WSR 17-16-028
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Economic Services Administration)
[Filed July 21, 2017, 1:02 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 17-12-029.

Title of Rule and Other Identifying Information: The department is proposing to amend WAC 388-450-0140 to comply with federal regulations for income allocation of ineligible assistance unit members of basic food households.

Hearing Location(s): Office Building 2, DSHS Headquarters, 1115 Washington, Olympia, WA 98504 (public parking at 11th and Jefferson. A map is available at https://www.dshs.wa.gov/sesa/rules-and-policies-assistance-unit/driving-directions-office-bldg-2), on September 5, 2017, at 10:00 a.m.

Date of Intended Adoption: Not earlier than September 6, 2017.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504, email DSHSRPAU RulesCoordinator@dshs.wa.gov, fax (360) 664-6185, by 5:00 p.m., September 5, 2017.

Assistance for Persons with Disabilities: Contact Jeff Kildahl, DSHS rules consultant, by August 22, 2017, phone (360) 664-6092, TTY (360) 664-6178, or email KildaJA@dshs.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: To comply with federal regulations regarding proration of the income of an ineligible assistance unit member. The proposed changes will reduce staff confusion and benefit errors in compliance with federal guidelines.

Reasons Supporting Proposal: See Purpose above.

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.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: DSHS, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Ezra Paskus, 712 Pear Street S.E., Olympia, WA 98501, (360) 725-4611.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The proposed rule does not have an economic impact on small businesses or nonprofits. It only impacts DSHS clients.

A cost-benefit analysis is not required under RCW 34.05.328. These amendments are exempt as allowed under RCW 34.05.328 (5)(b)(vii) which states in part, "this section does not apply to … rules of the department of social and health services relating only to client medical or financial eligibility and rules concerning liability for care of dependents."

July 21, 2017
Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 10-15-044, filed 7/13/10, effective 8/1/10)

WAC 388-450-0140 How does the income of an ineligible assistance unit member affect my eligibility and benefits for basic food? The department decides who must be in your assistance unit (AU) under WAC 388-408-0035. If an AU member is ineligible for basic food under WAC 388-408-0035, this affects your AU's eligibility and benefits as follows:

(1) We do not count the ineligible member(s) to determine your AU size for the gross monthly income limit, net monthly income limit, or maximum allotment under WAC 388-478-0060.

(2) If an AU member is ineligible because they are disqualified for an intentional program violation (IPV), ((~~they~~)) failed to meet work requirements under chapter 388-444 WAC, or ((~~they are~~)) is an ineligible fleeing felon((~~s~~)) under WAC 388-442-0010:

(a) We count all of the ineligible member's gross income as a part of your AU's income; and

(b) We count all of the ineligible member's allowable expenses as part of your AU's expenses.

(3) If an AU member is an ineligible able-bodied adult without dependents (ABAWD) under WAC 388-444-0030, is ineligible due to their alien status, failed to sign the application to state their citizenship or alien status, or refused to get or provide us a Social Security number:

(a) We ((~~allow the twenty percent earned income disregard for the ineligible member's earned income~~)) prorate the income of the ineligible member among all the AU members by excluding the ineligible member's share and counting the remainder to the eligible members;

(b) We ((~~prorate the remaining income of the ineligible member among all the AU members by excluding the ineligible member's share and counting the remainder to the eligible members; and~~)) allow the twenty percent earned income disregard for the ineligible member's earned income;

(c) We divide the ineligible member's allowable expenses evenly among all members of the AU when the ineligible member has income ((~~except that we do not divide the standard utility allowance (SUA).~~))

(d) We allow the full ((~~SUA based on the total number of members in your~~)) amount of the utility allowance the AU is eligible for under WAC 388-450-0195.

WSR 17-16-066
PROPOSED RULES
DEPARTMENT OF HEALTH
[Filed July 25, 2017, 3:15 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 17-07-068.

Title of Rule and Other Identifying Information: WAC 246-490-200 Electronic death registration, the department of health is creating a new rule to require the electronic reporting of deaths.

Hearing Location(s): Washington State Department of Health, Town Center 1, Room 133, 101 Israel Road S.E., Tumwater, WA 98504, on September 5, 2017, at 10 a.m.

Date of Intended Adoption: September 12, 2017.

Submit Written Comments to: Daniel O'Neill, P.O. Box 47814, Olympia, WA 98501, email https://fortress.wa.gov/doh/policyreview, fax (360) 753-4135, by September 5, 2017.

Assistance for Persons with Disabilities: Contact Daniel O'Neill by August 29, 2017, TTY (800) 833-6388 or 711.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposal will require the electronic reporting of deaths and no will no longer allow submitting death reports using paper forms. The proposed rule will affect funeral directors, and health care providers and others who certify the cause of death, as well as deputy registrars receiving death reports for filing with the department of health (department). Each will be able to complete their portion of a death report electronically through a web application.

The proposal will eliminate the need for funeral directors to travel to those who certify death reports and to deputy registrars in order to complete death reports, resulting in more timely submission of death reports. Electronic reporting will accelerate reporting of death data to the department and support rapid surveillance and response to communicable disease and other health threats.

Reasons Supporting Proposal: Death reports provide relevant data for rapid surveillance and response to health threats, potentially preventing further deaths and limiting outbreaks. Electronically registering deaths provides the department with death data in a more timely manner than registration using paper forms. The proposed rule will make Washington consistent with national standards required for vital records program accreditation from the public health accreditation board.

Statutory Authority for Adoption: RCW 70.58.061.

Statute Being Implemented: RCW 43.70.150.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Department of health, governmental.

Name of Agency Personnel Responsible for Drafting: Daniel O'Neill, 101 Israel Road S.E., Tumwater, WA 98504, (360) 236-4311; Implementation: Leigh Bacharach, 101 Israel Road S.E., Tumwater, WA 98504, (360) 236-4348; and Enforcement: Christie Spice, 101 Israel Road S.E., Tumwater, WA 98504, (360) 236-4307.

A small business economic impact statement has been prepared under chapter 19.85 RCW.

Small Business Economic Impact Statement

WAC 246-490-200, a rule concerning required use of the electronic death registration system.

SECTON [SECTION] 1: **Describe the proposed rule, including: A brief history of the issue; an explanation of why the proposed rule is needed; and a brief description of the probable compliance requirements and the kinds of professional services that a small business is likely to need in order to comply with the proposed rule.**

The department of health (department) is responsible under RCW 43.70.150 to identify and maintain the system for death registration and to prepare the necessary rules associated with accurate and timely death registration.

Death registration is a three step process completed by three separate entities; funeral directors, certifiers, and deputy registrars. Currently, death reports are submitted either electronically via the electronic death registration system (EDRS), or on paper.

Funeral directors (including those having the right to control the disposition of the human remains) are responsible for creating the report of death, including the decedent's demographic information, and facilitating completion of the death report. Certifiers are responsible for reporting the facts concerning the cause and manner of death. Certifiers include allopathic and osteopathic physicians, physician assistants, advanced registered nurse practitioners, chiropractors, local health officers, coroners, medical examiners, or the prosecuting attorney for counties with no coroner or medical examiner. Deputy registrars are responsible for submitting the report of death to the department after they verify the completeness and accuracy of its contents.

To complete a death report on paper, the funeral director must travel to the certifier and the deputy registrar to gather the required information and signature. It can take up to ninety days for the department to receive the report and register the death. This process is laborious and increases public health risk due to delays in the department receiving information on causes of death.

When a death report is submitted via EDRS, the funeral director, certifier, and deputy registrar can complete the report through a web application in as few as twenty-four hours. Death reports submitted via EDRS provide the department timely data for rapid surveillance and response, potentially preventing deaths and limiting outbreaks.

The proposed rule requires use of EDRS to submit all death reports, which will eliminate the need for funeral directors to travel to complete and submit the death report; accelerate reporting of death data; support rapid surveillance and response to communicable disease and other health threats; and make Washington consistent with national standards required for vital records and health statistics program accreditation through the public health accreditation board.

In 2011, the center for health statistics (center) deployed EDRS to replace the paper process of reporting deaths in Washington state. The center recruited certifiers and funeral directors to voluntarily use EDRS. Currently, eighty-six percent of the state's death records are reported electronically. To gain greater use of EDRS and the public health benefits of using an electronic reporting system, the department must adopt the proposed rule.

To comply with required use of EDRS, users would need to have access to computer with internet access. The proposed rule does not require that the EDRS user owns or maintains these tools and services, but does require users to have access to tools and services that may be available elsewhere (such as a public library).

SECTION 2: **Identify which businesses are required to comply with the proposed rule using the North American**

Industry Classification System (NAICS) codes and what the minor cost thresholds are.

Table A:

NAICS Code (4, 5 or 6 digit)	NAICS Business Description	# of businesses in WA	Minor Cost Threshold = 1% of Average Annual Payroll
8122	Death Care Services	275	$2,269
812210	Funeral Homes and Funeral Services	178	$2,269
621111	Offices of Physicians	3,120	$12,002

SECTION 3: **Analyze the probable cost of compliance. Identify the probable costs to comply with the proposed rule, including: Cost of equipment, supplies, labor, professional services and increased administrative costs; and whether compliance with the proposed rule will cause businesses to lose sales or revenue.**

Compliance with the proposed rule will not require affected users to purchase a computer if they do not have one. EDRS does not require an advanced computer system. Desktop and laptop computers are both acceptable. EDRS users can use a public access computer at libraries and still comply with the proposed rule.

If a user chooses to purchase a computer, the one-time cost of a new computer that is compatible with EDRS ranges from $179 to $529 (Appendix A). This cost can be divided over the useful life of a computer. Assuming a three year useful life, the annual cost would be one third of the cost of a computer resulting in an annual cost range of $59.67 to $176.33.

Internet service providers provide broadband internet in Washington ranging from $14.95 per month ($179.40 annually) to $49.95 per month ($599.40 annually) depending on location and business type.[1]

[1] https://www.seattle.gov/tech/comcast-rates, accessed 6/9/17; http://www.cheapinternet.com/states/washington-internet-service, accessed 6/9/17.

For the vast majority of EDRS users, the department assumes that the proposed rule will not impose new costs. For certifiers or funeral directors that choose to purchase a computer and begin to pay for internet service, the total annual cost of compliance ranges from $239.07 to $775.73.

The department assumes that compliance with the proposed rule will not cause businesses to lose sales or revenue.

SECTION 4: **Analyze whether the proposed rule may impose more than minor costs on businesses in the industry.**

The department assumes that the proposed rule will not impose more than minor costs on businesses in the industry. However, the department evaluated any disproportionate impact and considered mitigation measures for the proposed rule as described in the following sections.

SECTION 5: **Determine whether the proposed rule may have a disproportionate impact on small businesses as compared to the ten percent of businesses that are the largest businesses required to comply with the proposed rule.**

The proposed rule sets consistent requirements for all sizes of businesses and physicians that report deaths. The department assumes that very few death certifiers and funeral directors do not currently have the tools (a computer and internet connection) to comply. The department assumes that larger businesses already own an internet-accessible computer. The department further assumes the proposed rule will have a disproportionate impact on small business as compared with the largest ten percent of businesses required to comply with the proposed rule.

SECTION 6: **If the proposed rule has a disproportionate impact on small businesses, identify the steps taken to reduce the costs of the rule on small businesses. If the costs cannot be reduced provide a clear explanation of why.**

Compliance with the proposed rule will not require affected users to purchase a computer if they do not have one. EDRS does not require an advanced computer system. EDRS is a web-based application. Web-based applications are the least burdensome methods of submitting required data. Desktop and laptop computers are both acceptable. EDRS users can use a public access computer at libraries to comply with the proposed rule.

SECTION 7: **Describe how small businesses were involved in the development of the proposed rule.**

Potential small business users of EDRS responded to staff inquiries during EDRS recruitment. Using their feedback, the department spoke with the few individuals and businesses that currently do not comply with the proposed rule.

