested or necessary hearing(s);

(c) Identify accommodation and safety issues; or

(d) ((~~Set a deadline to exchange a proposed witness list and~~)) Establish a schedule for:

(i) The exchange and filing of briefs;

(ii) Provide a list of proposed witnesses;

(iii) Providing exhibit lists; and

(iv) Providing proposed exhibits before the hearing.

(5) After the prehearing conference ends, the presiding officer must enter a written order that recites the action taken at the prehearing conference, a case schedule outlining hearing dates and deadlines for exchanging witness lists and exhibits, and any other agreements reached by the parties.

(6) The presiding officer must ((~~mail~~)) serve the prehearing order to the parties at least fourteen calendar days before the next scheduled hearing.

(7) A party may object to the prehearing order by notifying the presiding officer in writing no later than ten days after the ((~~mailing~~)) service date of the order. The presiding officer must ((~~mail~~)) serve a written ruling on the objection.

(8) If no objection is made to the prehearing order, the order determines how the case will be conducted by the presiding officer, including whether a hearing will be in person or held by telephone conference, unless the presiding officer enters an amended prehearing conference order.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-16-082 Dispositive motions. (1) A dispositive motion is a written motion that could dispose of one or all the issues in an administrative hearing request, such as a motion to dismiss or motion for summary judgment. The presiding officer may only consider written dispositive motions filed with the presiding officer.

(2) ((~~Any party may~~)) To request a dispositive motion hearing ((~~by filing~~)) a party must file a written dispositive motion with the presiding officer and ((~~mailing~~)) serves a copy of the motion to all other parties. The presiding officer may also set a dispositive motion hearing, and request briefing from the parties, to address any possible dispositive issues the presiding officer believes must be addressed before the hearing.

(3) The deadline to ((~~mail~~)) file a timely dispositive motion shall be ten calendar days before the scheduled hearing.

(4) Upon receiving a dispositive motion, a presiding officer:

(a) Must convert the scheduled hearing to a dispositive motion hearing when:

(i) The dispositive motion is timely filed with the presiding officer at least ten calendar days before the date of the hearing; and

(ii) The party filing the dispositive motion has not previously filed a dispositive motion.

(b) May schedule a dispositive motion hearing in all instances other than described in (a) of this subsection.

(5) The presiding officer may conduct the dispositive motion hearing in person or by telephone conference. For dispositive motion hearings scheduled to be held in person, the hearing representative may choose to attend and participate in person or by telephone conference call.

(6) The party requesting the dispositive motion hearing must attend and participate in the dispositive motion hearing. If the party requesting the hearing does not attend and participate in the dispositive motion hearing, the presiding officer will enter an order of default.

(7) During a dispositive motion hearing, the presiding officer can only consider the filed dispositive ((~~motion(s)~~)) motions, any response to ((~~that motion(s)~~)) the motions, and argument on the ((~~motion(s)~~)) motions. Prior to rescheduling any necessary hearings, the presiding officer must ((~~mail~~)) serve a written order on the dispositive ((~~motion(s)~~)) motions.

(8) The presiding officer must ((~~mail~~)) serve the written order on the dispositive ((~~motion(s)~~)) motions to all parties no later than eighteen calendar days after the dispositive motion hearing is held. Orders on dispositive motions are subject to motions for reconsideration or petitions for judicial review ((~~pursuant to~~)) as described in WAC 182-16-105 and 182-16-110.

NEW SECTION

WAC 182-16-085 Subpoenas. (1) Presiding officers, the hearing representative, and attorneys for the parties may prepare subpoenas in accordance with Civil Rule 45, unless otherwise stated. Any party may request the presiding officer to prepare a subpoena on his or her behalf.

(2) The presiding officer may schedule a prehearing conference to decide whether to issue a subpoena.

(3) If a party requests the presiding officer prepare a subpoena on its behalf, the party is responsible for:

(a) Service of the subpoena; and

(b) Any costs associated with:

(i) Compliance with the subpoena; and

(ii) Witness fees as described in RCW 34.05.446(7).

(4) Service of a subpoena must be made by a person who is at least eighteen years old and not a party to the hearing. Service of the subpoena is complete when the person serving the subpoena:

(a) Gives the person or entity named in the subpoena a copy of the subpoena; or

(b) Leaves a copy of the subpoena with a person over the age of eighteen at the residence or place of business of the person or entity named in the subpoena.

(5) To prove service of a subpoena on a witness, the person serving the subpoena must file with the presiding officer's office a signed, written, and dated statement that includes:

(a) The name of the person to whom service of the subpoena occurred;

(b) The date of the service of the subpoena occurred;

(c) The address where the service of the subpoena occurred; and

(d) The name, age, and address of the person who provided service of the subpoena.

(6) A party may request the presiding officer quash (set aside) or change a subpoena request at any time before the deadline given in the subpoena.

(7) A presiding officer may quash (set aside) or change a subpoena if it is unreasonable.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-16-090 Orders of dismissal—Reinstating a hearing after an order of dismissal. (1) An order of dismissal is an order from the presiding officer ending the matter. The order is entered because the party who requested the hearing withdrew the administrative hearing request, the appellant is no longer aggrieved, the presiding officer granted a dispositive motion dismissing the matter, or the presiding officer entered an order of default because the party who requested a hearing failed to attend or refused to participate in the hearing.

(2) The order of dismissal becomes a final order if no party files a request to vacate the order ((~~pursuant to~~)) as described in subsections (3) through (7) of this section.

(3) If the presiding officer enters and ((~~mails~~)) serves an order dismissing the hearing, the ((~~party that originally requested the hearing~~)) appellant may file a written request to vacate (set aside) the order of dismissal. Upon receipt of a request to vacate an order of dismissal, the presiding officer must schedule and ((~~mail~~)) serve notice of a prehearing conference as described in ((~~accordance with~~)) WAC 182-16-071. At the prehearing conference, the party asking that the order of dismissal be vacated has the burden to show good cause according to subsection (8) of this section for an order of dismissal to be vacated and the matter to be reinstated.

(4) The request to vacate an order of dismissal must be filed with the presiding officer and the other parties. The party requesting that an order of dismissal be vacated should specify in the request why the order of dismissal should be vacated.

(5) The request to vacate an order of dismissal must be filed with the presiding officer no later than twenty-one calendar days after the date the order of dismissal was entered. If no request is received within that deadline, the dismissal order becomes a final order and the public employees benefits board (PEBB) appeals committee decision will stand.

(6) If the presiding officer finds good cause, as described in subsection (8) of this section, for the order of dismissal to be vacated, the presiding officer must enter and ((~~mail~~)) serve a written order to the parties setting forth the findings of fact, conclusions of law, and reinstatement of the matter.

(7) If the order of dismissal is vacated, the presiding officer will conduct a hearing at which the parties may present argument and evidence about issues raised in the original request for hearing. The hearing may occur immediately following the prehearing conference on the request to vacate only if agreed to by the parties and the presiding officer, otherwise a hearing date must be scheduled by the presiding officer.

(8) Good cause is a substantial reason or legal justification for failing to appear, act, or respond to an action using the provisions of Superior Court Civil Rule 60 as a guideline. This good cause exception applies only to this section. This good cause exception does not apply to any other chapter(s) or section(s) in Title 182 WAC.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-16-091 Settlement agreements. (1) If the parties reach a mutually agreeable solution the agreement must be in writing.

(2) Any written agreements will be entered into the record by either party for consideration by the presiding officer.

(3) If all of the issues are resolved by the written agreement, the presiding officer will enter and ((~~mail~~)) serve an order of dismissal.

(4) If all of the issues are not resolved by a written agreement, either party, or the presiding officer, may request a prehearing conference before a hearing on any remaining issues can occur.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-16-092 Withdrawing the request for an administrative hearing. (1) The ((~~party who requested an administrative hearing of a public employees benefits board (PEBB) appeals committee decision~~)) appellant may withdraw the administrative hearing request for any reason, and at any time, by contacting the hearing representative who will coordinate the withdrawal with the presiding officer.

(2) The request for withdrawal must generally be made in writing. An oral withdrawal by the appellant is permitted during a hearing when both the presiding officer and hearing representative are present.

(3) After a withdrawal request is received, the presiding officer must cancel any scheduled hearings and enter and ((~~mail~~)) serve a written order dismissing the case. If a hearing request is withdrawn, the ((~~party~~)) appellant will not be able to request another administrative hearing on the same PEBB appeals committee decision.

(4) If ((~~a party~~)) an appellant withdraws an administrative hearing request, the order of dismissal may only be vacated (set aside) ((~~according to~~)) as described in WAC 182-16-090.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-16-100 Final order deadline—Required information. (1) Within ninety days after the hearing record is closed, the presiding officer shall ((~~mail~~)) serve a final order that shall be the final decision of the authority. The presiding officer shall ((~~mail~~)) serve a copy of the final order to all parties.

(2) The presiding officer must include the following information in the written final order:

(a) Identify the order as a final order of the public employees benefits board (PEBB) program;

(b) List the name and docket number of the case and the names of all parties and representatives;

(c) Enter findings of fact used to resolve the dispute based on the evidence admitted in the record;

(d) Explain why evidence is, or is not, credible when describing the weight given to evidence related to disputed facts;

(e) State the law that applies to the dispute;

(f) Apply the law to the facts of the case in the conclusions of law;

(g) Discuss the reasons for the decision based on the facts and the law;

(h) State the result and remedy ordered; and

(i) Include any other information required by law or program rules.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-16-105 Motion for reconsideration and response—Process. (1) Reconsideration means asking the presiding officer to reconsider his or her final order because the party believes the presiding officer made a mistake of law, mistake of fact, or clerical error. Within ten business days after the date the presiding officer's service date of the final order, a party may file a motion for reconsideration, stating the specific grounds upon which the relief is requested.

(2) A motion for reconsideration must state in writing why the party wants the final order to be reconsidered.

(3) The other parties may respond to the motion for reconsideration. The response must state in writing why the final order should stand. Responses are optional. If a party chooses not to respond, that party will not be prejudiced because of that choice.

(4) Motions for reconsideration must be filed with the presiding officer who entered the final order.

(5) If a party files a motion for reconsideration:

(a) The presiding officer must receive the motion for reconsideration on or before the tenth business day after the service date of the final order ((~~was mailed~~)).

(b) The party filing the motion must send copies of the motion to all other parties.

(c) Within five business days of receiving a motion for reconsideration, the presiding officer must ((~~mail~~)) serve to all parties a notice that provides the date the motion for reconsideration was received.

(d) Responses to a motion for reconsideration must be received by the presiding officer no later than seven business days after the service date of the presiding officer's notice as described in (c) of this subsection ((~~was mailed~~)), or the response will not be considered.

(e) Service of responses to a motion for reconsideration must be ((~~mailed~~)) made to all parties.

(6) If a party needs more time to file a motion for reconsideration or respond to a motion for reconsideration, the presiding officer may extend the deadline if the party makes a written request by the deadline.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-16-110 Judicial review of final order. (1) Judicial review is the process of appealing a final order to a court.

(2) The ((~~party that requested the administrative hearing~~)) appellant may appeal a final order by filing a written petition for judicial review that meets the requirements of RCW 34.05.546. The public employees benefits board (PEBB) program may not request judicial review.

(3) The ((~~party~~)) appellant should consult RCW 34.05.510 through 34.05.598 for further details and requirements of the judicial review process.