Of the physicians and funeral directors who responded, one physician and two funeral directors reported not having internet access or a computer.

SECTION 8: **Identify the estimated number of jobs that will be created or lost as the result of compliance with the proposed rule.**

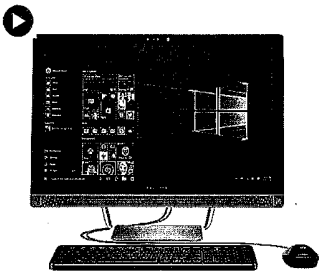
The department assumes that no jobs will be created or lost as a result of compliance with the proposed rule.

The department assumes that no jobs will be created or lost as a result of compliance with the proposed rule.

Appendix A

HP Pavilion 24-b016 All-in-One Desktop PC (Intel i3 Processor, 8GB RAM Memory, 1TB Hard Drive)

Item: 2257012 Model: V8P29AA#ABA (96) | Write a Review



Delivery
~~$649.99~~
$529.99
Each
Offer Details

1 ADD TO CART

Get it within 1 - 6 Business Days with Standard Shipping
This Item Ships Free

1-Hour Pick Up
$529.99

None Available at:
1740 National Ave,
Chehalis, WA 98532
Check Other Stores

Special Buy
Offer Expires on 05/13/2017
See Details

Also Consider

- ☐ 2-Yr PC Protection Plan $300 - $1999 — $99.99
- ☐ 1y Virus Protection and Removals — $99.99

Product Details

- 6th generation Intel® Core™ i3-6100T processor (Dual-Core)
- 23.8" diagonal widescreen FHD IPS WLED-backlit edge-to-edge display (1920 x 1080 Resolution)
- 8 GB DDR4-2133 SDRAM memory (2x4 GB)

View Full Product Details

- Special Financing Available
- Free Pick Up In Store

Add to Favorites

Bundle and Save $20

HP Pavilion 24-b016 All-in-One Desktop PC (Intel i3 Processor, 8GB RAM Memory, 1TB Hard
(96)
$529.99 ~~$649.99~~

Office 365 Personal, 1-year subscription...
(34)
Remove $69.99

Office 365 Personal, 1-year subsci

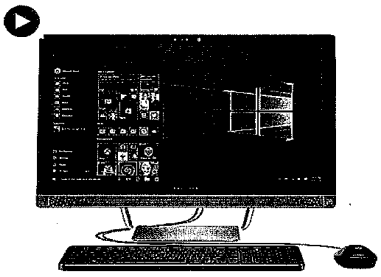
$579.98
Bundle Price
$599.98
If Purchased Separately
Bundle Savings
$20

ADD BUNDLE TO CART

CUSTOMERS WHO VIEWED THIS ITEM ALSO VIEWED

HP Pavilion 24-b016 All-in-One Desktop PC (Intel i3 Processor, 8GB RAM Memory, 1TB Hard Drive)

Item: 2257012 Model: V8P29AA#ABA (96) | Write a Review



Delivery
~~$649.99~~
$529.99
Each
Offer Details

1 ADD TO CART

Get it within 1 - 6 Business Days with Standard Shipping
This Item Ships Free

1-Hour Pick Up
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None Available at:
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View Full Product Details

- Special Financing Available
- Free Pick Up In Store

Add to Favorites

Bundle and Save $20

HP Pavilion 24-b016 All-in-One Desktop PC (Intel i3 Processor, 8GB RAM Memory, 1TB Hard
(95)
$529.99 $649.99

Office 365 Personal, 1-year subscription...
(34)
Remove $69.99
Office 365 Personal, 1-year subscr

$579.98
Bundle Price
$599.98
If Purchased Separately
Bundle Savings
$20

ADD BUNDLE TO CART

CUSTOMERS WHO VIEWED THIS ITEM ALSO VIEWED

5/8/2017 HP Chromebook 11 G5 11.6 Chromebook Intel Celeron N3050 Dual core 2 Core 1.60 GHz 4 GB DDR3L SDRAM 16 GB Flash Memory Chrome OS Engli...

Office DEPOT OfficeMax

HP Chromebook 11 G5 11.6" Chromebook - Intel Celeron N3050 Dual-core (2 Core) 1.60 GHz - 4 GB DDR3L SDRAM - 16 GB Flash Memory - Chrome OS (English) - 1366 x 768 Item # 552806

~~$179.99~~ each
$169.99 Sale (Save $10)

Add a Protection Plan (optional)

○ No Protection ○ 2 Year Protection **+$49.99**

Free delivery
Estimated delivery 3-5 business days

Description

Inspire learning and help elevate productivity to the next level with HP Chromebook 11. Affordable collaboration at school and work has never been so easy with Intel processors, long battery life, and an optional HD IPS Touch panel.

Product Details

Item #	552806
Manufacturer #	4K9841
battery type	lithium polymer (Li-polymer)
brand name	HP
depth	8.1 in.
ENERGY STAR	Yes
Environmental Certification	ENERGY STAR 6.1; WEEE; RoHS 2; IT Eco Declaration; RoHS; EU WEEE; REACH; EPEAT Gold
Flash Memory Capacity	16 GB
front camera/webcam	Yes
Graphics Controller Manufacturer	Intel
Graphics Controller Model	HD Graphics
Graphics Type	Shared
hard drive capacity	16 GB
hard drive type	flash storage
height	0.7 in.
Input Voltage	120 V AC; 230 V AC
Keyboard Localization	English
laptop battery life range	8 hours (or more)
LCD Backlight Technology	WLED backlight
manufacturer	HP Inc.
maximum battery life	12.50 hours

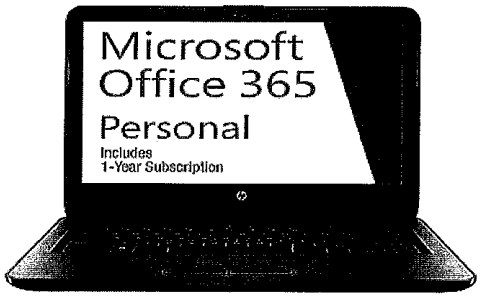
http://www.officedepot.com/a/products/552806/HP-Chromebook-11-G5-116-Chromebook/ 1/4

5/8/2017 HP 14 am052nr Laptop 14 Screen Intel Celeron 4GB Memory 32GB Solid State Drive Windows 10 Home by Office Depot & OfficeMax

Office DEPOT OfficeMax

Office SAVE $20 ON OFFICE when you buy a new PC, Windows or Android tablet Shop Now

HP 14-am052nr Laptop, 14" Screen, Intel® Celeron®, 4GB Memory, 32GB Solid State Drive, Windows® 10 Home Item # 159587



~~$299.99 each~~
$209.99 Sale (Save $90)

Limit: 5

Add a Protection Plan (optional)

○ No Protection ○ 2 Year Protection +$59.99

Free next business day delivery
Order in the next 1 hour 33 minutes and get it **Tuesday, May 9**
Free In Store Pickup
Sold in stores

Description

With crisp HD graphics, this laptop brings your photos, videos and games to life

- Includes Microsoft Office 365 Personal.
- 14" HD SVA BrightView display with LED backlighting produces vivid images.
- Powered by an Intel Celeron N3060 processor. Run multiple programs simultaneously.
- 4GB of memory available.
- 32GB eMMC drive holds photos, videos, games and more. Keeps your running programs active, while your computer resumes from suspension in just a few seconds.
- 1x1 802.11b/g/n WLAN wireless connectivity enables cable-free networking.
- 1 SuperSpeed USB 3.0 port and 2 USB 2.0 ports for fast data transfers.
- Front-facing TrueVision HD webcam offers an integrated digital microphone to help you keep in touch with friends and family.
- DTS Studio Sound with dual speakers provides high-quality audio.
- HDMI port lets you connect the laptop to your HDTV.
- Full-size, island-style keyboard makes typing up reports and papers comfortable.
- Kensington MicroSaver® lock slot and power-on password for security.
- Includes a free 30-day trial of McAfee® LifeSafe™.
- Includes 1 year of free cloud storage, which offers 25GB of DropBox storage.
- Battery lasts up to 7 hours to help you work away from home. Battery life will vary depending on the product configuration, product model, applications loaded on the product, power management setting of the product, and the product features used by the customer. As with all batteries, the maximum capacity of this battery will decrease with time and usage.
- Runs on the Windows® 10 Home operating system.
- Intel, the Intel Logo, Intel Inside, the Intel Inside logo, Intel Core, Intel Atom, Celeron, Pentium and Pentium Inside are trademarks of Intel Corporation in the U.S. and/or other countries.
- Eco-conscious choice — has one or more meaningful eco attributes or eco-labels.
- ENERGY STAR certified — meets federal guidelines for energy efficiency.
- EPEAT Silver certified — has multiple eco-attributes. Ranked in three tiers: Bronze, Silver or Gold.

Product Details

http://www.officedepot.com/a/products/159587/HP-14-am052nr-Laptop-14-Screen/ 1/11

A copy of the statement may be obtained by contacting Daniel O'Neill, P.O. Box 47814, Tumwater, WA 98501, phone (360) 236-4311, fax (360) 753-4135, email daniel.oneill@doh.wa.gov.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Daniel O'Neill, P.O. Box 47814, Tumwater, WA 98504, phone (360) 236-4311, fax (360) 753-4135, email daniel.oneill@doh.wa.gov.

Jessica Todorovich
Chief of Staff
for John Wiesman, DrPH, MPH
Secretary

NEW SECTION

WAC 246-490-200 Electronic reporting of deaths. All deaths that occur in Washington state, excluding fetal deaths, must be reported electronically using the format and system prescribed by the state registrar.

WSR 17-16-077
PROPOSED RULES
OLYMPIC REGION CLEAN AIR AGENCY
[Filed July 26, 2017, 2:13 p.m.]

Original Notice.

Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1).

Title of Rule and Other Identifying Information: Olympic Region Clean Air Agency (ORCAA) Regulations: Rule 1.11 Federal Regulation Reference Date.

Hearing Location(s): ORCAA, 2940 Limited Lane N.W., Olympia, WA 98502, on September 13, 2017, at 10:00 a.m.

Date of Intended Adoption: September 13, 2017.

Submit Written Comments to: Mark Goodin, 2940 Limited Lane N.W., Olympia, WA 98502, email mark.goodin@orcaa.org, fax (360) 491-6308, by September 11, 2017.

Assistance for Persons with Disabilities: Contact Dan Nelson, by September 1, 2017, (360) 539-7610.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: ORCAA is proposing to update the effective date of the federal regulations that have been adopted by the agency. Currently, where federal rules are referenced in agency regulations, the effective date of the federal regulations is July 1, 2016. The agency intends to update the date annually. This proposal would change the reference date to July 1, 2017.

Statutory Authority for Adoption: Chapter 70.94 RCW.

Statute Being Implemented: Chapter 70.94 RCW.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: ORCAA, governmental.

Name of Agency Personnel Responsible for Drafting: Mark Goodin, 2940 Limited Lane N.W., Olympia, (360) 539-7610; Implementation and Enforcement: Francea L. McNair, 2940 Limited Lane N.W., Olympia, (360) 539-7610.

No small business economic impact statement has been prepared under chapter 19.85 RCW. This agency is not subject to the small business economic impact provision of the Administrative Procedure Act, and the agency is not a school district.

A cost-benefit analysis is not required under RCW 34.05.328. RCW 34.05.328 does not apply to local air agencies, per RCW 70.94.141.

July 26, 2017
Francea L. McNair
Executive Director

AMENDATORY SECTION

Rule 1.11 FEDERAL REGULATION REFERENCE DATE

Whenever federal regulations are referenced in ORCAA's rules, the effective date shall be July 1, ((~~2016~~)) 2017.

WSR 17-16-098
PROPOSED RULES
DEPARTMENT OF HEALTH
(Dental Quality Assurance Commission)
[Filed July 27, 2017, 4:03 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 16-21-040.

Title of Rule and Other Identifying Information: WAC 246-817-120 Examination content, the dental quality assurance commission (commission) is proposing amendments to clarify that an applicant must pass a complete clinical examination with the same testing agency, and to accept the Canada clinical examination.

Hearing Location(s): Department of Health, Point Plaza East, Room 152/153, 310 Israel Road S.E., Tumwater, WA 98501, on September 8, 2017, at 8:05 a.m.

Date of Intended Adoption: September 8, 2017.

Submit Written Comments to: Jennifer Santiago, P.O. Box 47852, Olympia, WA 98504, email https://fortress.wa.gov/doh/policyreview, fax (360) 236-2901, by September 1, 2017.

Assistance for Persons with Disabilities: Contact Jennifer Santiago by September 1, 2017, TTY (800) 833-6388 or 711.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposed rule amendments clarify that a complete clinical examination must be passed through one testing agency, and changes "consider acceptance of" to "accept" for the Canada clinical examination.

Reasons Supporting Proposal: Each testing agency creates their examination as a whole examination, identifying each content section. The successful completion of a whole examination demonstrates the minimum competency necessary for licensure. Completing portions of examinations from multiple examination organizations may not provide a true assessment of minimum dentist competency. Licensure barriers are reduced by accepting the Canada clinical examination.

Statutory Authority for Adoption: RCW 18.32.002 and 18.32.0365.

Statute Being Implemented: RCW 18.32.040.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Dental quality assurance commission, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Jennifer Santiago, 111 Israel Road S.E., Tumwater, WA 98501, (360) 236-4893.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The proposed rule would not impose more than minor costs on businesses in an industry.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Jennifer Santiago, P.O. Box 47852, Olympia, WA 98504, phone (360) 236-4893, fax (360) 236-2901, email jennifer.santiago@doh.wa.gov.

July 27, 2017
John Carbery, D.M.D., Chairperson
Dental Quality Assurance Commission

AMENDATORY SECTION (Amending WSR 16-14-067, filed 6/30/16, effective 7/31/16)

WAC 246-817-120 Examination content. (1) An applicant seeking dentist licensure in Washington by examination, must successfully ((~~complete~~)) pass a written and practical examination approved by the Dental Quality Assurance Commission (commission).

The examination will consist of:

(a) A written examination. ((~~Only~~)) The National Board Dental Examination Parts I and II, or the Canadian National Dental Examining Board examination will be accepted, except as provided in subsection (4) of this section.

(b) A ((~~practical/practice~~)) practical examination containing at least the following sections:

(i) Restorative;

(ii) Endodontic;

(iii) Periodontal;

(iv) Prosthodontic; and

(v) Comprehensive treatment planning or diagnostic skills.

(2)(a) The commission accepts the following ((~~practical/practice~~)) practical examinations provided the testing agency offers at least the sections listed in subsection (1)(b) of this section ((~~and the candidate tests in those same sections~~)):

(i) The Western Regional Examining Board's (WREB) clinical examination;

(ii) The Central Regional Dental Testing Services (CRDTS) clinical examination;

(iii) The Commission on Dental Competency Assessments (CDCA) formally known as Northeast Regional Board (NERB) clinical examination;

(iv) The Southern Regional Testing Agency (SRTA) clinical examination;

(v) The Council of Interstate Testing Agency's (CITA) clinical examination;

(vi) ((~~Examination results of a~~)) U.S. state or territory with an individual state board clinical examination; or

(b) The commission will ((~~consider acceptance of~~)) accept the complete National Dental Examining Board (NDEB) of Canada clinical examination as meeting its standards if the applicant is a graduate of an approved dental school defined in WAC 246-817-110 (2)(a).

(3) The applicant must pass all sections listed in subsection (1)(b) of this section of the practical examination with the same testing agency.

(4) The commission will only accept results of approved ((~~practical/practice~~)) practical examinations taken within the preceding five years from the date of an application for licensure.

(((~~4~~))) (5) The commission may, at its discretion, give or require an examination in any other subject under subsection (1)(a) and (b) of this section, whether in written or practical form or both written and practical.

WSR 17-16-101
PROPOSED RULES
BUILDING CODE COUNCIL

[Filed July 27, 2017, 3:26 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 17-08-013.

Title of Rule and Other Identifying Information: The proposed rule is WAC 51-50-0907, amendment of the 2015 International Building Code; and WAC 51-54A-0907, amendment of the 2015 International Fire Code. The amended sections are identical and titled Fire alarm and detection systems. The proposed rule regulates fire alarms in schools, and delays the implementation of National Institute for Certification in Engineering Technologies (NICET) certification.

Hearing Location(s): Center Place Regional Event Center, 2426 North Discovery Place, Spokane Valley, WA 99216, on September 15, 2017, at 10 a.m.; and the DES Building, 1st Floor Presentation Room, 1500 Jefferson Street, Olympia, WA 98501, on October 13, 2017, at 10 a.m.

Date of Intended Adoption: November 17, 2017.

Submit Written Comments to: Steve Simpson, Chair, State Building Code Council, P.O. Box 41449, Olympia, WA 98504-1449, email sbcc@des.wa.gov, fax (360) 586-9088, by October 13, 2017.

Assistance for Persons with Disabilities: Contact Tim Nogler by September 8, 2017, (360) 407-9277.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposed rule provides an alternate method to meet the building and fire code requirements for fire alarms in schools. Section 907.2.3. The school district would have the option of installing an emergency voice alarm system prescribed by the fire and building codes, or a system developed as part of a safe school plan consistent with the provisions of RCW 28A.320.125 or 28A.320.126, and in accordance with the performance standards specified in the propose [proposed] rule. The proposed rule also delays the implementation of NICET certification for individuals conducting design review and inspection of fire alarm systems. The deadline for certification is changed from July 1, 2017, to July 1, 2018. Section 907.10.

Reasons Supporting Proposal: The purpose is to avoid unnecessary duplication of infrastructure installation and reduce school construction costs. The delay in NICET certification is to allow more time for individuals to qualify for certification.

Statutory Authority for Adoption: RCW 19.27.031 and 19.27.074.

Statute Being Implemented: Chapters 19.27 and 34.05 RCW.

Rule is not necessitated by federal law, federal or state court decision.

Agency Comments or Recommendations, if any, as to Statutory Language, Implementation, Enforcement, and Fiscal Matters: The council is seeking comments on the issues proposed in the rules shown below.

Name of Proponent: Washington state building code council, governmental.

Name of Agency Personnel Responsible for Drafting and Implementation: Tim Nogler, 1500 Jefferson Street, P.O. Box 41449, Olympia, WA, (360) 407-9277; and Enforcement: Washington State Building Code Council, 1500 Jefferson Street, P.O. Box 41449, Olympia, WA, (360) 407-9277.

No small business economic impact statement has been prepared under chapter 19.85 RCW. This rule provides alternate methods of compliance for schools to meet the alarm requirements. The requirement for NICET certification for fire alarm installers is delayed to allow installation businesses more time to comply. The rule provides added flexibility and potential cost savings and does not have any fiscal impact to small business.

The state building code council is not one of the agencies identified as required to prepare a school district impact statement.

A cost-benefit analysis is not required under RCW 34.05.328. The state building code council is not one of the agencies identified as required to prepare an analysis.

May 12, 2017
Steve K. Simpson
Council Chair

AMENDATORY SECTION (Amending WSR 16-03-064, filed 1/19/16, effective 7/1/16)

WAC 51-50-0907 Section 907—Fire alarm and detection systems.

[F] 907.2.3 Group E. ((~~A manual fire alarm system that initiates the occupant notification signal utilizing an emergency voice/alarm communication system meeting the requirements of Section 907.5.2.2 and installed in accordance with Section 907.6 shall be installed in Group E occupancies. When automatic sprinkler systems or smoke detectors are installed, such systems or detectors shall be connected to the building fire alarm system.~~

((~~EXCEPTIONS:~~ ~~1. A manual fire alarm system is not required in Group E occupancies with an occupant load of 50 or less.~~

~~2. Emergency voice/alarm communication systems meeting the requirements of Section 907.5.2.2 and installed in accordance with Section 907.6 shall not be required in Group E occupancies with occupant loads of 100 or less, provided that activation of the manual fire alarm system initiates an approved occupant notification signal in accordance with Section 907.5.~~

~~3. Manual fire alarm boxes are not required in Group E occupancies where all of the following apply:~~

~~3.1 Interior corridors are protected by smoke detectors.~~

~~3.2 Auditoriums, cafeterias, gymnasiums and similar areas are protected by heat detectors or other approved detection devices.~~

~~3.3 Shops and laboratories involving dusts or vapors are protected by heat detectors or other approved detection devices.~~

~~4. Manual fire alarm boxes shall not be required in Group E occupancies where the building is equipped throughout with an approved automatic sprinkler system installed in accordance with Section 903.3.1.1, the emergency voice/alarm communication system will activate on sprinkler water flow and manual activation.~~))

Group E occupancies shall be provided with a manual fire alarm system that initiates the occupant notification signal utilizing one of the following:

1. An emergency voice/alarm communication system meeting the requirements of Section 907.5.2.2 and installed in accordance with Section 907.6; or

2. A system developed as part of a safe school plan adopted in accordance with RCW 28A.320.125 or developed as part of an emergency response system consistent with the provisions of RCW 28A.320.126. The system must achieve all of the following performance standards:

2.1 The ability to broadcast voice messages or customized announcements;

2.2 Includes a feature for multiple sounds, including sounds to initiate a lock down;

2.3 The ability to deliver messages to the interior of a building, areas outside of a building as designated pursuant to the safe school plan, and to personnel;

2.4 The ability for two-way communications;

2.5 The ability for individual room calling;

2.6 The ability for a manual override;

2.7 Installation in accordance with NFPA 72;

2.8 Provide 15 minutes of battery backup for alarm and 24 hours of battery backup for standby; and

2.9 Includes a program for annual inspection and maintenance in accordance with NFPA 72.

EXCEPTIONS:

A manual fire alarm system is not required in Group E occupancies with an occupant load of 50 or less.

2. Emergency voice/alarm communication systems meeting the requirements of Section 907.5.2.2 and installed in accordance with Section 907.6 shall not be required in Group E occupancies with occupant loads of 100 or less, such as individual portable school classroom buildings; provided that activation of the manual fire alarm system initiates an approved occupant notification signal in accordance with Section 907.5.

3. Where an existing approved alarm system is in place, an emergency voice/alarm system is not required in any portion of an existing Group E building undergoing any one of the following repairs, alteration or addition:

3.1 Alteration or repair to an existing building including, without limitation, alterations to rooms and systems, and/or corridor configurations, not exceeding 35 percent of the fire area of the building (or the fire area undergoing the alteration or repair if the building is comprised of two or more fire areas); or

3.2 An addition to an existing building, not exceeding 35 percent of the fire area of the building (or the fire area to which the addition is made if the building is comprised of two or more fire areas).

4. Manual fire alarm boxes are not required in Group E occupancies where all of the following apply:

4.1 Interior *corridors* are protected by smoke detectors.

4.2 Auditoriums, cafeterias, gymnasiums and similar areas are protected by *heat detectors* or other *approved* detection devices.

4.3 Shops and laboratories involving dusts or vapors are protected by *heat detectors* or other *approved* detection devices.

5. Manual fire alarm boxes shall not be required in Group E occupancies where all of the following apply:

5.1 The building is equipped throughout with an *approved automatic sprinkler system* installed in accordance with Section 903.3.1.1.