WSR 16-20-087
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Economic Services Administration)

[Filed October 4, 2016, 1:41 p.m., effective February 1, 2017]

Effective Date of Rule: February 1, 2017.

Purpose: The department is amending WAC 388-412-0020 and 388-412-0015 to extend the time frame in which the department issues ongoing monthly benefits for basic food, the Washington combined application program (WASHCAP), the food assistance program (FAP) for legal immigrants, and transitional food assistance.

Citation of Existing Rules Affected by this Order: Amending WAC 388-412-0020 and 388-412-0015.

Statutory Authority for Adoption: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 7 C.F.R. 273.9.

Adopted under notice filed as WSR 16-10-041 on April 28, 2016.

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

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

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

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

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 2, Repealed 0.

Date Adopted: July 14, 2016.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 15-02-041, filed 1/2/15, effective 2/2/15)

WAC 388-412-0015 General information about your food assistance allotments. (1) Your monthly allotment under the Washington basic food program, food assistance program for legal immigrants (FAP), Washington combined application project (WASHCAP), or the transitional food assistance (TFA) ((~~programs~~)) program is the total dollar value of benefits your assistance unit (AU) receives for a calendar month.

(2) **How we determine monthly allotments:**

(a) We calculate your monthly allotment for federally funded basic food as described under WAC 388-450-0162((~~,~~)).

(b) We calculate your monthly allotment for state-funded food assistance as described under WAC 388-400-0050.

(3) **Maximum allotment**:

(a) The maximum allotment for the number of people in your AU eligible for federally funded basic food benefits is described under WAC 388-478-0060.

(b) The maximum allotment for the number of people in your AU eligible for state-funded FAP benefits is set by the legislature in the biennial operating budget as described in WAC 388-400-0050.

(4) **Prorated benefits in the first month((~~,~~)).** If we determine you are eligible for food assistance, your first month's benefits are calculated from the date you applied through the end of the month of your application. This is called proration and is based on a thirty-day month:

(a) If your prorated benefits for the first month are under ten dollars, you will not receive an allotment for the first month.

(b) If there was a delay in processing your application, we determine when your benefits start under WAC 388-406-0055.

(5) **Combined allotment for first and second month's benefits((~~,~~)).** If you apply for benefits on or after the sixteenth of the month((~~,~~)) and we determine you are eligible for food assistance((~~, we issue~~)) for both the first and second ((~~months~~)) month, we will issue both months' benefits in one allotment ((~~if you are eligible for both months~~)).

(6) **Minimum allotment((~~,~~)).** Unless it is the first month of your certification period and your benefits are prorated as described in subsection (4) of this section, your monthly allotment will be at least:

(a) Sixteen dollars if your AU has one or two members((~~,~~)) and at least one person is eligible for federally funded basic food((~~,~~)); or

(b) ((~~Twelve~~)) Sixteen dollars if your AU has one or two members((~~,~~)) and all members of your AU are eligible for state-funded FAP.

(7) **Use of food assistance benefits((~~,~~)).** Your food assistance benefits may only be used to buy eligible food items as described under WAC 388-412-0046. If you use your benefits in any other way, it is an intentional program violation under WAC 388-446-0015 and could result in fines, imprisonment, disqualification from receiving food assistance benefits, or any combination of these penalties.

AMENDATORY SECTION (Amending WSR 03-22-038, filed 10/28/03, effective 12/1/03)

WAC 388-412-0020 When do I get my benefits? (1) If you get your cash benefits on an electronic benefits card (EBT), you get your cash benefits deposited on the first of each month.

(2) If you get your cash benefits deposited directly to your bank account((~~,~~)) by electronic funds transfer (EFT)((~~,~~)), your money is deposited on the first working day of the month. When the first of the month is a federal holiday or a Sunday, the benefits are deposited the following day.

(3) If you get basic food, your benefits are issued by the ((~~tenth~~)) twentieth day of each month. ((~~The day you get your benefits is the same as the last number of your assistance unit (AU) number for Basic Food. If the last number of your AU number is zero, you get your benefits on the tenth~~)) Our eligibility system automatically assigns the day you get your benefits when we approve your basic food. We tell you the date you will get your monthly benefits on your approval letter.

WSR 16-20-095
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Long-Term Support Administration)

[Filed October 4, 2016, 3:02 p.m., effective November 4, 2016]

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

Purpose: SB 5600 from the 2015 legislative session requires that certain definitions concerning vulnerable adults must be amended, including the definitions of abuse and sexual abuse. The department is amending sections of chapter 388-76 WAC to assure compliance with this requirement. Since the implementation of Executive Order 10-06 in 2010 suspending noncritical rule development and adoption, the department has communicated clarifying information and changes to stakeholders through Dear Provider Letters whenever the change or changes did not meet the moratorium criteria for rule change. However, with the recent revision of the criteria for rule change, the department is incorporating the aforementioned information into rule.

Other sections of the rule are either being amended to clarify the rule or revise the language in the rule to better align with the intent of statute. Additionally, revisions to this rule associated with the physical environment of the adult family home are being made for the health and safety of the residents residing in the home, such as ensuring adequate

grab bars when showering or toileting, and stable barriers around fireplaces or woodstoves to prevent incidental contact. Lastly, the department is repealing sections in this rule to condense the emergency evacuation sections in chapter 388-76 WAC.

Reasons supporting proposal: This amendment will ensure the department is in compliance with the newly passed law, and that rules are clear so that the rights and safety of residents are protected.

Citation of Existing Rules Affected by this Order: Repealing WAC 388-76-10820 and 388-76-10880; and amending WAC 388-76-10000, 388-76-10145, 388-76-10463, 388-76-10535, 388-76-10540, 388-76-10650, 388-76-10655, 388-76-10715, 388-76-10730, 388-76-10825, 388-76-10845, 388-76-10865, and 388-76-10895.

Statutory Authority for Adoption: Chapter 70.128 RCW.

Adopted under notice filed as WSR 16-14-037 on June 28, 2016.

Changes Other than Editing from Proposed to Adopted Version: WAC 388-76-10000 Definitions.

- Updated RCW reference contained in definition of "financial exploitation."

WAC 388-76-10535 Resident rights—Notice of change to services.

- Added "scope of care" to subsection (1).
- Added clarifying language to subsection (1)(b).
- Changed "or" to "and" in subsection (1)(d).

WAC 388-76-10650 Medical devices.

- Added clarifying language.

WAC 388-76-10655 Physical restraints.

- Clarified language in WAC 388-76-10655(2) regarding less restrictive alternatives to physical or mechanical restraints.

WAC 388-76-10730 Grab bars and hand rails.

- Changed October 1, 2016, date to November 1, 2016.
- The phrase, "if needed by any resident" was added back into this section.
- Added language that homes licensed before November 1, 2016, should also have grab bars and hand rails securely installed.

WAC 388-76-10825 Space heaters and stoves.

- Added clarifying language.

WAC 388-76-10845 Emergency drinking water supply.

- Clarified the requirement of emergency drinking water for the adult family home's resident capacity.

WAC 388-76-10865 Evacuation from adult family home.

- Date in WAC 388-76-10865(3) changed to November 1, 2016.

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 14, Repealed 2.

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 14, Repealed 2.

Date Adopted: September 28, 2016.

Katherine I. Vasquez
Rules Coordinator

Reviser's note: The material contained in this filing exceeded the page-count limitations of WAC 1-21-040 for appearance in this issue of the Register. It will appear in the 16-21 issue of the Register.

WSR 16-20-100
PERMANENT RULES
DEPARTMENT OF REVENUE
[Filed October 5, 2016, 7:44 a.m., effective November 5, 2016]

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

Purpose: WAC 458-50-160 explains the distinction between intangible personal property and the characteristics or attributes of property, both real and personal. Intangible personal property is exempt from property taxation per RCW 84.36.070. However, some characteristics or attributes of property, even though intangible, may be considered in establishing the taxable value of tangible property.

This rule has been revised to clarify that the intangible personal property tax exemption provided by RCW 84.36.070 only applies to intangible personal property and not to attributes of property like location, view, zoning regulations, office organization, trained workforce, etc. These "attributes" of property can be considered by the appraiser in determining the fair market value of taxable property.

Citation of Existing Rules Affected by this Order: Amending WAC 458-50-160 Exempt intangible property distinguished from other intangibles.

Statutory Authority for Adoption: RCW 84.08.010, 84.08.070, and 84.36.865.

Adopted under notice filed as WSR 16-16-048 on July 26, 2016.

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 0, Repealed 0.

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

Date Adopted: October 5, 2016.

Kevin Dixon
Rules Coordinator

AMENDATORY SECTION (Amending WSR 06-24-043, filed 11/30/06, effective 12/31/06)

WAC 458-50-160 Exempt intangible property distinguished from other intangibles. (1) **Distinction between property, and characteristics or attributes of property.** The statute (RCW 84.36.070) draws a distinction between intangible personal property and the characteristics or attributes of property, both real and personal. Intangible personal property is exempt from property taxation. However, some characteristics or attributes of property, even though intangible, may be considered in establishing the taxable value of tangible property.

(2) **What intangible personal property is exempt?** The listings of examples of intangible personal property contained in RCW 84.36.070(2) must be consulted, but those listings can be summarized as follows:

(a) Financial intangible property, such as moneys, credits, and publicly issued bonds and warrants, and the bonds, stocks, or shares of private corporations;

(b) Private personal service contracts and athletic or sports franchises, or sports agreements that do not pertain to the use or possession or any interest in tangible personal or real property; and

(c) Miscellaneous types of intangible personal property, such as trademarks, trade names, brand names, patents, copyrights, trade secrets, franchise agreements, licenses, permits, core deposits of financial institutions, noncompete agreements, customer lists, patient lists, favorable contracts, favorable financing agreements, reputation, exceptional management, prestige, good name, integrity of a business, and other similar types of intangible personal property.

(3) **Identifying exempt intangible personal property.** ((~~Intangible property is only exempt if it is personal property capable of being individually owned, used, transferred, or held separately from other property.~~)) The market value of separate items of intangible personal property should not be identified or characterized solely using residual accounting methods, or other indirect techniques, such as isolating "excess earnings," from a total business valuation. Market value of exempt intangible personal property should be verifiable, to the extent possible, in an openly traded market where the value of comparable intangible properties can be observed and considered. Intangible assets that are separately identified and valued in reports filed with any state or federal regulatory agency, may be considered when identifying and valuing intangible personal property of the types listed in subsection (2)(c) of this section.

(4) **What intangible characteristics, attributes or other factors affect value and may be considered?** Nonproperty intangible characteristics or attributes are elements or components of value associated with a real or tangible asset. These characteristics or attributes are "intangible" but they are not "property" and therefore are not tax exempt intangible personal property. They are contingent and dependent upon other property and cannot be owned, used, transferred, or held separately from other property. To the extent that these characteristics, attributes, or other factors contribute to, or affect, the value of property, they must be appropriately considered when determining taxable value. They include the following types:

(a) Zoning, location, view, geographic features, easements, covenants, proximity to raw materials, condition of surrounding property, proximity to markets, or the availability of a skilled work force;

(b) Grants of licenses, permits, and franchises by a government agency that affect the use of the property being valued; and

(c) Other characteristics of property, such as scarcity, uniqueness, adaptability, or utility as an integrated unit.

WSR 16-20-104
PERMANENT RULES
DEPARTMENT OF VETERANS AFFAIRS

[Filed October 5, 2016, 9:24 a.m., effective November 5, 2016]

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

Purpose: The veteran owned business WAC will further outline and explain the process for a Washington state veteran owned business to become certified by the Washington department of veterans affairs. RCW 43.60A.190 - 43.60A.200 set forth the parameters for the program, this WAC will further define and explain the process.

Statutory Authority for Adoption: Chapter 43.60A RCW.

Adopted under notice filed as WSR 16-17-119 on August 23, 2016.

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

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

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

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

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

Date Adopted: October 5, 2016.

Heidi C. Audette
Communications and
Legislative Director

Chapter 484-60 WAC

VETERAN OWNED BUSINESS CERTIFICATION

NEW SECTION

WAC 484-60-005 Certified veteran and servicemember owned business list—WEBS registration. (1) To be listed as a certified veteran or servicemember owned business the business must:

Register on the department of enterprise services Washington electronic business solution (WEBS) and indicate the business is at least fifty-one percent owned by a veteran or service member as defined in this chapter.

(a) When notified by WEBS, the business owner must complete the certification process by sending requested documentation to Washington state department of veterans affairs (WDVA) that verifies the business meets the eligibility requirements.

(b) WEBS notifies the business owner whether or not they have been certified by WDVA.

(2) A list of all certified veteran or servicemember owned businesses shall be maintained on WDVA's public web site.

NEW SECTION

WAC 484-60-010 Certified veteran and servicemember owned business list—Certification process. (1) **Eligibility for certification.** WDVA must verify that the business is:

(a) At least fifty-one percent owned and controlled by:

(i) A veteran, defined as every person who at the time he or she seeks certification has received a discharge with an honorable characterization or received a discharge for medical reasons with an honorable record, where applicable, and who has served in at least one of the capacities listed in RCW 41.04.007; or

(ii) An active or reserve member in any branch of the armed forces of the United States, including the National Guard, Coast Guard, and armed forces reserves; and

(b) An enterprise which is incorporated in the state of Washington as a Washington domestic corporation, or an enterprise whose principal place of business is located within the state of Washington for enterprises which are not incorporated.

(c) The business may also be eligible if at least one veteran and the business meet the criteria in (a) and (b) of this subsection and the business:

(i) Is owned and controlled by a married couple or registered domestic partnership where only one spouse or partner is an eligible veteran, provided that the business is controlled and operated by the eligible veteran; or

(ii) Is operated by the nonveteran widow(er) of a veteran spouse or registered domestic partner who has not remarried or reregistered for up to ten years following the death of the veteran or until he or she remarries or reregisters, whichever is shorter, as long as the widow(er) remains an active participant in the day-to-day operations of the business and maintains at least fifty-one percent ownership; or

(iii) Is owned by more than one veteran and at least fifty-one percent of the business is owned by eligible veterans and the business is controlled and operated by those veterans; or

(iv) Is a corporate sponsored dealership, otherwise known as a franchise, and the business meets the following ownership standards:

(A) The veteran owner(s) have entered into a written agreement, contract, or arrangement with a national or regional corporation and has been granted a license to offer, sell, or distribute goods or services at wholesale or retail, leasing or otherwise use the name, service mark, trademark, or related characteristics of the sponsoring corporation.

(B) The veteran owner(s) must declare that the relationship between the corporate sponsor and the veteran owner(s) was not formed for the primary purpose of achieving certification under chapter 43.60A RCW as a veteran or servicemember owned business, or any similar provision of any ordinance, regulation, rule or law; or

(v) Is a nonprofit veteran service organization department or office in Washington state and is listed by the U.S. Department of Veterans Affairs in the Directory of Veterans Service Organizations and registered as a nonprofit with the Washington secretary of state; or

(vi) Is a business that is certified by the Vets First Verification Program or VetBiz and the business provides that certification letter and proof that the business is incorporated in the state of Washington as a Washington domestic corporation, or proof that the business is an enterprise whose principal place of business is located within the state of Washington for enterprises which are not incorporated.

(2) **Required documentation.** Before WDVA can certify a veteran or servicemember owned business, the business must supply WDVA with all requested documents to verify eligibility.

(3) **Decertification.** A business may be decertified at any time WDVA determines that the business does not meet the current criteria for eligibility.

(a) A certified business shall notify the office, in writing, within thirty calendar days of any changes in its veteran ownership status, control, operations, or incorporation status in the state of Washington. Failure to provide such notice in a timely manner may lead to decertification.

(b) When WDVA has determined that a certified business (i) no longer meets the certification criteria, or (ii) failed to supply additional information requested by the office in a timely manner, or (iii) failed to give timely notice of changes, WDVA will decertify the business in writing.

(4) **Administrative review of decertification decisions.**

(a) Upon receipt of a notice of decertification letter, the business may request an administrative review of the decision as authorized by RCW 34.05.482; 34.05.485; and 34.05.494. The request for administrative review must be received by WDVA within twenty calendar days of mailing of the notice of decertification to the last address supplied to WDVA by the business. The request for an administrative

review must set forth the reasons the business believes WDVA's decision to decertify is in error and must include all supporting information and documentation.

(b) If WDVA has not received a request for an administrative review within twenty days of mailing of the notice of decertification letter, the decision to decertify becomes final.

(c) Upon receipt of the request for an administrative review, WDVA will review the request and any additional information provided and may conduct further investigation. An administrative review will be conducted by WDVA and the business will be given an opportunity to present evidence and argument.

(d) WDVA will thereafter notify the business in writing of its decision to either affirm or reverse the firm's decertification.

(e) If the business disagrees with WDVA's decision, the business may appeal in writing to the director of WDVA within twenty days of the initial decision. The business shall remain certified until:

(i) The entry of a final decertification decision by the director.

(ii) Decertification shall be effective immediately upon the entry of the final decision, and will not be stayed pending review by any court.

(f) Decertified businesses must remove any stickers, logos, or statements that identify them as a veteran or servicemember owned business to the public.

NEW SECTION

WAC 484-60-015 Linked deposit program. Certified veteran or servicemember owned businesses may apply for the linked deposit program if:

(1) The veteran or service member owner possesses and exercises sufficient expertise specifically in the business' field of operation to make decisions governing the long-term direction and the day-to-day operations of the business; and

(2) The business is organized for profit and performing a commercially useful function; and

(3) The business meets the criteria for a small business concern as established under chapter 39.19 RCW; and

(4) The business meets the criteria for participation in the program as described in chapters 326-02 and 326-70 WAC.

WSR 16-20-105
PERMANENT RULES
DEPARTMENT OF VETERANS AFFAIRS

[Filed October 5, 2016, 9:25 a.m., effective November 5, 2016]

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

Purpose: These rules update several WAC regarding the Washington veterans homes. Old sections that are no longer relevant because programs have changed over the years are deleted. Other sections are deleted because the veterans homes must follow other federal laws or laws/rules put forth by DSHS and so the WAC indicates that staff members are to follow those federal or DSHS laws/rules. In addition, legislation was passed in 2014 which directs the state veterans homes to provide care to Gold Star Parents, so these individuals are added to the list of those eligible for care in a state veterans home.

Citation of Existing Rules Affected by this Order: Repealing WAC 484-20-040, 484-20-062, 484-20-089, 484-20-115 and 484-20-117; and amending WAC 484-20-010, 484-20-015, 484-20-023, 484-20-030, 484-20-035, 484-20-045, 484-20-055, 484-20-060, 484-20-061, 484-20-063, 484-20-065, 484-20-068, 484-20-070, 484-20-080, 484-20-085, 484-20-086, 484-20-087, 484-20-088, 484-20-090, 484-20-103, 484-20-105, 484-20-111, 484-20-116, 484-20-120, and 484-20-135.

Statutory Authority for Adoption: Chapter 72.36 RCW.

Other Authority: Chapter 184, Laws of 2014.

Adopted under notice filed as WSR 16-17-120 on August 23, 2016.

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

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

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

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

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

Date Adopted: October 5, 2016.

Heidi C. Audette
Communications and
Legislative Director

AMENDATORY SECTION (Amending WSR 04-19-026, filed 9/9/04, effective 10/10/04)

WAC 484-20-010 Definitions. The following words or phrases are used in this chapter in the meaning given, unless the context clearly indicates another meaning.

(1) Admission team - A team consisting of a designated veterans benefit specialist, an admissions coordinator, and designated medical or nursing staff.

(2) Adjudicative proceeding - In accordance with RCW 34.05.010(1), an adjudicative proceeding is a proceeding before an agency in which an opportunity for hearing before that agency is required by statute or constitutional right before or after the entry of an action by the agency.

(3) Administrative action - An act (as defined in RCW 34.05.010(3)) taken by the agency or state veterans home which implements or enforces a statute, applies an agency rule or order, or imposes sanctions or withholds benefits.

(4) Comprehensive care plan - A plan which outlines details of health care for medicaid certified nursing facility residents.

(5) Cost of care.

(a) Daily rate - ((~~The maximum daily cost (rate) to provide care and services to a medicaid recipient. The daily rate is set annually by the department of social and health services and applies to all medicaid certified nursing facility residents. A different daily rate is established for the Washington veterans home, the Washington soldiers home, and the eastern Washington veterans home (also known as the Spokane veterans home).~~)) The daily charge for room and board, nursing care, and covered ancillary items and services.

(b) Private rate - ((~~The daily cost (rate) to provide services to state veterans home residents who have resource levels exceeding standards in WAC 484-20-040. There is a different private rate for nursing care and domiciliary care. The private rate is based on actual operating costs.~~)) The daily rate, established by WDVA, to provide care and services to residents who do not meet medicaid institutional long-term care eligibility requirements according to WAC 182-513-1315. There is a different rate for nursing care and domiciliary care.

(c) Resident contribution - The monthly amount a resident pays to the state veterans home ((~~as partial payment of~~)) for the cost of care. If the resident is a medicaid recipient, the resident contribution is determined by the appropriate community service office. If the resident is not a medicaid recipient, the resident contribution is determined by the facility. The resident contribution is recalculated with any change in the resident's monthly income.

(6) Department - The department of veterans affairs.

(7) Director - The director of the department of veterans affairs or his/her designee.

(8) Domiciliary care - ((~~Is the provision of a home, with necessary ambulant medical care. To be entitled to domiciliary care, the applicant must consistently have a disability, disease or injury which is chronic in nature and produces disablement of such a degree and probable persistency as will incapacitate from earning a living for a prospective period.~~)) Shelter, food, and necessary medical care on an ambulatory self-care basis to assist eligible veterans who are suffering from a disability, disease or defect of such a degree that incapacitates the veteran from earning a living. However, the veteran, although not in need of hospitalization or nursing care services, needs to attain the physical, mental, and social well-being through special rehabilitative programs to restore the veteran to the highest level of functioning.

(9) Facility - Refers to either the Washington veterans home, or the Washington soldiers home, or the eastern Washington veterans home (also known as the Spokane veterans home), ((~~but **does not** include the medicaid certified nursing facility~~)) or the Walla Walla veterans home.

(10) ((~~Furlough - An approved absence for facility residents.~~)) Gold star parent - A parent whose child or children died while serving in the armed forces.

(11) Grievance - An oral or written statement of any difficulty, disagreement, or dispute relating in any way to a facility, a resident or facility staff.