5.2 The emergency voice/alarm communication system will activate on sprinkler waterflow.

5.3 Manual activation is provided from a normally occupied location.

[F] 907.2.3.1 Sprinkler systems or detection. When automatic sprinkler systems or smoke detectors are installed, such systems or detectors shall be connected to the building fire alarm system.

[F] 907.2.6 Group I. A manual fire alarm system that activates the occupant notification system shall be installed in Group I occupancies. An automatic smoke detection system that notifies the occupant notification system shall be provided in accordance with Sections 907.2.6.1, 907.2.6.2, 907.2.6.3.3 and 907.2.6.4.

EXCEPTIONS: 1. Manual fire alarm boxes in resident or patient sleeping areas of Group I-1 and I-2 occupancies shall not be required at exits if located at nurses' control stations or other constantly attended staff locations, provided such stations are visible and continually accessible and that travel distances required in Section 907.4.2 are not exceeded.

2. Occupant notification systems are not required to be activated where private mode signaling installed in accordance with NFPA 72 is approved by the fire code official.

[F] 907.2.6.1 Group I-1. An automatic smoke detection system shall be installed in *corridors*, waiting areas open to *corridors* and *habitable spaces* other than *sleeping units* and kitchens. The system shall be activated in accordance with Section 907.4.

EXCEPTIONS: 1. For Group I-1 Condition 1 occupancies, smoke detection in *habitable spaces* is not required where the facility is equipped throughout with an *automatic sprinkler system* installed in accordance with Section 903.3.1.1.

2. Smoke detection is not required for exterior balconies.

[F] 907.2.6.4 Group I-4 occupancies. A manual fire alarm system that initiates the occupant notification signal utilizing an emergency voice/alarm communication system meeting the requirements of Section 907.5.2.2 and installed in accordance with Section 907.6 shall be installed in Group I-4 occupancies. When automatic sprinkler systems or smoke detectors are installed, such systems or detectors shall be connected to the building fire alarm system.

EXCEPTIONS: 1. A manual fire alarm system is not required in Group I-4 occupancies with an occupant load of 50 or less.

2. Emergency voice alarm communication systems meeting the requirements of Section 907.5.2.2 and installed in accordance with Section 907.6 shall not be required in Group I-4 occupancies with occupant loads of 100 or less, provided that activation of the manual fire alarm system initiates an approved occupant notification signal in accordance with Section 907.5.

[F] 907.5.2.1.2 Maximum sound pressure. The maximum sound pressure level for audible alarm notification appliances shall be 110 dBA at the minimum hearing distance from the audible appliance. For systems operating in public mode, the maximum sound pressure level shall not exceed 30 dBA over the average ambient sound level. Where the average ambient noise is greater than 95 dBA, visible alarm notification appliances shall be provided in accordance with NFPA 72 and audible alarm notification appliances shall not be required.

[F] 907.10 NICET: National Institute for Certification in Engineering Technologies.

907.10.1 Scope. This section shall apply to new and existing fire alarm systems.

907.10.2 Design review. All construction documents shall be reviewed by a NICET III in fire alarms or a licensed professional engineer (PE) in Washington prior to being submitted for permitting. The reviewing professional shall submit a stamped, signed, and dated letter; or a verification method approved by the local authority having jurisdiction indicating the system has been reviewed and meets or exceeds the design requirements of the state of Washington and the local jurisdiction. (Effective July 1, ((~~2017~~)) 2018.)

907.10.3 Testing/maintenance. All inspection, testing, maintenance and programing not defined as "electrical construction trade" by chapter 19.28 RCW shall be completed by a NICET II in fire alarms. (Effective July 1, ((~~2017~~)) 2018.)

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency and appear in the Register pursuant to the requirements of RCW 34.08.040.

AMENDATORY SECTION (Amending WSR 17-10-028, filed 4/25/17, effective 5/26/17)

WAC 51-54A-0907 Fire alarm and detection systems.

907.2.3 Group E. ((~~A manual fire alarm system that initiates the occupant notification signal utilizing an emergency voice/alarm communication system meeting the requirements of Section 907.5.2.2 and installed in accordance with Section 907.6 shall be installed in Group E occupancies. When automatic sprinkler systems or smoke detectors are installed, such systems or detectors shall be connected to the building fire alarm system.~~

EXCEPTIONS: ~~1. A manual fire alarm system is not required in Group E occupancies with an occupant load of 50 or less.~~

~~2. Emergency voice/alarm communication systems meeting the requirements of Section 907.5.2.2 and installed in accordance with Section 907.6 shall not be required in Group E occupancies with occupant loads of 100 or less, provided that activation of the manual fire alarm system initiates an approved occupant notification signal in accordance with Section 907.5.~~

~~3. Manual fire alarm boxes are not required in Group E occupancies where all of the following apply:~~

~~3.1 Interior corridors are protected by smoke detectors.~~

~~3.2 Auditoriums, cafeterias, gymnasiums and similar areas are protected by heat detectors or other approved detection devices.~~

~~3.3 Shops and laboratories involving dusts or vapors are protected by heat detectors or other approved detection devices.~~

~~4. Manual fire alarm boxes shall not be required in Group E occupancies where the building is equipped throughout with an approved automatic sprinkler system installed in accordance with Section 903.3.1.1, the emergency voice/alarm communication system will activate on sprinkler water flow and manual activation.~~))

Group E occupancies shall be provided with a manual fire alarm system that initiates the occupant notification signal utilizing one of the following:

1. An emergency voice/alarm communication system meeting the requirements of Section 907.5.2.2 and installed in accordance with Section 907.6; or

2. A system developed as part of a safe school plan adopted in accordance with RCW 28A.320.125 or developed as part of an emergency response system consistent with the provisions of RCW 28A.320.126. The system must achieve all of the following performance standards:

2.1 The ability to broadcast voice messages or customized announcements;

2.2 Includes a feature for multiple sounds, including sounds to initiate a lock down;

2.3 The ability to deliver messages to the interior of a building, areas outside of a building as designated pursuant to the safe school plan, and to personnel;

2.4 The ability for two-way communications;

2.5 The ability for individual room calling;

2.6 The ability for a manual override;

2.7 Installation in accordance with NFPA 72;

2.8 Provide 15 minutes of battery backup for alarm and 24 hours of battery backup for standby; and

2.9 Includes a program for annual inspection and maintenance in accordance with NFPA 72.

Exceptions:

1. A manual fire alarm system is not required in Group E occupancies with an occupant load of 50 or less.

2. Emergency voice/alarm communication systems meeting the requirements of Section 907.5.2.2 and installed in accordance with Section 907.6 shall not be required in Group E occupancies with occupant loads of 100 or less, such as individual portable school classroom buildings; provided that activation of the manual fire alarm system initiates an approved occupant notification signal in accordance with Section 907.5.

3. Where an existing approved alarm system is in place, an emergency voice/alarm system is not required in any portion of an existing Group E building undergoing any one of the following repairs, alteration or addition:

3.1 Alteration or repair to an existing building including, without limitation, alterations to rooms and systems, and/or corridor configurations, not exceeding 35 percent of the fire area of the building (or the fire area undergoing the alteration or repair if the building is comprised of two or more fire areas); or

3.2 An addition to an existing building, not exceeding 35 percent of the fire area of the building (or the fire area to which the addition is made if the building is comprised of two or more fire areas).

4. Manual fire alarm boxes are not required in Group E occupancies where all of the following apply:

4.1 Interior *corridors* are protected by smoke detectors.

4.2 Auditoriums, cafeterias, gymnasiums and similar areas are protected by *heat detectors* or other *approved* detection devices.

4.3 Shops and laboratories involving dusts or vapors are protected by *heat detectors* or other *approved* detection devices.

5. Manual fire alarm boxes shall not be required in Group E occupancies where all of the following apply:

5.1 The building is equipped throughout with an *approved automatic sprinkler system* installed in accordance with Section 903.3.1.1.

5.2 The emergency voice/alarm communication system will activate on sprinkler waterflow.

5.3 Manual activation is provided from a normally occupied location.

907.2.3.1 Sprinkler systems or detection. When automatic sprinkler systems or smoke detectors are installed, such systems or detectors shall be connected to the building fire alarm system.

907.2.6 Group I. A manual fire alarm system that activates the occupant notification system shall be installed in Group I occupancies. An automatic smoke detection system that notifies the occupant notification system shall be provided in accordance with Sections 907.2.6.1, 907.2.6.2, 907.2.6.3.3 and 907.2.6.4.

EXCEPTIONS:

1. Manual fire alarm boxes in resident or patient sleeping areas of Group I-1 and I-2 occupancies shall not be required at exits if located at nurses' control stations or other constantly attended staff locations, provided such stations are visible and continually accessible and that travel distances required in Section 907.4.2 are not exceeded.

2. Occupant notification systems are not required to be activated where private mode signaling installed in accordance with NFPA 72 is approved by the fire code official.

907.2.6.1 Group I-1. An automatic smoke detection system shall be installed in *corridors*, waiting areas open to *corridors* and *habitable spaces* other than *sleeping units* and kitchens. The system shall be activated in accordance with Section 907.4.

EXCEPTIONS:

1. For Group I-1 Condition 1 occupancies, smoke detection in *habitable spaces* is not required where the facility is equipped throughout with an *automatic sprinkler system* installed in accordance with Section 903.3.1.1.

2. Smoke detection is not required for exterior balconies.

907.2.6.4 Group I-4 occupancies. A manual fire alarm system that initiates the occupant notification signal utilizing an emergency voice/alarm communication system meeting the requirements of Section 907.5.2.2 and installed in accordance with Section 907.6 shall be installed in Group I-4 occupancies. When automatic sprinkler systems or smoke detectors are installed, such systems or detectors shall be connected to the building fire alarm system.

EXCEPTIONS:

1. A manual fire alarm system is not required in Group I-4 occupancies with an occupant load of 50 or less.

2. Emergency voice alarm communication systems meeting the requirements of Section 907.5.2.2 and installed in accordance with Section 907.6 shall not be required in Group I-4 occupancies with occupant loads of 100 or less, provided that activation of the manual fire alarm system initiates an approved occupant notification signal in accordance with Section 907.5.

907.5.2.1.2 Maximum sound pressure. The maximum sound pressure level for audible alarm notification appliances shall be 110 dBA at the minimum hearing distance from the audible appliance. For systems operating in public mode, the maximum sound pressure level shall not exceed 30 dBA over the average ambient sound level. Where the average ambient noise is greater than 95 dBA, visible alarm notification appliances shall be provided in accordance with NFPA 72 and audible alarm notification appliances shall not be required.

907.10 NICET: National Institute for Certification in Engineering Technologies.

907.10.1 Scope. This section shall apply to new and existing fire alarm systems.

907.10.2 Design review: All construction documents shall be reviewed by a NICET III in fire alarms or a licensed professional engineer (PE) in Washington prior to being submitted for permitting. The reviewing professional shall submit a stamped, signed, and dated letter; or a verification method approved by the local authority having jurisdiction indicating the system has been reviewed and meets or exceeds the design requirements of the state of Washington and the local jurisdiction (effective July 1, ((~~2017~~)) 2018).

907.10.3 Testing/maintenance: All inspection, testing, maintenance and programing not defined as "*electrical construction trade*" by chapter 19.28 RCW shall be completed by a NICET II in fire alarms (effective July 1, ((~~2017~~)) 2018).

WSR 17-16-103
PROPOSED RULES
DEPARTMENT OF COMMERCE

[Filed July 28, 2017, 9:51 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 17-12-094.

Title of Rule and Other Identifying Information: WAC 194-37-135, Energy Independence Act, documentation of incremental biomass energy.

Hearing Location(s): Washington State Department of Commerce, 1011 Plum Street S.E., Olympia, WA 98504, on September 6, 2017, at 10:00 a.m.

Date of Intended Adoption: September 13, 2017.