(12) Grievance investigator - State veterans home social service staff or another appropriate person requested by the resident who investigates a grievance.

(13) Income - The receipt by an individual of any property or service which he/she can apply either directly, by sale, or conversion to meet his/her basic needs for food, clothing, and shelter.

(a) Earned income - Gross wages for services rendered and/or net earnings from self-employment. Earned income received at predictable intervals other than monthly or in unequal amounts will be converted to a monthly basis.

(b) Unearned income - All other income.

(14) Medicaid certified nursing facility - Refers to those nursing care units of each state veterans home that are medicaid certified as described under WAC ((~~388-97-005~~)) 388-97-0001.

(15) Personal needs allowance - In accordance with chapter 72.36 RCW the amount which a resident may retain from his/her income.

(16) ((~~Rehabilitation leave - A period of time granted to permit a resident to attempt to reestablish independent living or other care arrangements in a community of his/her choice while retaining the right to return to the facility without reapplying for admission.~~

~~(17) Rehabilitation plan - Describes individualized goals for professional treatment, counseling and/or guidance necessary to restore to the maximum extent possible the physical, mental and psychological functioning of an ill or disabled person.~~

~~(18)~~)) Resources - Cash or other liquid assets or any real or personal property that an individual or spouse, if any, owns and could convert to cash to be used for support or maintenance.

(a) When an individual can reduce a liquid asset to cash, it is a resource.

(b) If an individual cannot reduce an asset to cash, it is not considered an available resource.

(c) Liquid - Assets that are in cash or are financial instruments which are convertible to cash such as, but not limited to, cash in hand, stocks, savings, checking accounts, mutual fund shares, mortgage, promissory notes.

(d) Nonliquid - All other property both real and personal shall be evaluated according to the price that can reasonably be expected to sell for on the open market in the particular geographical area involved.

((~~(19)~~)) (17) Resident - An individual who resides at a state veterans home.

((~~(20)~~)) (18) Resident council - A group of residents elected in accordance with RCW 72.36.150 by facility residents.

((~~(21)~~)) (19) Social leave - An approved absence for residents ((~~of medicaid certified nursing facility units~~)).

((~~(22)~~)) (20) State veterans home - Refers to the Washington soldiers home and colony in Orting, the Washington veterans home in Retsil, the eastern Washington veterans home (also known as the Spokane veterans home), the Walla Walla veterans home, or all.

((~~(23)~~)) (21) Staff - Any individual hired ((~~or contracted~~)) to provide care and services at the state veterans homes.

((~~(24)~~)) (22) Superintendent - The licensed nursing home administrator appointed by the director to administer the day-to-day operations of a state veterans home.

Interim superintendent is a licensed nursing home administrator, appointed by the director to administer the day-to-day operations of a state veterans home, and who may or may not be a veteran. The director may appoint an interim superintendent while a superintendent candidate is completing an administrator in training program, or whenever a suitable candidate is not available.

AMENDATORY SECTION (Amending WSR 04-19-026, filed 9/9/04, effective 10/10/04)

WAC 484-20-015 Application for admission. (1) Applications for admission to a state veterans home shall be made using forms prescribed by the department.

(2) All applications shall include either a copy of the applicant's military discharge or a statement from the applicable military service denoting the dates and character of service. An individual whose eligibility is based on the military service of a spouse shall provide proof of the spouse's military service.

(3) An admissions team shall:

(a) Review each application to ensure inclusion of all information and documents necessary to determine eligibility for admission;

(b) For admission to a medicaid certified nursing facility, ensure a preadmission screening (in accordance with state regulations at WAC ((~~388-97-247~~)) 388-97-1910 through ((~~388-97-388~~)) 388-97-2000) and if necessary a preadmission screening and resident review (PASRR) (in accordance with state regulations at WAC ((~~388-97-247 through 388-97-260~~)) 388-97-2000) have been conducted; and

(c) ((~~Recommend to the director that the application be approved or denied.~~)) The applicant shall receive written notice of the decision in accordance with WAC 484-20-103.

(4) Applications are reviewed and approved or denied in the order of receipt.

AMENDATORY SECTION (Amending WSR 94-22-050, filed 10/31/94, effective 12/1/94)

WAC 484-20-023 Admission to a state veterans home. (1) Each state veterans home maintains several waiting lists, one for each program or service offered. The names of applicants approved for admission shall be placed on the waiting list for the program or service which the admission team has determined shall be most appropriate based on their health care/service needs. Applicants shall be listed in order of approval.

(2) Applicants are admitted from the waiting lists in the order in which their applications are approved; subject to bed availability in the program or service area for which admission has been approved.

(3) An applicant may be denied admission, or be moved from one waiting list to another when in the interim between application approval and scheduled admission:

(a) The applicant's health care needs have changed to the extent that the program or service for which he/she was originally approved can no longer meet his/her health care needs; or

(b) The applicant's service needs have changed to such an extent that the facility can no longer meet the applicant's health care/service needs.

(4) Any applicant whose name has been on a waiting list over ninety days is required to submit an up-to-date medical information form completed by his/her physician prior to being given an admission date.

(5) If an applicant declines a scheduled admission, (s)he will be placed at the bottom of the appropriate service waiting list. The next person on the waiting list will be invited for admission.

((~~(6) If the applicant's financial status changes substantially in the interim between application approval and scheduled admission, or additional financial information becomes available, the applicant must submit an updated financial information form. If the change in financial status makes the applicant ineligible, due to excess resources, the applicant may be admitted under the provisions of WAC 484-20-040.~~))

AMENDATORY SECTION (Amending WSR 94-22-050, filed 10/31/94, effective 12/1/94)

WAC 484-20-030 Eligibility—Military service. (1) An applicant must have served on active duty in:

(a) The armed forces of the United States government and must have received a discharge under honorable conditions; or

(b) The state militia ((~~(Washington national guard)~~)), and have been disabled in line of duty or have received a discharge under honorable conditions; or

(c) The Coast Guard, Merchant Mariners, or other nonmilitary organization when such service was recognized by the United States government as equivalent to service in the armed forces and have received a discharge under honorable conditions as evidenced by possession of a DD214, or similar document in accordance with WAC 484-20-015(2).

(2) Admission priorities are granted in the following order:

(a) Veterans who meet all eligibility requirements of this chapter;

(b) ((~~Veterans who meet all eligibility requirements except indigency and who will become indigent through purchase of necessary health care;~~

~~(c)~~)) Spouses or registered domestic partners of veterans as described in WAC 484-20-055; and

(((~~(d) Veterans who meet all eligibility requirements except indigency and agree to pay at the private rate.~~)) (c) Gold star parents, as described in WAC 484-20-010.

(3) Seventy-five percent or more of a veterans home's residents must be veterans meeting all eligibility requirements.

AMENDATORY SECTION (Amending WSR 04-19-026, filed 9/9/04, effective 10/10/04)

WAC 484-20-035 Eligibility—Transfer of resources. Eligibility for admission as related to transfer of resources is determined by application of medical assistance eligibility rules as defined in ((~~WAC 388-513-1364 through 388-513-1366~~)) chapter 182-513 WAC.

AMENDATORY SECTION (Amending WSR 04-19-026, filed 9/9/04, effective 10/10/04)

WAC 484-20-045 Eligibility—Inability to support self/need for care. (((~~(1)~~))) To be eligible for admission an applicant must ((~~be indigent as defined in WAC 484-20-040 and~~)) be in need of:

(((~~(a)~~))) (1) Medicaid certified nursing facility care as described in ((~~WAC 388-513-1315~~)) chapter 182-513 WAC; or

(((~~(b)~~))) (2) Nursing care other than medicaid certified nursing facility care; or

(((~~(c)~~))) (3) Domiciliary care.

(((~~(2) Applicants who are not in need of care as described in subsection (1) of this section are eligible for admission only if their application includes a rehabilitation plan. Such applicants shall be admitted for a specific period as defined by the rehabilitation plan. Any reductions or extensions of the period of residency are made upon recommendation of the interdisciplinary patient care team and are based on the resident's progress toward meeting or refusal to meet goals outlined in the rehabilitation plan.~~))

AMENDATORY SECTION (Amending WSR 94-22-050, filed 10/31/94, effective 12/1/94)

WAC 484-20-055 Eligibility—Surviving spouse of veteran. The surviving spouse of a veteran may be admitted to a state veterans home provided:

(1) The veteran was a state resident at the time of death and would have been eligible for admission ((~~except for his/her income or resources~~)); and

(2) The spouse or registered domestic partner:

(a) Meets the provisions of WAC 484-20-045; and

(b) Has not remarried or registered a new domestic partnership with the Washington state secretary of state, a person who is not a state resident or who is not eligible for admission.

AMENDATORY SECTION (Amending WSR 94-22-050, filed 10/31/94, effective 12/1/94)

WAC 484-20-060 Eligibility—Married couple or domestic partnership. A ((~~married~~)) couple may be admitted to a state veterans home provided:

(1) They both meet the requirements of WAC 484-20-045.

(2) They are legally married or domestic partners registered with the Washington state secretary of state, and if not living together, are separated because of different health care needs.

(3) They have been married, or registered domestic partners, at least three years prior to application, or the spouse or registered domestic partner is personally eligible for admission.

(4) At least one meets the requirement of WAC 484-20-030.

AMENDATORY SECTION (Amending WSR 94-22-050, filed 10/31/94, effective 12/1/94)

WAC 484-20-061 Resident assessment and care plan. (((~~(1)~~))) In accordance with federal regulations at 42 C.F.R. § 483.20 and 38 C.F.R. § 51.110, the medicaid certified nursing facilities shall provide resident care based on a systematic, comprehensive, interdisciplinary assessment, and care planning process in which the resident actively participates.

(((~~(2) The medicaid certified nursing facility shall:~~

~~(a) Conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity;~~

~~(b) At the time each resident is admitted, have physician orders for the resident's immediate care; and~~

~~(c) Ensure that the comprehensive assessment of a resident's needs describes the resident's capability to perform daily life functions and significant impairments in the functional capacity.~~

~~(3) The comprehensive assessment shall include at least the following information:~~

~~(a) Medically defined conditions and prior medical history;~~

~~(b) Medical status measurement;~~

~~(c) Physical and mental functional status;~~

~~(d) Sensory and physical impairments;~~

~~(e) Nutritional status and requirements;~~

~~(f) Special treatments or procedures;~~

~~(g) Mental and psychosocial status;~~

~~(h) Discharge potential;~~

~~(i) Dental condition;~~

~~(j) Activities potential;~~

~~(k) Rehabilitation potential;~~

~~(l) Cognitive status; and~~

~~(m) Drug therapy.~~

~~(4) The medicaid certified nursing facility shall conduct comprehensive assessments:~~

~~(a) No later than fourteen days after the date of admission;~~

~~(b) Promptly after any significant change in the resident's physical or mental condition; and~~

~~(c) In no case less often than once every twelve months.~~

~~(5) The medicaid certified nursing facility shall ensure:~~

~~(a) Each resident is examined no less than once every three months, and as appropriate, the resident's assessment is revised to assure the continued accuracy of the assessment; and~~

~~(b) The results of the assessment are used to develop, review and revise the resident's comprehensive plan or care under subsection (6) of this section.~~

~~(6) Comprehensive care planning. The medicaid certified nursing facility in compliance with federal regulations at 42 C.F.R. § 483.20 shall develop a comprehensive care plan for each resident that includes measurable objective and timetables to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan shall:~~

~~(a) Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being;~~

~~(b) Describe any services that would otherwise be required, but are not provided due to the resident's exercise of rights, including the right to refuse treatment;~~

~~(c) Be developed within seven days after completion of the comprehensive assessment;~~

~~(d) Be prepared by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs; and~~

~~(e) Include the participation of the resident, the resident's family or the resident's legal representative.~~

~~(7) The medicaid certified nursing facility shall follow the informed consent process as specified in WAC 388-97-060 regarding the interdisciplinary team's care plan recommendations. The resident care plan shall contain the resident's statement of consent to or refusal of care and service goals. Consent or refusal may be provided by the resident's legal representative when allowed by state law.~~))

AMENDATORY SECTION (Amending WSR 94-22-050, filed 10/31/94, effective 12/1/94)

WAC 484-20-063 Bed hold. ((~~(1)~~)) All ((~~medicaid certified nursing~~)) facility residents shall receive written notice of the bed hold policy in accordance with federal regulations at 42 C.F.R. § ((~~486.12.~~

~~(2) Other facility residents shall pay the full resident contribution to hold a bed during periods of absence from the facility, unless an exception is made under the provisions of WAC 484-20-117~~)) 483.12 and 38 C.F.R. § 51.80.

AMENDATORY SECTION (Amending WSR 04-19-026, filed 9/9/04, effective 10/10/04)

WAC 484-20-065 Use of residents' income and resources. (1) **Monthly payments.** Each month residents shall pay ((~~to the state veterans home all income in excess of the established personal needs allowance. This payment shall be known as the~~)) his or her resident contribution as defined in WAC 484-20-010 ((~~(5)(c).~~)) on the department ((~~policy establishes the~~)) established payment due date. The amount paid shall not exceed the private rate for the program/service area in which the resident resides. Subsections (3) and (5) of this section list exceptions.

(2) **Personal needs allowance.**

(a) **Single residents.** If the resident's monthly income equals or exceeds the established personal needs allowance, he/she may retain the established personal needs allowance. If the individual's monthly income is less than the established personal needs allowance, his/her personal needs allowance shall be limited to:

(i) For residents who are medicaid recipients, the personal needs allowance authorized by the appropriate department of social and health services community service office; or

(ii) For residents who are not medicaid recipients to the income which he/she receives.

(b) **Married residents or registered domestic partners, both residing in the state veterans home.** If each individual's income equals or exceeds the established personal needs allowance, each may retain the established personal needs allowance. If one of the individual's monthly income is less than the established personal needs allowance, his/her personal needs allowance shall be limited to:

(i) For residents who are medicaid recipients, the personal needs allowance authorized by the appropriate department of social and health services community service office; or

(ii) For residents who are not medicaid recipients, to the income to which he/she has an individual right.

(3) **Exceptions to monthly payments.** (Note: This subsection (3) only applies to residents who are not medicaid recipients. The department of social and health services makes these ((~~types of~~)) determinations for residents who are medicaid recipients in accordance with applicable medicaid rules.) Residents may be authorized to retain (in addition to their personal needs allowance) ((~~the following:~~

~~(a) If a resident is on approved rehabilitation leave, monthly income which he/she would be entitled to receive if living in the community.~~

~~(b) If a resident is participating in an approved vocational rehabilitation program, the monthly vocational rehabilitation program earnings.~~

~~(c) If a resident is participating in a therapeutic employment program and it is documented in his/her plan of care, monthly therapeutic employment earnings; except for medicaid recipients the amount retained shall not exceed limits established under medical assistance eligibility rules (WAC 388-478-0070, 388-513-1315, and 388-513-1395)~~)) monthly therapeutic employment earnings, if the resident is participating in a therapeutic employment program and it is documented in his/her plan of care. The amount retained shall not exceed limits established under medical assistance eligibility rules.

(4) **Application for benefits/entitlements.**

(a) Residents are required to apply for any and all entitlements or benefits as soon as they become eligible. Residents and/or their representative must fully disclose all information required for determining eligibility for all entitlements and benefits.

(b) Agency veterans benefit staff shall assist residents to make application for entitlements and benefits.

(c) Residents who apply for medicaid and meet medical need requirements but are over the resource limits outlined in chapter 182-513 WAC, shall be advised ((~~to seek the necessary assistance (to include legal advice) to reduce their resources~~)) of their options and the consequences of being over medicaid resource limits. Residents shall be billed at the private rate until medicaid resource limits are met.

(5) **Support of a nonresident spouse.**

(a) If a resident is a medicaid recipient and has a community spouse, the provisions of chapter ((~~388-513~~)) 182-513 WAC apply; except where preempted by federal law; shall apply to income and resources.

(b) If a resident is not a medicaid recipient and has a community spouse, the provisions of chapter ((~~388-513~~)) 182-513 WAC apply; except where preempted by federal law; shall be used to determine:

(i) Available and exempt income and resources with regard to eligibility and resident participation;

(ii) Ownership of income and resources; and

(iii) Participation by the community spouse.

(6) Only subsection (4)(a) and (b) of this section applies to residents of the colony at the Washington soldiers home.

(7) **Resource limits.**

(a) For residents who are medicaid recipients, resource limits are in accordance with medicaid rules found at chapter ((~~388-513~~)) 182-513 WAC.

(b) For residents who are not medicaid recipients, resource limits shall be established by the facility using the medicaid resource limit for a single or a married individual; whichever is applicable.

(c) If a resident who is a medicaid recipient receives or accumulates funds in excess of resource limits in (a) of this subsection, the case shall be referred to the appropriate department of social and health services community service office to adjust the resident contribution and/or determine continuing medicaid eligibility. If the community service office determines the resident is no longer eligible to receive medicaid benefits, the resident shall pay at the private rate until medicaid eligibility is reestablished.

(d) If a resident who is not a medicaid recipient receives or accumulates funds in excess of resource limits in (b) of this subsection, the resident shall pay at the private rate until accumulated funds are reduced to the resource limit.

(e) Exceptions to the resource limits in (b) of this subsection may be granted on a case-by-case basis if a resident has an approved discharge plan which includes a goal to reestablish independent community living through either an approved rehabilitation leave or participation in an approved vocational rehabilitation program.

(8) **Retroactive, lump sum benefits.**

(a) If a medicaid recipient receives a retroactive, lump sum award of benefits, he/she shall be required to report the award to the appropriate department of social and health services community service office. If the resident continues to be eligible for medicaid, the community service office will issue a new medicaid award letter which adjusts the resident contribution if appropriate. If the community service office determines the resident is no longer medicaid eligible, the award shall be counted as income for the month(s) in which moneys would have been received and the resident shall pay retroactively the resident contribution due from date of admission to date of receipt of the retroactive lump sum award; except the resident contribution will not be collected for those months during which the resident received medicaid benefits. If the resident's resources still exceed medicaid resource limits, the resident shall pay at the private rate until medicaid eligibility is reestablished.

(b) If a resident who is not a medicaid recipient receives a retroactive lump sum award, the award shall be counted as income for the month(s) in which moneys would have been received and the resident shall pay retroactively the resident contribution due from date of admission to date of receipt of the retroactive lump sum award.

(9) The estate of any individual who is a resident at the time of death will be charged for the balance of any cost of care which the resident did not pay during his/her residency in the state veterans home. The state veterans home shall ((~~periodically~~)) inform the resident of the total amount of any past due cost of care. For residents who are medicaid recipients, recovery shall be in accordance with chapter ((~~388-527~~)) 182-527 WAC. For any resident who is not a medicaid recipient, recovery shall be in accordance with a written agreement made at the time of admission.

(10) For any partial months of residency the resident's contribution shall apply first.

AMENDATORY SECTION (Amending WSR 94-22-050, filed 10/31/94, effective 12/1/94)

WAC 484-20-068 Resident council. (1) Each facility shall have resident council consisting of representatives elected by facility residents. Elections shall be held annually.

(2) The council shall annually elect a chair from among its members. The chair shall call and preside at council meetings.

(3) The resident council shall serve in an advisory capacity to the respective superintendents and to the director in all matters related to policy and operational decisions affecting resident care and life in the facility, to include, but not be limited to, input into the resident council biennial budget making process and facility supplementary policies and procedures. The superintendent shall give due and proper consideration to such input.

(4) Each resident council shall:

(a) Actively participate in development of choices regarding activities, food, living arrangements, personal care and other aspects of resident life; and

(b) When so requested by a resident, serve as an advocate in resolving grievances and ensuring resident rights are observed.

(5) Benefit fund.

(a) The resident council for each state veterans home shall annually review the proposed expenditures from the benefit fund. The resident council approves expenditures from the state veterans home benefit fund.

(b) Disbursements from the benefit fund shall be authorized by the superintendent after approval by the state veterans home resident council.

(6) Governance of the resident council.

(a) Bylaws, approved by the majority vote of the residents, shall define resident council operations.

(b) Bylaws shall be reviewed annually and amended as deemed appropriate by a majority vote of the residents.

(c) Bylaws shall include, but not be limited to definitions of mechanisms for:

(i) Annual elections of council members and chair;

(ii) Make up and responsibilities of any council committees;

(iii) Meeting schedules;

(iv) Determining the number of council members; and

(v) To ensure provisions for participation and representation from the medicaid certified nursing facility sections, should those residents choose to participate in resident council activities. When considering benefit fund related issues/expenditures in accordance with chapter 72.36 RCW and WAC 484-20-070, state veterans home benefit fund, the resident council shall ensure representation from ((~~the medicaid certified nursing facility sections~~)) all levels of care.

(d) The superintendent at each facility shall review and sign the bylaws, indicating agreement with and support of the bylaws.

(7) The resident council shall meet with the superintendent monthly and with the department director three times annually.

(8) Each resident council shall be provided the following:

(a) Meeting space;

(b) Appropriate equipment and supplies; and

(c) Clerical support for minutes of all resident council meetings as requested.

(9) All residents are eligible to serve on the resident council providing that they have signed the resident agreement which all residents receive upon admission to a state veterans home, and that they have not violated the provisions of WAC 484-20-090, the resident agreement or any agency or veterans home policies within the past twelve months.

AMENDATORY SECTION (Amending WSR 94-22-050, filed 10/31/94, effective 12/1/94)

WAC 484-20-070 State veterans home benefit fund. (1) Each veterans home shall maintain a benefit fund into which all private donations, bequeaths, and gifts to the facility shall be deposited, unless the donor made a specific request for use of the funds.

(2) The resident council shall participate in the identification of resident and facility needs for benefit fund solicitations.

(3) The resident council shall develop proposals for expenditures from the benefit fund. The minutes of the resident council meetings shall reflect the council's discussion and decision-making process related to proposed benefit fund expenditures. Facility fiscal staff may assist the resident council in the development of expenditure proposals as requested. The resident council shall ensure all areas of the state veterans home((~~, including the medicaid certified nursing facility,~~)) are represented during the council's discussion and decision-making process related to proposed benefit fund expenditures.

(4) Expenditures from the benefit fund shall be made as approved by the resident council and authorized by the superintendent. Whenever individuals or groups have made a donation, bequeath or gift to a state veterans home and have designated a specific purpose for such donation, bequeath or gift, the resident council and the superintendent shall take such designated purpose into account when approving expenditure of the funds. Should the resident council and the superintendent disagree over an expenditure approved by the resident council, the resident council or the superintendent may request a review by the director.