Submit Written Comments to: Glenn Blackmon, Energy Office, P.O. Box 42525, Olympia, WA 98504-2525, email EIA@commerce.wa.gov, by September 6, 2017.

Assistance for Persons with Disabilities: Contact Carolee Sharp by August 30, 2017, TTY (360) 586-0772 or (360) 725-3118.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposed amendment establishes documentation requirements and the baseline generation methodology for incremental generation from qualified biomass energy facilities, consistent with the requirements of chapter 315, Laws of 2017 (ESB 5128).

Reasons Supporting Proposal: The 2017 legislation expands the eligibility under the Energy Independence Act (chapter 19.285 RCW) of electricity generated by pre-1999 biomass generating facilities. Incremental generation, above a historical baseline, is eligible if it results from capital investment completed in 2010 or after. The rule is required in order to establish documentation requirements and to provide a methodology for determining the baseline level of generation.

Statutory Authority for Adoption: RCW 19.285.080(2); chapter 315, Laws of 2017.

Statute Being Implemented: Chapter 19.285 RCW.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Washington state department of commerce, governmental.

Name of Agency Personnel Responsible for Drafting: Glenn Blackmon, Department of Commerce, 1011 Plum Street S.E., Olympia, WA 98504-2525, (360) 725-3115; Implementation and Enforcement: Washington State Department of Commerce, 1011 Plum Street S.E., Olympia, WA 98504-2525, (360) 407-6000.

No small business economic impact statement has been prepared under chapter 19.85 RCW. A small business economic impact statement is not required for this rule making as none of the affected entities are small businesses. Not applicable.

A cost-benefit analysis is not required under RCW 34.05.328. Subsection (5)(a)(i) of RCW 34.05.328 does not require commerce to provide a cost-benefit analysis. Not applicable.

July 28, 2017
Jaime Rossman
Rules Coordinator

AMENDATORY SECTION (Amending WSR 14-04-015, filed 1/24/14, effective 2/24/14)

WAC 194-37-135 Documentation of multifuel biomass energy ((~~and~~)), qualified biomass energy, and incremental biomass energy. (1) **Multifuel biomass energy.** A utility using biomass energy produced by a multifuel generating facility, where the biomass energy fuel provides less than ninety-eight percent of the total heat input, must document the eligible renewable energy using RECs created by WREGIS pursuant to the multifuel generating unit procedures of WREGIS.

(2) **Qualified biomass energy.** A utility using qualified biomass energy must document the eligible renewable energy using RECs created by WREGIS and must document:

(a) Information about the facility generating electricity from biomass energy:

(i) Ownership of the biomass energy facility;

(ii) Date of commercial operation of the biomass energy facility; and

(iii) Specific type of biomass used for generation by the biomass energy facility.

(b) Information about the industrial facility that hosts the biomass energy facility:

(i) The utility's load in megawatt hours that results from serving the industrial facility;

(ii) Evidence that the industrial facility had not ceased operation, other than for purposes of maintenance or upgrade, during the target year;

(iii) Evidence that the industrial facility engages in industrial pulping or wood manufacturing; and

(iv) If the facility generating electricity from biomass energy is not owned by the utility, evidence that the industrial facility owns the biomass energy facility and is directly interconnected with the electricity facilities that are owned by the utility and capable of carrying electricity at transmission voltage.

(3) **Incremental biomass energy.**

(a) A utility using incremental electricity produced as a result of a capital investment at a qualified biomass energy facility must document the eligible renewable energy using RECs created by WREGIS and must document:

(i) The status of the generating facility as a qualified biomass energy facility as provided in subsection (2) of this section;

(ii) Evidence of the quantity, in megawatt hours, of renewable energy electric power generation during the baseline period, which must be determined using the methodology provided in (b) of this subsection;

(iii) Evidence of the nature and amount of the capital investment, demonstrating that the capital investment project was completed after January 1, 2010, and that the expenditure was not on operation and maintenance in the normal course of business;

(iv) Evidence demonstrating that the incremental generation was a result of the capital investment; and

(v) The method or procedures that the facility owner uses to measure or calculate incremental generation and to track incremental generation within WREGIS separately from qualified biomass energy produced by the facility.

(b) Methodology for establishing baseline generation.

(i) The baseline level of generation for determining incremental generation must be established as the average quantity of net generation using eligible renewable energy fuel sources during the most recent three consecutive years of operation prior to the effect of the first capital investment completed after January 1, 2010. The three-year period must begin on or after January 1, 2007. Subsequent capital investments that result in additional amounts of incremental generation do not require a new baseline determination.

(ii) The baseline period must exclude any periods in which operation of the qualified biomass generation facility was unrepresentative of normal operating conditions.

(iii) Baseline generation must be documented using plant-level reports of net generation by fuel type submitted to the U.S. Energy Information Administration or, if such reports are not available, by business records of the generation facility owner.

WSR 17-16-118
PROPOSED RULES
DEPARTMENT OF HEALTH
(Pharmacy Quality Assurance Commission)
[Filed July 31, 2017, 12:27 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 15-16-024.

Title of Rule and Other Identifying Information: WAC 246-869-040 New pharmacy registration and 246-869-190 Pharmacy inspections, the pharmacy quality assurance commission (commission) is proposing updates to the pharmacy inspections process.

Hearing Location(s): Comfort Inn Conference Center, Evergreen Room, 1620 74th Avenue S.W., Tumwater, WA 98501, on September 14, 2017, at 9:15 a.m.

Date of Intended Adoption: September 14, 2017.

Submit Written Comments to: Tracy West, Pharmacy Quality Assurance Commission, P.O. Box 47852, Olympia, WA 98504-7852, email https://fortress.wa.gov/doh/policyreview, fax (360) 236-2260, by September 7, 2017.

Assistance for Persons with Disabilities: Contact Doreen Beebe by September 7, 2017, TTY (800) 833-6388 or 711.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposed rules change the inspection model used by the commission in conducting routine inspections of pharmacies in Washington state. The current inspection model is a points-based classification system which is outdated and requires updating. The commission is proposing to adopt a notice of deficiency and plan of correction model similar to other facilities inspected by the department of health and used in a majority of states.

Reasons Supporting Proposal: The proposed rules are necessary to reflect changes in pharmacy practice and improve regulatory relationships. The proposed rules are consistent with current industry standards and align pharmacy inspections with other inspection processes followed by the department of health.

Statutory Authority for Adoption: RCW 18.64.005.

Statute Being Implemented: Chapter 18.64 RCW.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Pharmacy quality assurance commission, governmental.

Name of Agency Personnel Responsible for Drafting: Tracy West, Rules Coordinator, 111 Israel Road S.E., Tumwater, WA 98501, (360) 236-4988; Implementation and Enforcement: Steve Saxe, Executive Director, 111 Israel Road S.E., Tumwater, WA 98501, (360) 236-4853.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The proposed rule would not impose more than minor costs on businesses in an industry.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Tracy West, Pharmacy Quality Assurance Commission, P.O. Box 47852, Olympia, WA 98504-7852, phone (360) 236-4988, fax (360) 236-2260, email tracy.west@doh.wa.gov.

July 31, 2017
Tim Lynch, PharmD, MS, Chair
Pharmacy Quality Assurance Commission

AMENDATORY SECTION (Amending WSR 91-18-057, filed 8/30/91, effective 9/30/91)

WAC 246-869-040 New pharmacy registration. The ((~~state board of pharmacy~~)) commission shall issue ((~~no~~)) a new pharmacy registration((~~s after December 1, 1976 unless~~)) to an applicant:

(1) ((~~The pharmacy will operate a bona fide prescription department.~~)) That dispenses or prepares medications and operates with such equipment, facilities, supplies, and pharmaceuticals as are specified by ((~~state board~~)) commission regulations and appropriate with the scope of services provided;

(2) ((~~The pharmacy passes inspection with a minimum of an "A" grade;~~)) That completes an inspection without any deficiencies identified or with an approved plan of correction; and

(3) ((~~The~~)) If a pharmacy is in a new or remodeled building ((~~can~~)), produces evidence of being built or remodeled in accordance with all building, health and fire codes required for the particular area.

AMENDATORY SECTION (Amending WSR 92-12-035, filed 5/28/92, effective 6/28/92)

WAC 246-869-190 Pharmacy inspections and self-inspection worksheets. (1) ((~~All pharmacies shall be~~)) Self-inspections. Effective March 1, 2018, the responsible manager, or designee, is required to conduct an annual self-inspection of the pharmacy on the responsible manager self-inspection worksheet(s) provided by the commission. The self-inspection must be completed within the month of March each year.

(a) The responsible manager must sign and date the completed self-inspection worksheet(s), and maintain completed worksheets for two years from the date of completion.

(b) When a change in responsible manager occurs, the new responsible manager, or designee, shall conduct a self-inspection on the responsible manager self-inspection worksheet(s). The new responsible manager must sign and date the self-inspection worksheet(s) within thirty days of becoming responsible manager, and maintain completed worksheets for two years from the date of completion.

(2) Commission inspection. A pharmacy is subject to periodic inspections to determine compliance with the ((~~laws~~)) statutes and regulations regulating the practice of pharmacy.

(((~~(2) Each inspected pharmacy shall receive a classification rating which will depend upon the extent of that pharmacy's compliance with the inspection standards.~~

~~(3) There shall be three rating classifications:~~

~~(a) "Class A" - for inspection scores of 90 to 100;~~

~~(b) "Conditional" - for inspection scores of 80 to 89; and,~~

~~(c) "Unsatisfactory" - for inspection scores below 80.~~

~~(4) Any pharmacy receiving a conditional rating shall have sixty days to raise its inspection score rating to 90 or better. If upon reinspection after sixty days, the pharmacy fails to receive a rating of 90 or better, then the pharmacy will be subject to disciplinary action.~~

~~(5) Any pharmacy receiving an unsatisfactory rating shall have fourteen days to raise its inspection score rating to 90 or better. If upon reinspection after fourteen days, the pharmacy fails to receive a rating of 90 or better, then the pharmacy will be subject to disciplinary action.~~

~~(6) The certificate of inspection must be posted in conspicuous view of the general public and shall not be removed or defaced.~~

~~(7) Noncompliance with the provisions of chapter 18.64A RCW (Pharmacy assistants) and, chapter 246-901 WAC (Pharmacy assistants) resulting in a deduction of at least five points shall result in an automatic unsatisfactory rating regardless of the total point score.~~

~~(8) Pharmacies receiving an unsatisfactory rating which represent a clear and present danger to the public health, safety and welfare will be subject to summary suspension of the pharmacy license.~~)) (a) Notice of deficiency. Issues identified as noncompliant at the end of a periodic commission inspection, must be identified in writing, describing the noncompliant issue(s) in detail with a reference to the applicable statutes or regulations.

(i) At the end of the inspection, the commission, or its designee, will conduct an exit meeting with the responsible manager or designee(s), addressing deficiencies identified during the inspection;

(ii) The commission, or its designee, shall provide a written notice of deficiency to the pharmacy within fourteen calendar days of the exit meeting.

(b) Plan of correction. A pharmacy must submit a plan of correction to the commission, or its designee, addressing each deficiency identified.

(i) A "plan of correction" is a proposal devised by the applicant or pharmacy that includes specific corrective actions that must be taken to correct identified deficiencies with time frames to complete them.

(ii) The commission, or its designee, must notify the pharmacy within a time frame set by the commission, whether or not a submitted plan of correction adequately addresses the notice of deficiency.

(iii) Implementation of the corrective action is required within the time frames set in the approved plan of correction, and are subject to verification by the commission, or its designee, which may require the pharmacy to submit a progress report(s) attesting to the correction of deficiencies, or a follow-up inspection.

(c) Pharmacies with deficiencies that represent an imminent or immediate risk or threat to public health, safety, and welfare may be subject to summary suspension of the pharmacy license, at the discretion of the commission.