(5) Disbursements from the benefit fund shall be for the benefit and welfare of the residents of the respective state veterans home.

(6) The resident council shall receive monthly reports of income to and expenditures from the benefit fund.

AMENDATORY SECTION (Amending WSR 01-23-001, filed 11/7/01, effective 12/8/01)

WAC 484-20-080 Annual declaration of income and resources. (1) Each resident shall promptly provide the superintendent or designated representative with a statement reflecting all income and resources:

(a) Annually, at such time as determined by department policy;

(b) Within fourteen days of any change in income;

(c) Within fourteen days of receipt of any lump sum/back-award payment of benefits. The department shall provide forms for reporting of income and resources; and

(d) If the resident is able to demonstrate good cause, exceptions may be made to the reporting deadlines in (b) and (c) of this subsection.

(2) Each resident shall comply with any reporting requirements necessary to initiate/continue any benefits and/or pensions to which he/she is entitled.

(3) Reports shall be made at intervals and on forms prescribed by the entity paying the benefits and/or pension. Copies shall be submitted to the facility's administration for filing in the resident's administrative file:

(a) U.S. Department of Veterans Affairs benefits - As prescribed by the U.S. Department of Veterans Affairs.

(b) Social Security benefits - As prescribed by the Social Security Administration.

(c) Medicaid benefits - As prescribed by the department of social and health services.

(d) Other pensions and benefits - As prescribed by the entity paying the pension/benefit.

(4) When a resident is authorized to contribute to the support of a dependent under WAC 484-20-065, the dependent shall also be required to comply with any required reporting intervals, using the prescribed form(s).

(5) The veterans benefit specialist and business office staff ((~~at each facility~~)) shall be available to assist residents to complete and submit appropriate reports in a timely manner and to resolve any underpayment or overpayment of benefits.

(6) Failure to comply with all income and resource reporting requirements may result in overpayment or underpayment of the resident contribution. Underpayment of the resident contribution may be grounds to begin discharge proceedings in accordance with WAC 484-20-120. Notice of such administrative action shall be given in accordance with WAC 484-20-103.

AMENDATORY SECTION (Amending WSR 95-03-053, filed 1/12/95, effective 2/12/95)

WAC 484-20-085 ((~~Residents' rights and facility rules.~~)) Resident behavior and facility practices. All residents and facility staff shall be furnished a copy of the facility's policies regarding resident rights and a copy of chapter 484-20 WAC. Residents receive this information at the time of admission and within fifteen days of any change.

AMENDATORY SECTION (Amending WSR 01-23-001, filed 11/7/01, effective 12/8/01)

WAC 484-20-086 Restraints/prevention of abuse—Medicaid certified nursing facility. (((~~(1) Restraints. In accordance with~~)) State veterans homes shall follow federal regulations ((~~at~~)) in 42 C.F.R. § 483.13((~~, the resident has the right to be free from any physical or chemical restraints imposed for purposes of:~~

~~(a) Discipline or convenience, and not required to treat the resident's medical symptoms; or~~

~~(b) Preventing or limiting independent mobility or activity, except that a restraint may be used in a bona fide emergency situation when necessary to prevent a person from inflicting injury upon self or others. The medicaid nursing facility shall obtain within seventy-two hours a physician's order for proper treatment resolving the emergency situation and eliminating the cause for the restraint.~~

~~(2) Abuse. The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.~~

~~(a) The medicaid certified nursing facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property.~~

~~(b) The medicaid certified nursing facility shall:~~

~~(i) Not use verbal, mental, sexual, or physical abuse, corporal punishment or involuntary seclusion; and~~

~~(ii) Not employ persons who have been:~~

~~(A) Found guilty of abusing, neglecting or mistreating residents, by a court of law; or~~

~~(B) Have had a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents, and misappropriation of their property; and~~

~~(iii) Report any knowledge it has of actions by court of law against an employee, which would indicate unfitness for services as a nurse aide or other medicaid certified nursing facility staff to the state nurse aid registry or licensing authorities.~~

~~(c) The medicaid certified nursing facility shall ensure that all alleged violations involving mistreatment, neglect or abuse including injuries of unknown source, and misappropriation of resident property are reported immediately to the superintendent or designated representative of the medicaid certified nursing facility and to other officials in accordance with state law through established procedures (including the state survey and certification agency).~~

~~(d) The medicaid certified nursing facility shall:~~

~~(i) Have evidence that all alleged violations are thoroughly investigated; and~~

~~(ii) Prevent further potential abuse while the investigation is in progress.~~

~~(e) The results of all investigations shall be reported to the superintendent or his/her designated representative and to other officials in accordance with state law (including to the state survey and certification agency) within five working days of the incident, and if the alleged violation is verified, appropriate corrective action must be taken~~)) and 38 C.F.R. § 51.90.

AMENDATORY SECTION (Amending WSR 04-19-026, filed 9/9/04, effective 10/10/04)

WAC 484-20-087 Resident rights. ((~~In compliance with~~)) State veterans homes shall follow federal requirements ((~~at~~)) in 42 C.F.R. § 483.10((~~, residents of a state veterans home have the right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the state veterans home. The state veterans homes shall protect and promote the rights of each resident, including those with limited cognition or other barriers that limit the exercise of rights:~~

~~(1) Exercise of rights.~~

~~(a) The resident has the right to exercise his or her rights as a resident of the state veterans home and as a citizen or resident of the United States.~~

~~(b) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the state veterans home in exercising his or her rights.~~

~~(c) In the case of a resident adjudged incompetent under the laws of the state by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under state law to act on the resident's behalf.~~

~~(d) In the case of a resident who has not been adjudged incompetent by the state court, any legal surrogate designated in accordance with state law may exercise the resident's rights to the extent provided by state law.~~

~~(e) The state veterans home shall not require the resident to sign any contract or agreement that purports to waive any right of the resident.~~

~~(2) Notice of rights and services.~~

~~(a) The state veterans home shall inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the state veterans home. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it shall be acknowledged in writing.~~

~~(b) The resident or his or her surrogate decision maker has the right:~~

~~(i) Upon an oral or written request, to access all records pertaining to the resident including clinical records within twenty-four hours for medicaid certified nursing facility residents and according to chapter 70.129 RCW, for other facility residents; and~~

~~(ii) After receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard, photocopies of the records or any portions of them upon request and two working days advance notice to the state veterans home.~~

~~(c) The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.~~

~~(d) The resident has the right to refuse treatment, and to refuse to participate in experimental research; and~~

~~(e) The state veterans home shall according to federal regulations at 42 C.F.R. § 483.10 (e)(8):~~

~~(i) Inform each resident who is entitled to medicaid benefits, in writing, at the time of admission to the medicaid cer-~~

tified nursing facility or, when the resident becomes eligible for medicaid of:

(A) The items and services that are included in medicaid certified nursing facility services under the state plan and for which the resident may not be charged;

(B) Those other items and services that the state veterans home offers and for which the resident may be charged, and the amount of charges for those services; and

(ii) Inform each resident when changes are made to the items and services specified in (e)(i)(A) and (B) of this subsection.

(f) The state veterans home shall inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the state veterans home and of charges for those services, including any charges for services not covered under medicaid or the medicaid certified nursing facility daily rate.

(g) Disclosure of fees. Prior to admission, the state veterans home shall provide the applicant information on the amount which will be due upon admission.

(h) The state veterans home shall furnish a written description of legal rights which includes:

(i) A description of the manner of protecting personal funds, under subsection (3) of this section;

(ii) In the case of a medicaid certified nursing facility resident, a description of the requirements and procedures for establishing eligibility for medicaid, including the right to request an assessment which determines the extent of a couple's nonexempt resources at the time of admission and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the resident's medical care in his or her process of spending down to medicaid eligibility levels;

(iii) A posting of names, addresses, and telephone numbers of all pertinent state client advocacy groups such as the state survey and certification agency and the state ombudsman program, the protection and advocacy network, and the medicaid fraud control unit; and

(iv) A statement that the resident may file a complaint with the state survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the state veterans home.

(i) The state veterans home shall inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

(j) The medicaid certified nursing facility shall prominently display in the medicaid certified nursing facility written information and provide to residents and applicants for admission oral and written information about how to apply for and use of medicare and medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

(k) Notification of changes.

(i) The state veterans home must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's surrogate decision maker and when appropriate, with the resident's consent, an interested family member when there is:

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(B) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

(D) A decision to transfer or discharge the resident from the state veterans home.

(ii) The state veterans home shall also promptly notify the resident and, if known, the resident's surrogate decision maker and when appropriate, with the resident's consent an interested family member when there is:

(A) A change in room or roommate assignment; or

(B) A change in resident rights under federal or state law or regulations.

(iii) The facility must record and periodically update the address and phone number of the resident's surrogate decision maker and interested family member.

(3) Protection of resident funds.

(a) The resident has the right to manage his or her financial affairs, and the state veterans home may not require residents to deposit their personal funds with the state veterans home.

(b) Management of personal funds. Upon written authorization of a resident, the state veterans home shall hold, safeguard, manage, and account for the personal funds of the resident deposited with the state veterans home.

(c) Accounting and records. The state veterans home must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

(i) The system must preclude any commingling of resident funds with state veterans home funds or with the funds of any person other than another resident.

(ii) The individual financial records must be available through quarterly statements on request to the resident or his or her legal representative.

(d) Notice of certain balances. The state veterans home shall notify each resident that receives medicaid benefits:

(i) When the amount in the resident's account reaches two hundred dollars less than the SSI limit for one person; and

(ii) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI limit for one person, the resident may lose eligibility for medicaid or SSI.

(e) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the state veterans home, the state veterans home must convey within thirty days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.

(f) Assurance of financial security. The state veterans homes are self-insured and assure the security of personal funds of residents deposited with the state veterans home.

(g) Limitation on charges to personal funds. The state veterans home may not impose a charge against the personal funds of a resident for any item or service for which payment is made under medicaid, medicare or the U.S. Department of Veterans Affairs.

(h) The state veterans home shall:

(i) Not charge a resident (or the resident's representative) for any item or service not requested by the resident;

(ii) Not require a resident (or the resident's representative) to request any item or service as a condition of admission or continued stay; and

(iii) Inform the resident (or the resident's representative) requesting an item or services for which a charge will be made that there will be a charge for the item or service and what the charge will be.

(4) Free choice. The resident has the right to:

(a) Choose a personal attending physician;

(b) Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being; and

(c) Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the state, participate in planning care and treatment or changes in care and treatment.

(5) Privacy and confidentiality. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

(a) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the state veterans home to provide a private room for each resident;

(b) Except as provided in (c) of this subsection, the resident may approve or refuse the release of personal and clinical records to any individual outside the state veterans home;

(c) The resident's right to refuse release of personal and clinical records does not apply when:

(i) The resident is transferred to another health care institution; or

(ii) Record release is required by law.

(6) Grievances. A resident has the right to:

(a) Voice grievance without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished; and

(b) Prompt efforts by the state veterans home to resolve grievances the resident may have, including those with respect to the behavior of other residents.

(7) Examination of survey results. A resident has the right to:

(a) Examine the results of the most recent survey or complaint investigation of the medicaid certified nursing facility conducted by federal or state surveyors or inspectors and any plan of correction in effect with respect to the medicaid certified nursing facility. The medicaid certified nursing facility shall:

(i) Publicly post a copy of the most recent survey and complaint investigation until the violation is corrected to the satisfaction of the department of social and health services, up to a maximum of one hundred twenty days;

(ii) Make a copy of the survey results available for examination in a place readily accessible to residents;

(iii) Post a notice that the results of the survey or investigation are available and the location of the surveys when not posted; and

(iv) Post surveys and notices in a place or places in plain view of the residents in the medicaid certified nursing facility, persons visiting those residents, and persons who inquire about placement in the medicaid certified nursing facility; and

(b) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.

(8) Work. The resident has the right to:

(a) Refuse to perform services for the state veterans home;

(b) Perform services for the state veterans home, if he or she chooses, when:

(i) The state veterans home has documented the need or desire for work in the plan of care;

(ii) The plan specifies the nature of the services performed and whether the services are voluntary or paid; and

(iii) The resident agrees to the work arrangement described in the plan of care.

(9) Mail. The resident has the right to privacy in written communications, including the right to:

(a) Send and promptly receive mail that is unopened; and

(b) Have access to stationery, postage, and writing implements at the resident's own expense.

(10) Access and visitation rights.

(a) The resident has the right and the state veterans home shall provide immediate access to any resident by the following:

(i) Any representative from the federal or state agency administering medicaid or U.S. Department of Veterans Affairs health care programs;

(ii) The resident's individual physician;

(iii) Any representative of the state long term care ombudsman (established under section 307 (a)(12) of the Older American's Act of 1965);

(iv) Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and

(v) Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with consent of the resident.

(b) The state veterans home shall provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

(c) The state veterans home shall allow representatives of the state ombudsman, described in (a)(iii) of this subsection, to examine a resident's clinical records with the written permission of the resident or the resident's surrogate decision maker, and consistent with state law.

(11) Telephone. The resident has the right to have twenty-four-hour access to a telephone which:

(a) Provides auditory privacy; and

(b) Is accessible to a person with a disability and accommodates a person with sensory impairment.

(12) Personal property. The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

(a) No medicaid certified nursing facility shall require residents to sign waivers of potential liability for losses of personal property.

(b) The state veterans home shall have a system in place to safeguard personal property within the state veterans home.

(13) Roommates rooms.

(a) A resident shall have the right to share a room with his or her spouse when married residents live in the same state veterans home and both spouses consent to the arrangement.

(b) A resident shall have the right to receive three days notice of change in room or roommate except where the move is at the resident's request, a longer or shorter notice is required to protect the health or safety of the person or other resident, or an admission is necessary.

(c) The medicaid certified nursing facility shall make reasonable efforts to accommodate residents wanting to share the same room.

(14) Self-administration of drugs. An individual resident may self-administer drugs if the interdisciplinary care team has determined that this practice is safe.

(15) Refusal of certain transfers.

(a) An individual has the right to refuse a transfer to another room within the state veterans home, if the purpose of the transfer is to relocate a resident from a distinct part of the state veterans home that is a medicaid certified nursing facility to a part of the state veterans home that is not a medicaid certified nursing facility.

(b) A resident's exercise of the right to refuse transfer under (a) of this subsection does not affect the individual's eligibility or entitlement to medicare or medicaid benefits)) and 38 C.F.R. § 51.70.

AMENDATORY SECTION (Amending WSR 94-22-050, filed 10/31/94, effective 12/1/94)

WAC 484-20-088 Quality of life—Medicaid certified nursing facility. ((In accordance with)) State veterans homes shall follow federal requirements ((at)) in 42 C.F.R. § 483.15((, the medicaid certified nursing facility shall care for its residents in a manner and in an environment that promotes maintenance or enhancement or each resident's quality of life.

(1) Dignity.

(a) The medicaid certified nursing facility shall promote care for residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.

(b) The medicaid certified nursing facility shall provide treatment and care of each resident's personal care needs in a private area free from exposure to persons not involved in providing that care.

(2) Self-determination and participation. The resident has the right to:

(a) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care;

(b) Interact with members of the community both inside and outside the state veterans home; and

(c) Make choices about aspects of his or her life in the state veterans home that are significant to the resident.

(3) Participation in resident and family groups.

(a) A resident has the right to organize and participate in resident groups in the state veterans home;

(b) A resident's family has the right to meet in the state veterans home with the families of other residents in the state veterans home;

(c) The medicaid certified nursing facility shall provide a resident or family group, if one exists, with private space;

(d) Staff or visitors may attend meetings at the group's invitation;

(e) The medicaid certified nursing facility shall provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings; and

(f) When a resident or family group exists, the medicaid certified nursing facility shall listen to the views and act upon the grievance and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the medicaid certified nursing facility.

(4) Participation in other activities. A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the state veterans home.

(5) Accommodation of needs. A resident has the right to reside and receive services in the medicaid certified nursing facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

(6) Activities. The medicaid certified nursing facility shall:

(a) Provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

(b) Provide activities meaningful to the residents seven days a week at various times throughout the day and evening based on individual resident's need and preference;

(c) The activities program must be directed by a qualified professional who:

(i) Is a qualified therapeutic recreation specialist or an activities professional who:

(A) Is licensed or registered, if applicable, by the state; and

(B) Is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or

(ii) Has two years of experience in a social or recreational program within the last five years, one or which was full-time in a patient activities program in a health care setting; or

~~(iii) Has completed a training course approved by the state.~~

~~(7) Social services.~~

~~(a) The state veterans home shall provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.~~

~~(b) A medicaid certified nursing facility with more than one hundred twenty beds shall employ a qualified social worker on a full-time basis.~~

~~(c) A qualified social worker is an individual with:~~

~~(i) A bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and~~

~~(ii) One year of supervised social work experience in a health care setting working directly with individuals.~~

~~(8) Environment. The state veterans home shall:~~

~~(a) Provide a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible;~~

~~(b) Provide housekeeping and maintenance service necessary to maintain a sanitary, orderly, and comfortable interior;~~

~~(c) Maintain comfortable sound levels, to include:~~

~~(i) Minimizing the use of the public address system to ensure each use is in the best interest of the residents; and~~

~~(ii) Taking reasonable precautions with noisy services so as not to disturb residents, particularly during their sleeping time.~~

~~(9) Pets. Each resident shall have a reasonable opportunity to have regular contact with animals.~~

~~(a) The state veterans home shall consider the recommendations of residents, resident councils, and staff, and shall:~~

~~(i) Determine the method or methods of providing residents access to animals;~~

~~(ii) Determine the type and number of animals available in the state veterans home. Such animals may include those customarily considered domestic pets. Wild or exotic animals prohibited as pets under state law are not allowed;~~

~~(iii) Ensure the rights, preferences, and medical needs of the individual resident is not compromised by the presence of the animal; and~~

~~(iv) Ensure any animal visiting or living on the premises has a suitable temperament, is healthy, and otherwise poses no significant health or safety risks to residents, staff or visitors.~~

~~(b) Animals living on the state veterans home premises shall:~~

~~(i) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington state; and~~

~~(ii) Be veterinarian certified to be free of diseases transmittable to humans.~~

~~(c) Pets shall be restricted from areas where food is prepared, treatments are being performed, or when residents object to the presence of pets~~)) and 38 C.F.R. § 51.100.

AMENDATORY SECTION (Amending WSR 01-23-001, filed 11/7/01, effective 12/8/01)

WAC 484-20-090 State veterans home rules. Residents of the state veterans homes are expected to comply with the following facility rules. Facility rules apply to all residents:

(1) Health and safety rules.

(a) Emergency evacuation. Any time a fire or alarm is sounded, domiciliary residents must immediately evacuate the building and report to the designated evacuation area. Residents may not enter the evacuated building until designated staff indicate all is clear. Nursing care unit residents must follow the instructions of the nursing staff.

(b) Community living skills. The condition of residents living quarters must meet existing fire, safety and health-sanitation codes. Residents shall accomplish and/or assist with maintaining their living quarters as defined in their comprehensive care plan. Vacated rooms shall be left in a clean condition.

(c) Electrical appliances. Only low wattage household type electrical appliances such as television sets, electric clocks, electric razors, fans of 150 watts or less with acceptable finger guards, small refrigerators rated at not more than 1.5 amps and approved by the facility ((~~electrician~~)), radios, audio and/or video recorders (VCRs), and disc playing machines may be used in resident's rooms. Use of any other electrical equipment requires the written approval of the superintendent or designated representative.

(d) Repair of rooms. Residents shall not alter or repair their living quarters or other common use areas. This includes but is not limited to walls (e.g., for hanging pictures), other flat surfaces, electrical systems, television/cable hook-ups, phone hook-ups, heating systems, and plumbing. State veterans home staff shall assist residents in personalizing their rooms, including but not limited to hanging personal pictures and checking electrical appliances as authorized in (c) of this subsection. Requests for alterations and/or repairs shall be made to the state veterans home ((~~plant~~)) facilities manager.

(e) ((~~Alcohol - Drugs. Possession or use of intoxicating beverages, narcotics, or controlled substances on the grounds of a state veterans home or during off-grounds activities sponsored by the state veterans home, without a physician's written prescription is prohibited. Drugs which were prescribed by a physician but which are no longer used by the resident to whom they were issued, shall be turned in to the state veterans home pharmacy.~~)) Alcohol, marijuana and illegal drugs are prohibited on the premises of any state veterans home. Neither medical nor recreational marijuana use is allowed at a state veterans home. According to the Washington state department of health, health care providers cannot write prescriptions for medical marijuana. They may provide a recommendation for use of medical marijuana; however, this is not considered a prescription for marijuana. This applies to all residents, family members, staff, visitors and volunteers in the home.

(f) Weapons, firearms and edged weapons. Possession of firearms, ammunition, explosives ((~~or~~)), dangerous or edged weapons is prohibited on the premises of any state veterans home.

(g) Animals. Unauthorized possession or feeding of animals on state veterans home property is prohibited except when specifically sanctioned by the superintendent or designated representative.

(h) ((~~Smoking. Residents may not smoke in bed or in any area in the state veterans home where no smoking signs are posted.~~)) Tobacco products and electronic smoking devices. Use of tobacco products or electronic smoking devices is allowed only in designated outdoor smoking areas.

(2) General facility rules.

(a) Visiting hours. Normal visiting hours for guests are 8:00 a.m. to 10:00 p.m.

(b) Program listening. Radios, TVs, and tape recording-playing devices such as video tape recorders (VCRs) and cassette players may be used in resident's rooms. Volume levels of such equipment must be kept at a level that does not disturb others. Between the hours of 10:00 p.m. and 7:00 a.m., volume on such equipment must be reduced to match reduced noise levels in the general surroundings so that others will not be disturbed. The use of headphones is strongly encouraged for those who wish to use such equipment after 10:00 p.m.

(c) Leave. Pursuant to U.S. Department of Veterans Affairs census reporting requirements, residents leaving the grounds for any purpose must sign out at designated locations. Upon returning, the resident must sign in again. After returning from overnight pass((~~, furlough~~)) or social leave, the resident must remain on the grounds overnight before permission to go on an additional overnight pass((~~, furlough~~)) or social leave can be granted, except in the case of emergency. Leaving the grounds without proper authorization, or failure to return from overnight pass((~~, furlough~~)) or social leave at the prescribed time without obtaining permission for an extension, may result in the resident being discharged in accordance with WAC 484-20-120. Residents being admitted to the facility must remain on the grounds overnight before overnight pass or leave privileges may be exercised unless an exception is granted by the superintendent or designated representative.