WSR 17-16-126
PROPOSED RULES
HEALTH CARE AUTHORITY
(Public Employees Benefits Board)
[Order 2017-01—Filed July 31, 2017, 2:08 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 17-09-051.

Title of Rule and Other Identifying Information: The public employees' benefits board (PEBB) rules related to enrollment in chapter 182-08 WAC; eligibility in chapter 182-12 WAC; and appeals in chapter 182-16 WAC.

Hearing Location(s): Health Care Authority (HCA), Cherry Street Plaza Building, Sue Crystal Conference Room 106A, 626 8th Avenue, Olympia, WA 98504 (metered public parking is available street side around building. A map is available at http://www.hca.wa.gov/documents/directions_to_csp.pdf or directions can be obtained by calling (360) 725-1000), on September 5, 2017, at 10:00 a.m.

Date of Intended Adoption: Not sooner than September 6, 2017.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 45504, Olympia, WA 98504-5504, delivery 626 8th Avenue, Olympia, WA 98504, email arc@hca.wa.gov, fax (360) 586-9727, by September 1, 2017.

Assistance for Persons with Disabilities: Contact Amber Lougheed by September 1, 2017, phone (360) 725-1309, email amber.lougheed@hca.wa.gov, or TTY (800) 848-5429 or 711.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: **Amends existing rules in Title 182 WAC specific to the PEBB program with the following effect:**

1. Implement PEBB policy resolutions to create a definition of "season" as it relates to seasonal employees, amend surviving dependent eligibility requirements to clarify the timing on receiving retirement benefits, amend appointed officials eligibility requirements for retiree benefits, and amend SmartHealth eligibility requirements to incorporate a new wellness incentive.

2. Makes technical amendments to:

- Within chapters 182-08, 182-12, and 182-16 WAC insert the "PEBB" or "Public Employees' Benefits Board (PEBB)" in front of the words "insurance coverage" for clarity where it is missing.
- Amend chapters 182-08 and 182-12 WAC where premiums and premium payments are discussed to ensure payment of premium surcharges are also addressed.
- Correcting the reference to treasury regulation 26 C.F.R. §54.9801-6 throughout chapters 182-08 and 182-12 WAC.
- Amend the definition of "subscriber" in chapters 182-08, 182-12, and 182-16 WAC so it is clear that they must be determined eligible by HCA and are the individual to whom HCA and contracted vendors will issue all notices.
- Amend the title and structure of WAC 182-08-187 to more accurately reflect content of section and to more accurately describe error categories that would necessitate error correction. Also amending WAC 182-08-187 to incorporate more details regarding under what circumstances and how errors will be corrected retroactively.
- Amend WAC 182-08-196 and 182-08-198 to address how the PEBB program will resolve health plan enrollment when a subscriber has a change in residence and fails to select a new health plan within the required time.
- Amend chapter 182-08 WAC to clarify where life insurance paperwork must be turned in.
- Created new rule within chapter 182-12 WAC regarding the term "appointed official" and survivors of elected state official, full-time appointed state official of the legislative or executive branch of state government. This new rule supports retiree eligibility determinations for this population.
- Amend WAC 182-12-138 to align with 182-08-180 which describes how delinquent payments are handled.
- Amend the structure of the sections of WAC 182-12-142 to make it easier to reference individual subsections.
- Amend chapter 182-12 WAC to incorporate federal COBRA requirements pertaining to continuation coverage.
- Amend WAC 182-12-171 to clarify that substantive eligibility must be established before procedural requirements are considered and to make some minor nontechnical corrections.
- Amend WAC 182-12-260 to eliminate redundancy of state registered domestic partner reference in rule and clarify that dissolution, termination, divorce, annulment or death may be used to describe the termination of a state registered domestic partnership. Also, amending WAC 182-12-260 to clarify that the PEBB program will receive input from the contracted vendor when certifying the eligibility of a dependent child with a disability.
- Amend WAC 182-12-262 to include the timeline for when a subscriber must turn in a disabled dependent recertification form and to reflect that optional employee life insurance for a newborn child does not begin until the child is fourteen days old.
- Amend WAC 182-12-265 to clarify when a surviving spouse must start to receive a retirement benefit to be eligible for PEBB insurance coverage, and add the requirement that eligibility for a non K-12/educational service districts (ESD) employer group surviving spouse or domestic partner will end at the end of the month when the employer group ends participation with the PEBB program.
- Amend chapter 182-16 WAC to account for former employees and the process required for their appeals.
- Remove the special open enrollment event for a child becoming eligible as a dependent with a disability from WAC 182-08-198, 182-08-199, 182-12-128 and 182-12-262.
- Amend chapter 182-16 WAC so that life insurance premium payment decision may be appealed with the life insurance contracted vendor.
- Amend chapters 182-08 and 182-12 WAC to update the definition of life insurance to distinguish in rule the difference between life insurance for eligible employees

and eligible retirees. The updated definition of life insurance was also added into chapter 182-16 WAC.

- Create a definition of "contracted vendor" within chapters 182-08, 182-12, and 182-16 WAC to provide clarity and consistency in our use of "contracted vendor" in rule.
- Amend the definition of "annual open enrollment" within chapters 182-08 and 182-12 WAC to clarify employees must be eligible to participate in the salary reduction plan.
- Amend WAC 182-12-209 to specify the category of life insurance offered by life insurance vendor.
- Amend 182-12-128 and 182-12-262 to address when coverage begins for the birth or adoption of a child.

Reasons Supporting Proposal: Compliance with federal regulation, state law.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Statute Being Implemented: 26 C.F.R. § 54.9801-6.

Rule is necessary because of federal law, 26 C.F.R. § 54.9801-6.

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Rob Parkman, Cherry Street Plaza, 626 8th Avenue S.E., Olympia, WA, (360) 725-0883; Implementation: Barbara Scott, Cherry Street Plaza, 626 8th Avenue S.E., Olympia, WA, (360) 725-0830; and Enforcement: David Iseminger, Cherry Street Plaza, 626 8th Avenue S.E., Olympia, WA, (360) 725-1108.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The joint administrative rules review committee (JARRC) has not requested the filing of a small business economic impact statement, and there will be no costs to small businesses.

A cost-benefit analysis is not required under RCW 34.05.328. RCW 34.05.328 does not apply to HCA rules unless requested by JARRC or applied voluntarily.

July 31, 2017
Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 16-20-080, filed 10/4/16, effective 1/1/17)

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. During the annual open enrollment, subscribers may transfer from one health plan to another, enroll or remove dependents from coverage, or enroll in or waive enrollment in PEBB medical((~~, or~~)). Employees eligible to participate in the salary reduction plan 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((,)) and 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.

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

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

"Defer" means to postpone enrollment or interrupt enrollment in a PEBB health plan by a retiree or 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, 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 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~~)) RCW 41.05.011 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" means group medical related to a current employment relationship. It does not include medical coverage available to retired employees, individual market medical coverage, or government-sponsored programs such as medicare or medicaid.

"Employer contribution" means the funding amount paid to the 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 26 C.F.R. 54.4980B-8.

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

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

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

"Life insurance" for eligible employees includes basic life insurance and accidental death and dismemberment (AD&D) insurance paid for by the employing agency, as well as optional life insurance and optional AD&D insurance offered to and paid for by employees ((~~on an optional basis, and~~)) for themselves and their dependents. Life insurance for eligible retirees includes retiree term life insurance offered to and paid for by retirees.

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

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

"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 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.

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

"State agency" means an office, department, board, commission, institution, or other separate unit or division, however designated, of the state government 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~~)) continuation coverage enrollee, or survivor who has been ((~~designated~~)) determined eligible by the ((~~HCA as~~)) PEBB program, employer group, state agency, or charter school and is the individual to whom the ((~~HCA~~)) PEBB program 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.

"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, TRICARE, or medicare as allowed under WAC 182-12-128, or is on approved educational leave and obtains another employer-based group health plan as allowed under WAC 182-12-136.

AMENDATORY SECTION (Amending WSR 16-20-080, filed 10/4/16, effective 1/1/17)

WAC 182-08-180 Premium payments and premium refunds. Premiums and applicable premium surcharges 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)~~)) (3) or (4).

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

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

(a) 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 premiums or applicable premium surcharges must be paid, and are due from the employing agency, subscriber, or a subscriber's legal representative to the health care authority (HCA). 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 from the original due date, the subscriber's PEBB insurance coverage will be terminated retroactive to the last

day of the month for which the monthly premium and any premium surcharge was paid. If it is determined by the authority that 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 the subscriber's legal representative upon request.

(c) A monthly premium or premium surcharge 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 or premium surcharge 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 or premium surcharge remains underpaid for thirty days past the date the monthly premium or premium surcharge was due.

(2) **Premium refunds.** PEBB premiums and premium surcharges 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 and premium surcharges paid during the three month adjustment period, except as indicated in WAC 182-12-148(5).

(b) If a PEBB subscriber, dependent, or beneficiary submits a written appeal as described in WAC 182-16-025, 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 ((~~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 and premium surcharges paid during the time he or she was enrolled under the federal program if approved by the PEBB ((~~division~~)) director or designee.

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

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

AMENDATORY SECTION (Amending WSR 16-20-080, filed 10/4/16, effective 1/1/17)

WAC 182-08-187 How do employing agencies and contracted vendors correct enrollment errors and is there a limit on retroactive enrollment? (1) An employing agency ((~~that fails to timely enroll an employee, or his or her dependent, in public employees benefits board (PEBB) benefits~~)) or contracted vendor that makes one or more of the following enrollment errors must correct the error as described in ((~~this section. An agency must correct a~~)) subsections (2) through (4) of this section.

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

(b) Failure to ((~~accurately~~)) enroll the employee and his or her dependents in PEBB insurance coverage as elected by the employee, if the elections were timely; ((~~or a~~))

(c) Failure to ((~~accurately~~)) enroll PEBB insurance coverage as described in WAC 182-08-197 (1)(b); or ((~~a~~))

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

The employing agency or the ((~~PEBB program's designee~~)) applicable contracted vendor 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~~)) by the due date required under the new enrollment period must be defaulted according to WAC 182-08-197 (1)(b). This notice requirement does not remove the ability to offer recourse.

((~~(1)~~)) (2) **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 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 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 during the period of leave, optional LTD insurance is reinstated the first day of the month the

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

(iii) If the employee was eligible to continue optional life insurance 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)~~)) (3) **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 PEBB 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 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)~~)) (4) **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 receive approval from the authority, to implement retroactive PEBB insurance coverage within the following parameters:

(i) Retroactive enrollment in a PEBB health plan;

(ii) Reimbursement of claims paid;

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

(iv) Other legal remedy received or offered; or

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

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

AMENDATORY SECTION (Amending WSR 16-20-080, filed 10/4/16, effective 1/1/17)

WAC 182-08-196 What happens if my health plan becomes unavailable due to a change in contracted service area or eligibility for medicare? (1) 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 for their current plan because of his or her enrollment in medicare.

(a) Employees must ((~~notify~~)) submit the required form to their employing agency ((~~of~~)) electing their new health plan ((~~election~~)).

(b) All other subscribers must submit the required form to notify the PEBB program ((~~of~~)) electing their new health plan ((~~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~~)) an existing 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 16-20-080, filed 10/4/16, effective 1/1/17)

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~~)) is eligible to waive PEBB medical and elects 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 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 or contracted vendor as required. An employee may apply for enrollment in optional life and optional LTD insurance over the guaranteed issue at any time during the calendar year by submitting the required form to the contracted vendor for approval.