(d) Respect for property. No person may deface or destroy walls, buildings, trees, shrubbery, fences, grounds, or any other property or possessions belonging to the state of Washington or to any other person. Appropriation of the property of another person, corporate entity or the state of Washington without permission is also prohibited. Residents are required to reimburse the state veterans home for theft and intentional or negligent injury to state property.

(e) Vehicle registration. Vehicles kept on state veterans home property must be registered at least annually with the state veterans home administration. Residents who drive on the state veterans home property must: Possess a valid Washington state driver's license; provide proof of ownership and/or registration; and, show proof of at least minimal insurance as required by Washington state financial responsibility law. The requirement to register applies to vehicles owned by residents, owned by another and registered in the name of the resident, and/or any vehicle regardless of ownership that is regularly in the possession of the resident. Vehicles must have current license tags ((~~and they must display the state veterans home identification sticker~~)). All traffic and parking control signs must be obeyed.

(f) Personal conduct between residents and others. Residents are expected to refrain from obscene, sexually or racially demeaning, threatening language, or behavior, or physically assaultive behavior. Such behavior, directed at another person, whether on the grounds or off the grounds during a state veterans home-sponsored activity, will be considered a violation of this rule.

AMENDATORY SECTION (Amending WSR 04-19-026, filed 9/9/04, effective 10/10/04)

WAC 484-20-103 Administrative action, notice of. (1) The state veterans home must notify the resident and the resident's representative, and make a reasonable effort to notify, if known, an interested family member of any proposed administrative action, as defined in RCW 34.05.010(3) and this chapter. Exceptions are indicated in subsection (4) of this section.

(2) All notices of proposed administrative actions must be given in writing, in a manner which the resident understands at least thirty days before the proposed administrative action will occur. Except, notice may be given as soon as practical before a transfer or discharge when:

(a) The safety of individuals in the state veterans home would be endangered;

(b) The health of individuals in the state veterans home would be endangered;

(c) An immediate transfer or discharge is required by the resident's urgent medical needs; or

(d) A resident has not resided in the facility for thirty days.

(3) All written notices must include:

(a) The reason for the proposed action;

(b) The effective date of the proposed action;

(c) If the proposed action is a transfer or discharge, the location to which the resident is to be transferred or discharged;

(d) The name, address and telephone number of the state long-term care ombudsman.

(4) For ((~~medicaid certified nursing~~)) facility residents notice of transfer or discharge is governed by ((~~WAC 388-97-042~~)) chapter 388-97 WAC.

(5) For all transfers or discharges, staff must give sufficient preparation and orientation to residents to ensure a safe transfer or discharge from the state veterans home.

AMENDATORY SECTION (Amending WSR 04-19-026, filed 9/9/04, effective 10/10/04)

WAC 484-20-105 Dispute settlement. Residents have two avenues to appeal an administrative action.

Exception: Transfer and/or discharge of a medicaid certified nursing facility resident is governed by WAC ((~~388-97-042~~)) 388-97-0120. Transfer and/or discharge appeals is governed by WAC ((~~388-97-043~~)) 388-97-0140.

(1) **Informal settlement.** Informal settlement of matters that may make more elaborate proceedings unnecessary under this chapter is strongly encouraged. Use of the informal settlement process does not preclude a resident from request-

ing an adjudicative proceeding at any time during the informal settlement process.

(a) An informal settlement to review an administrative action by the department may be requested by forwarding a written request to the superintendent, not later than twenty-one days following receipt of the written notice of an administrative action by the state veterans home.

(b) Within fourteen days of receipt of the request for review, the superintendent or his/her designee shall review the administrative action and shall inform the resident of his/her decision to uphold, modify or reverse the administrative action. Notification of the superintendent's decision will be given in writing and in all cases the superintendent's decision shall be final except in the case of a request to continue the matter through an adjudicative proceeding.

(2) **Adjudicative proceeding.** An adjudicative proceeding is a formal appeal of an administrative action.

(a) An adjudicative proceeding may be requested by forwarding a written request to the superintendent not later than twenty-one days from the date the resident receives the notice of an administrative action or a final decision under the informal settlement provisions of this section.

(b) All such requests shall include a statement of whether the resident is represented and, if so, the name and address of the representative and be signed by the resident or his/her legal representative.

(c) The department shall immediately forward the request to the office of administrative hearings for scheduling of an administrative hearing pursuant to chapters 34.05 and 34.12 RCW and chapter 10-08 WAC.

(d) Any administrative action imposed pursuant to this chapter shall be deferred until the outcome of the administrative hearing except in cases of discharge under WAC 484-20-120 (1)(a), (b), and (c).

(e) Administrative hearings pursuant to this subsection shall be conducted in the state veterans home in which the client resides except that in cases of discharge under WAC 484-20-120 (1)(e), the hearing shall be conducted in a location which is jointly agreed upon by both parties.

(f) Initial orders issued by the administrative law judge shall become final twenty-one days following issuance, unless the complaining party or the state veterans home requests a review of the order. In the case of such a review, the director or his/her designee, serving as the department's reviewing officer, shall conduct a review pursuant to chapter 34.05 RCW and issue a final order in the matter under consideration.

AMENDATORY SECTION (Amending WSR 94-22-050, filed 10/31/94, effective 12/1/94)

WAC 484-20-111 Grievance procedure. (1) Department grievance procedures shall consist of an optional informal discussion process and a formal process.

(a) Any resident, his or her appointed representative, family member or advocate may file a grievance related in any way to the state veterans home, another resident or a state veterans home staff.

(i) Filing. Grievance may be filed either orally or in writing to designated social work staff. Any oral grievance shall be reduced to writing by the staff receiving the grievance.

(ii) Grievances must be filed within fourteen days of the event or discovery of the event being grieved. This deadline may be extended for good cause at the discretion of the designated social work staff.

(iii) Grievance forms are available and located in easily accessed locations throughout the state veterans home. Completed grievance forms must be signed by the resident or individual filing the grievance on behalf of the resident and forwarded to designated social work staff for investigation.

(b) A resident shall not be subject to discipline or retaliation for participating in any manner in the state veterans home's grievance process.

(c) Residents are not prohibited from requesting an adjudicative proceeding or from filing a grievance with any state client advocacy group such as the state survey and certifications agency or the state ombudsman program at any time during the grievance resolution process.

(2) Informal discussion process. Residents are encouraged to attempt to resolve grievances through an informal discussion with individuals who are involved. A grievance investigator shall facilitate such a discussion upon request.

(3) Formal grievance process.

(a) Investigation. Designated social work staff shall investigate all grievances received.

(i) In accordance with federal regulations at 42 C.F.R. § 483.13 and C.F.R. § 51.90, the medicaid certified nursing facility shall:

(A) Ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the superintendent and to other officials in accordance with federal and state law through established procedures (including the federal and state survey and certification ((~~agency~~)) agencies);

(B) Have evidence that all alleged violations are thoroughly investigated; and

(C) Prevent further potential abuse while the investigation is in progress.

(ii) The results of all investigations shall be reported to the superintendent or his/her designated representative and to other officials in accordance with federal and state law (including to the federal and state survey and certification ((~~agency~~)) agencies) within five working days of the incident, and if the alleged violation is verified, appropriate corrective action must be taken.

(b) At any point in the grievance process, a resident may choose to have another individual (including the resident council grievance committee, if one exists) to advocate on his/her behalf and/or accompany him/her to any investigative interviews.

(c) The grievance investigation shall be completed within seven days of receipt of the written grievance by the designated social work staff.

(d) The resident and/or person filing the grievance on behalf of the resident shall be informed in writing of the results of the investigation and the actions that will be taken to correct any identified problems.

(e) The grievance investigation shall be conducted in such a manner as to maintain the confidentiality of the resident. Should the resident request assistance of an outside resident advocate, access to the resident's clinical or personal files shall be granted only with the written authorization from the resident.

(4) Should the resident not be satisfied with the results of the investigation or the recommended actions, he/she may request a review by the superintendent.

(a) Such a request shall be made in writing and submitted within seven days of receipt of the notice of the results of the grievance investigation.

(b) The superintendent shall consider all available information related to the grievance and issue a written decision on the matter within fourteen days of receipt of the review request.

(c) The superintendent's decision is final except when the resident chooses to access the dispute settlement process allowed in WAC 484-20-105.

(5) Upon admission, each resident or his/her appointed representative shall receive oral and written information related to the state veterans home's grievance procedure. Posters informing residents of the state veterans home's grievance procedure and listing names and phone numbers of state veterans home staff and outside resident advocates who are available to assist with grievance resolution shall be placed in locations within each state veterans home where they are easily visible to residents.

AMENDATORY SECTION (Amending WSR 04-19-026, filed 9/9/04, effective 10/10/04)

WAC 484-20-116 Social leave((—Medicaid funded program residents)). (((~~(1) Medicaid certified nursing~~)) Facility residents and staff shall comply with state regulations related to social leave under WAC ((~~388-97-047.~~

~~(2) Medicaid certified nursing facility staff shall assist residents in obtaining CSO approval for social leave~~)) 388-97-0160.

AMENDATORY SECTION (Amending WSR 04-19-026, filed 9/9/04, effective 10/10/04)

WAC 484-20-120 Transfer and discharge of state veterans home residents. (((~~(1)~~))) Transfer and discharge of state veterans home residents shall be in accordance with ((~~RCW 70.129.110. The state veterans home must not transfer or discharge a resident unless:~~

~~(a) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;~~

~~(b) The safety of individuals in the facility is endangered;~~

~~(c) The health of individuals in the facility would otherwise be endangered;~~

~~(d) The resident has failed to make the required payment for his/her stay; or~~

~~(e) The facility ceases to operate.~~

~~(2) In addition, WAC 388-97-042 applies to the transfer and discharge of medicaid certified facility residents.~~

~~(3) Notice of any transfer or discharge given under the authority of this section must be given in accordance with WAC 484-20-103 and is subject to the provisions of WAC 484-20-105~~)) 42 C.F.R. § 483.12 and 38 C.F.R. § 51.80.

AMENDATORY SECTION (Amending WSR 01-23-001, filed 11/7/01, effective 12/8/01)

WAC 484-20-135 Transfer from one state veterans home to another. (1) A resident may apply for transfer to any state veterans home ((~~or the colony located at Orting~~)). Requests for transfer are to be forwarded to the admissions team.

(2) All such requests shall be reviewed by the admissions team, using the admissions criteria.

(3) In addition, the admission team shall contact the superintendent or designated representative of each state veterans home to obtain other information which may be pertinent to the transfer request.

(4) The admission team shall make a recommendation to approve or deny the transfer.

(5) The names of residents who are approved for transfer shall be placed on the waiting list for the program or service which the admission team has determined shall be most appropriate for their health care needs. The position on the waiting list shall be determined by the date on which the transfer was approved.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 484-20-040	Eligibility—Indigency.
WAC 484-20-062	Vocational rehabilitation programs—Eligibility, admission and discharge.
WAC 484-20-089	Washington Soldiers Home Colony—Rights and responsibilities.
WAC 484-20-115	Furlough—Residents other than medicaid certified nursing facility residents.
WAC 484-20-117	Rehabilitation leave.