(ii) If an employee is eligible to participate in the 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, or contracted vendor in the case of life insurance, 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 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, or life insurance contracted vendor, if required, no later than thirty-one days after the employee regains eligibility, except as described in subsection (3)(b) of this section:

(i) An employee who self-paid for optional life PEBB 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 PEBB insurance coverage must submit evidence of insurability to the contracted vendor if he or she chooses to reenroll when he or she regains eligibility for the employer contribution;

(iii) An employee who was eligible to continue optional LTD under continuation coverage but discontinued that PEBB insurance coverage must submit evidence of insurability for optional LTD insurance to the ((~~PEBB designee~~)) contracted vendor 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, or contracted vendor accepting forms directly, 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 the medical FSA ((~~administrator~~)) contracted vendor 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 16-20-080, filed 10/4/16, effective 1/1/17)

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 submits the enrollment forms to 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 submits the enrollment forms to 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; or

(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 has a change in employment status that affects the subscriber's eligibility for his or her employer contribution toward his or her employer-based group health 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 26 C.F.R. 54.9801-6.

(e) Subscriber or a subscriber's dependent has a change in residence that affects health plan availability. If the subscriber moves and the subscriber's current health plan is not available in the new location the subscriber must select a new health plan((~~. 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)~~));

(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);

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

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

(i) Subscriber or a subscriber's dependent becomes entitled to coverage under medicare, or the subscriber or a subscriber's dependent loses eligibility for coverage under medicare, or enrolls in or terminates enrollment in a medicare Part D plan. If the subscriber's current health plan becomes unavailable due to the subscriber's or a subscriber's dependent's entitlement to medicare, the subscriber must select a new health plan as described in WAC 182-08-196(1);

(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;

(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 16-20-080, filed 10/4/16, effective 1/1/17)

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 elect to enroll in or ((~~change~~)) waive his or her ((~~election~~)) participation under the state's premium payment plan((~~, medical FSA, or DCAP~~)) during the annual open enrollment. An eligible employee may elect to enroll in the medical FSA, DCAP, or both 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~~)) applicable contracted vendor. All required forms must be received no later than the last day of the annual open enrollment. The enrollment or new election becomes effective January 1st of the following year.

(3) **During a special open enrollment:** An employee who is eligible to participate in the salary reduction plan 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~~)) 26 U.S.C. Sec. 152 without regard to the income limitations of that section. It does not include a state registered domestic partner unless the domestic partner otherwise qualifies as a dependent for tax purposes under IRC ((~~Section~~)) 26 U.S.C. Sec. 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; or

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

~~• A child becoming eligible as a dependent with a disability~~)).

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

• Employee has a change in marital status;

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

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

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

• An eligible dependent dies.

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

(iv) Employee has a change in employment status that affects the employee's eligibility for his or her employer contribution toward his or her employer-based group health 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 26 C.F.R. 54.9801-6.

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

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

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

(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);

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

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

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

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

(xiv) Employee or an employee's dependent experiences a disruption of care 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 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.

(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; or

• 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 medical 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; or

• 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 an employer-based group health 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~~)) 26 U.S.C. Sec. 21 (b)(1);

(vi) Employee's dependent care provider imposes a change in the cost of dependent care; employee may make a change in the DCAP 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~~)) IRC 26 U.S.C. Sec. 152.

AMENDATORY SECTION (Amending WSR 16-20-080, filed 10/4/16, effective 1/1/17)

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).

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

Employer groups 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 (2)(a) through (c) of this section;

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 (iv) of this subsection:

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

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

(iii) Employer group or charter school tax ID number (TIN); and

(iv) A statement of whether the group is 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.

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

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

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

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

(ii) Age;

(iii) Gender;

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

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

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

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

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

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

(iii) Summary of historical plan costs; and

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

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

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

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

(iii) Executive summary of benefits;

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

(v) Summary of historical plan costs.

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

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

AMENDATORY SECTION (Amending WSR 16-20-080, filed 10/4/16, effective 1/1/17)

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 this chapter and chapter 182-12 WAC unless otherwise approved by the authority 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, 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 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 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.

(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.

(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 health plan as COBRA subscribers for the remainder of the months available to them based on their qualifying event.

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

Exception: If an employer group, other than 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 16-20-080, filed 10/4/16, effective 1/1/17)

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. During the annual open enrollment, subscribers may transfer from one health plan to another, enroll or remove dependents from coverage, or enroll or waive enrollment in PEBB medical((~~, or~~)). Employees eligible to participate in the salary reduction plan 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((,)) and 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.

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

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

"Defer" means to postpone enrollment or interrupt enrollment in a PEBB health plan by a retiree or 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, 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 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~~)) RCW 41.05.011 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" means group medical related to a current employment relationship. It does not include medical coverage available to retired employees, individual market medical coverage, or government-sponsored programs such as medicare or medicaid.

"Employer contribution" means the funding amount paid to the 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.

"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.

"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" for eligible employees includes basic life insurance and accidental death and dismemberment (AD&D) insurance paid for by the employing agency, as well as optional life insurance and optional AD&D insurance offered to and paid for by employees ((~~on an optional basis, and~~)) for themselves and their dependent. Life insurance for eligible retirees includes retiree term life insurance offered to and paid for by retirees.

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

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby state and public employ-

ees 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 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.

"Season" means any recurring annual period of work at a specific time of year that lasts three to eleven consecutive months.

"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. During the special open enrollment subscribers may change health plans and enroll or remove dependents from coverage. Additionally, employees may enroll in or waive enrollment in PEBB medical((~~, and~~)). Employees eligible to participate in the salary reductions plan may enroll in or change their election under the DCAP, medical FSA, or the premium payment plan. For special open enrollment events related to specific PEBB benefits, see WAC 182-08-198, 182-08-199, 182-12-128, and 182-12-262.

"State agency" means an office, department, board, commission, institution, or other separate unit or division, however designated, of the state government 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~~)) continuation coverage enrollee, or ((~~eligible~~)) survivor who has been ((~~designated~~)) determined eligible by the ((~~HCA as~~)) PEBB program, employer group, state agency, or charter school and is the individual to whom the ((~~HCA~~)) PEBB program 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.

"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, TRICARE, or medicare as allowed under WAC 182-12-128, or is on approved educational leave and obtains another employer-based group health plan as allowed under WAC 182-12-136.

AMENDATORY SECTION (Amending WSR 16-20-080, filed 10/4/16, effective 1/1/17)

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 described in subsections (2) through (5) of this section:

(a) **Eligibility.** An employee is eligible if he or she is anticipated to work an average of at least eighty hours per month and 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 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 as described in WAC 182-12-131(1).

(d) **When PEBB insurance coverage begins.** Medical, dental, basic life insurance, and basic long-term disability insurance 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 is anticipated to work an average of at least eighty hours per month and 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 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 as described in WAC 182-12-131(1).

(d) **When PEBB insurance coverage begins.** Medical, dental, basic life insurance, and basic long-term disability insurance 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 cri-

teria 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 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, dental, basic life insurance, and basic long-term disability insurance 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, dental, basic life insurance, and basic long-term disability insurance 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, dental, basic life insurance, and basic long-term disability insurance 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.

(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, dental, basic life insurance, and basic long-term disability insurance 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.

AMENDATORY SECTION (Amending WSR 16-20-080, filed 10/4/16, effective 1/1/17)

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, 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 enrolled in other employer-based group medical, TRICARE, or medicare 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 as follows:

(i) For a newly born child, PEBB medical will begin the date of birth;

(ii) For a newly adopted child, PEBB medical will begin on the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier;

(iii) For an employee enrolling in order to enroll a newly born or newly adopted child, PEBB medical will begin the first day of the month in which the event occurs;

(iv) For the spouse or state registered domestic partner of an employee, PEBB medical will begin the first day of the month in which the event occurs.

(4) **Special open enrollment:** Any one of the events in (a) through (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; or

(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 has a change in employment status that affects the employee's eligibility for his or her employer contribution toward his or her employer-based group medical;

(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 26 C.F.R. 54.9801-6.

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

(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;

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

(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;

(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);

(j) Employee or employee's dependent becomes eligible and enrolls in TRICARE, or loses eligibility for TRICARE;

(k) Employee becomes eligible and enrolls in medicare, or loses eligibility for medicare.

AMENDATORY SECTION (Amending WSR 16-20-080, filed 10/4/16, effective 1/1/17)

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 PEBB benefits begin 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 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 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 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 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 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 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 PEBB 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 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.

(d) Two-year averaging: All benefits-eligible faculty (eligible 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 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 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 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 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 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 premium and applicable premium surcharge set by the health care authority (HCA). These options are available 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 16-20-080, filed 10/4/16, effective 1/1/17)

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 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)~~)) (b)(i) through (vi) of this subsection may continue PEBB insurance coverage by self-paying the premium and applicable premium surcharge set by the health care authority (HCA) from the date eligibility for 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 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).~~

~~(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 (LTD) insurance.

(((~~(c)~~)) (b) 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)~~)) 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.

(c) The employee's election must be received by the PEBB program no later than sixty days from the date the employee's PEBB health plan coverage ended or from the postmark date on the election notice sent by the HCA, whichever is later.

(d) Employees may self-pay for a maximum of twenty-nine months. The employee's first premium payment and applicable premium surcharge is due no later than forty-five days after the employee's election is received by the HCA. Premiums and applicable premium surcharges associated with continuing PEBB medical, must be made to the HCA as well as premiums associated with continuing PEBB dental or LTD insurance coverage. Premiums associated with continuing life insurance coverage must be made to the contracted vendor. Following the employee's first premium payment, the employee must pay the premium amounts for PEBB insurance coverage as premiums become due.

(e) If the employee's monthly premium or premium surcharge remains unpaid for sixty days from the original due date, the employee's PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharge was paid as described in WAC 182-08-180 (1)(b).

(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, 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 16-20-080, filed 10/4/16, effective 1/1/17)

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~~)) monthly premium or premium surcharge remains unpaid for sixty days ((~~delinquent,~~)) from the original due date, the employee's PEBB insurance coverage will ((~~end as of~~)) be terminated retroactive to the last day of the month for which ((~~a~~)) the monthly premium and premium surcharge was paid.

(3) If an employee exhausts the period of leave approved under FMLA, PEBB insurance coverage may be continued by self-paying the premium and applicable premium surcharge set by the HCA, with no contribution from the employer, as described in WAC 182-12-133(1) while on approved leave.

AMENDATORY SECTION (Amending WSR 16-20-080, filed 10/4/16, effective 1/1/17)

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 premium and applicable premium surcharge set by the health care authority (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)((~~,~~)):

(a) The employee's election must be received by the PEBB program no later than sixty days from the date the employee's PEBB health plan coverage ended or from the postmark date on the election notice sent by the HCA, whichever is later;

(b) The employee's first premium payment and applicable premium surcharge is due to the HCA no later than forty-five days after the employee's election is received by the HCA. Premiums and applicable premium surcharges associated with continuing PEBB medical must be made to the HCA as well as premiums associated with continuing PEBB dental. Premiums associated with continuing life insurance coverage must be made to the contracted vendor;

(c) Following the employee's first premium payment, the employee must pay the premium amounts associated with PEBB insurance coverage as premiums become due; and

(d) If the employee's monthly premium or premium surcharge remains unpaid for sixty days((~~,~~)) from the original due date, the employee's 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 PEBB 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 premium and applicable premium surcharge set by the HCA under WAC 182-12-133.

AMENDATORY SECTION (Amending WSR 16-20-080, filed 10/4/16, effective 1/1/17)

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 by self-paying the premium and applicable premium surcharge set by the health care authority (HCA), with no contribution from the employer, for a maximum of twelve months between periods of eligibility((~~,~~)):

(a) The employee's election must be received by the public employees benefits board (PEBB) program no later than sixty days from the date the employee's PEBB health plan coverage ended or from the postmark date on the election notice sent by the HCA, whichever is later;

(b) The employee's first premium payment and applicable premium surcharge is due to the HCA no later than forty-five days after the employee's election is received by the HCA. Premiums and applicable premium surcharges associated with continuing PEBB medical must be made to the HCA as well as premiums associated with continuing PEBB dental. Premiums associated with continuing life insurance coverage must be made to the contracted vendor;

(c) Following the employee's first premium payment, the employee must pay the premium amounts associated with ((~~public employees benefits board (~~))PEBB((~~)~~)) insurance coverage as premiums become due((~~,~~)); and

(d) If the employee's monthly premium or premium surcharge remains unpaid for sixty days((~~,~~)) from the original due date, the employee's PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium ((~~or~~)) and 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 by self-paying the premium and applicable premium surcharge set by the ((~~health care authority (~~))HCA((~~)~~)), with no contribution from the employer, for a maximum of twelve months between periods of eligibility((~~,~~)):

(a) The employee's election must be received by the PEBB program no later than sixty days from the date the employee's PEBB health plan coverage ended or from the postmark date on the election notice sent by the HCA, whichever is later;

(b) The employee's first premium payment and applicable premium surcharge is due to the HCA no later than forty-five days after the employee's election is received by the HCA. Premiums and applicable premium surcharges associated with continuing PEBB medical must be made to the HCA as well as premiums associated with continuing PEBB dental. Premiums associated with continuing life insurance coverage must be made to the contracted vendor;

(c) Following the employee's first premium payment, the employee must pay the premium amounts associated with PEBB insurance coverage as premiums become due((~~,~~)); and

(d) If the employee's monthly premium or premium surcharge remains unpaid for sixty days((~~,~~)) from the original due date, the employee's 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) **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 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 16-20-080, filed 10/4/16, effective 1/1/17)

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)? (1) 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 premium set by the health care authority (HCA)((~~. Premiums must be paid as described in WAC 182-08-180 (1)(b).~~

~~(1)~~)) :

(a) The enrollee's election must be received by the PEBB program no later than sixty days from the date the enrollee's PEBB health plan coverage ended or from the postmark date on the election notice sent by the HCA, whichever is later;

(b) The enrollee's first premium payment and applicable premium surcharge is due to the HCA no later than forty-five days after the enrollee's election is received by the HCA. Following the enrollee's first premium payment, premiums and applicable premium surcharges must be paid as described in WAC 182-08-180 (1)(b);

(c) Enrollees who request to voluntarily terminate their COBRA coverage must do so in writing. The written termination request must be received by the PEBB program. Enrollees who terminate their COBRA coverage will not be eligible to reenroll in COBRA coverage unless they regain eligibility. COBRA 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, COBRA coverage will end on the last day of the previous month; and

(d) Medical flexible spending arrangement (FSA) enrollees who on the date of the qualifying event, have a greater number of remaining benefits than remaining contribution payments for the current year, will have an opportunity to continue making contributions to their medical FSA by electing COBRA. The enrollee's first premium payment is due to the contracted vendor no later than forty-five days after the enrollee's election is received by the contracted vendor. The enrollee's election must be received by the contracted vendor no later than sixty days from the date the enrollee's PEBB health plan coverage ended or from the postmark date on the election notice sent by the contracted vendor, whichever is later.

(2) 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)~~)) (3) 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)~~)) (4) A retired employee who loses eligibility for PEBB retiree insurance because an employer group, with the exception of school districts, educational service districts, and charter schools ceases participation in PEBB insurance coverage may continue medical, dental, or both.

((~~(4)~~)) (5) A retired employee, or a dependent of a retired employee, who is no longer eligible to continue coverage as described in WAC 182-12-171 may continue medical, dental, or both.

((~~(5)~~)) (6) A blind vendor who ceases to actively operate a facility as described in WAC 182-12-111 (5)(a) may continue enrollment in 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 16-20-080, filed 10/4/16, effective 1/1/17)

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 premium and applicable premium surcharge 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 from the original due date, 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 (4) of this section.

(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.

(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 and premium surcharges 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 and premium surcharges 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 16-20-080, filed 10/4/16, effective 1/1/17)

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), and (3) of this section. An elected state official or full-time appointed state official of the legislative or executive branch of state government is eligible as described in WAC 182-12-180.

(1) **Procedural requirements.** A retiring employee must enroll or defer enrollment in PEBB retiree insurance coverage as described in (a) ((~~and~~)), (b), and (c) 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) The employee's first premium payment and applicable premium surcharge is due to the HCA no later than forty-five days after the employee's election is received by the HCA. Following the employee's first premium payment, premiums and applicable premium surcharges must be paid as described in WAC 182-08-180 (1)(b); and

(c) To defer enrollment in a PEBB health plan, the employee must meet substantive eligibility requirements in subsection (2) of this section and 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 eligible for PEBB benefits or an employee who is enrolled in basic benefits through a Washington state school district, 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 (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 PEBB retiree insurance coverage;

(c) A retiring employee of a Washington higher education institution who is a member of a higher education retirement 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, 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 with that employer group or tribal government.

(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, or charter school 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, 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(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.~~)) 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 a PEBB health plan. 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.

(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.

NEW SECTION

WAC 182-12-180 When is an elected state official, full-time appointed state official of the legislative or executive branch of state government, or their survivor eligible to continue enrollment in public employees benefits board (PEBB) retiree insurance coverage? (1) The following officials are eligible to continue enrollment or defer enrollment in public employees benefits board (PEBB) insurance coverage under the same terms as outgoing legislators, when they voluntarily or involuntarily leave public office, if they meet the procedural requirements as described in subsection (3) of this section:

(a) A member of the state legislature;

(b) A statewide elected official of the executive branch;

(c) An executive official appointed directly by the governor as the single head of an executive branch agency; or

(d) An official appointed directly by a state legislative committee as the single head of a legislative branch agency or an official appointed to secretary of the senate or chief clerk of the house of representatives.

(2) The spouse, state registered domestic partner, or child of an official described in subsection (1) of this section who loses eligibility due to the death of the official may enroll or defer enrollment as a survivor under retiree insurance coverage as described in (a) and (b) of this subsection and in subsection (3)(b) and (c) of this section.

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

(b) The official's child may continue health plan enrollment until they lose eligibility as described in WAC 182-12-260.

(3) **Procedural requirements.** An official described in subsection (1) of this section or their survivor described in subsection (2) of this section must enroll or defer enrollment in PEBB retiree insurance coverage no later than sixty days after the official leaves public office or the death of the official:

(a) To enroll in PEBB retiree insurance coverage the required forms must be received by the PEBB program no later than sixty days after the official leaves public office or the death of the official. The effective date of PEBB retiree insurance coverage is the first day of the month after the official leaves office or the death of the official;

(b) The official's or survivor's first premium payment and applicable premium surcharge is due to the HCA no later than forty-five days after the official's or survivor's election is received by the PEBB program. Following the official's or survivor's first premium payment, premiums and applicable premium surcharges must be paid as described in WAC 182-08-180 (1)(b);

(c) To defer enrollment in a PEBB health plan the official or the survivor must meet deferral enrollment requirements as described in WAC 182-12-200 or 182-12-205.

(4) If the official, an enrolled dependent, or their survivor is or 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.

AMENDATORY SECTION (Amending WSR 16-20-080, filed 10/4/16, effective 1/1/17)

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 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 as described in WAC 182-08-180 (1)(b);

(4) Misconduct. If a retiree's PEBB insurance coverage is 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 PEBB insurance coverage on behalf of the HCA, its employees, or other persons.

If a retiree's PEBB insurance coverage is terminated by HCA for the above reasons, PEBB insurance coverage for all of the retiree's eligible dependents is also terminated.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-12-209 Who is eligible for retiree term life insurance? Eligible employees who participate in public employees benefits board (PEBB) life insurance as an employee and meet qualifications for PEBB retiree insurance coverage as provided in WAC 182-12-171 are eligible for PEBB retiree term life insurance. They must submit the required forms to the PEBB program. Forms must be received by the PEBB program no later than sixty days after the date their PEBB employee life insurance ends.

(1) Employees whose life insurance premiums are being waived under the terms of the life insurance contract are not eligible for retiree term life insurance until their waiver of premium benefit ends.

(2) Retirees may not defer enrollment in retiree term life insurance, except as allowed in subsection (3)(b) of this section.

(3) If a retiree returns to active employment status and becomes eligible for the employer contribution toward PEBB employee life insurance, he or she may choose:

(a) To continue to self-pay premiums and keep retiree life insurance ((~~in place~~)), the employee must pay retiree term life insurance premiums directly to the contracted vendor during the period he or she is eligible for employee life insurance; or

(b) To stop self-paying retiree term life insurance premiums during the period he or she is eligible for employee life insurance and ((~~resume self-paying premiums for~~)) reelect retiree term life insurance when he or she is no longer eligible for the employer contribution toward PEBB employee life insurance.

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

WAC 182-12-211 May an employee who is determined to be retroactively eligible for disability retirement enroll in public employees benefits board (PEBB) retiree insurance coverage? (1) An employee who is determined to be retroactively eligible for a disability retirement is eligible to enroll or defer enrollment (as described in WAC 182-12-200 or 182-12-205) in public employees benefits board (PEBB) retiree insurance coverage if:

(a) The employee submits the required form and a copy of the formal determination letter he or she received from the Washington state department of retirement systems (DRS) or the appropriate higher education authority;

(b) The employee's form and a copy of his or her Washington state-sponsored retirement system's formal determination letter are received by the PEBB program no later than sixty days after the date on the determination letter; and

(c) The employee immediately begins to receive a monthly pension benefit or a supplemental retirement plan benefit under his or her higher education retirement plan

(HERP), with exceptions described in WAC 182-12-171 (2)(((~~(b)~~))) (a).

(2) Premiums and applicable premium surcharges are due from the effective date of enrollment in PEBB retiree insurance coverage. The employee, at his or her option, must indicate the effective date of PEBB retiree insurance coverage on the form. The employee may choose from the following dates:

(a) The employee's retirement date as stated in the formal determination letter; or

(b) The first day of the month following the date the formal determination letter was written.

(3) The director may make an exception to the date PEBB retiree insurance coverage begins; however, such request must demonstrate extraordinary circumstances beyond the control of the retiree.

AMENDATORY SECTION (Amending WSR 16-20-080, filed 10/4/16, effective 1/1/17)

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 PEBB 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 PEBB 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 PEBB 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 contin-

uous 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 PEBB 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 16-20-080, filed 10/4/16, effective 1/1/17)

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 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 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 based on establishment of a parent-child relationship as described in RCW 26.26.101;

(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~~)) marriage 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. The child's relationship to the subscriber (and eligibility as a PEBB dependent) ends, for purposes of this rule, on the same date the subscriber's legal relationship with the state registered domestic partner as defined in RCW 26.60.020(1) ends through divorce, annulment, dissolution, termination, or death;

(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 with input from the applicable contracted vendor 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 16-20-080, filed 10/4/16, effective 1/1/17)

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, except if the employee enrolls a newborn child in optional dependent life insurance. The newborn child's dependent life insurance coverage will be effective on the date the child becomes fourteen days old.

(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 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.**

(a) 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.

((▲)) (i) 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.

((▲)) (ii) Enrollment of an extended dependent or a dependent with a disability will be the first day of the month following eligibility certification.

((▲)) (iii) 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.

((▲)) (iv) 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~~)) as follows:

• For the newly born child, health plan coverage will begin the date of birth;

• For a newly adopted child, health plan coverage will begin on the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier;

• For a spouse or state registered domestic partner of a subscriber, health plan coverage will begin the first day of the month in which the event occurs. The spouse or state registered domestic partner will be removed from health plan coverage the last day of the month in which the event occurred;

A newly born child must be at least fourteen days old before optional dependent life insurance coverage purchased by the employee becomes effective.

Any one of the following events may create a special open enrollment:

(((~~(a)~~))) (b) 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; or

(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)~~)).

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

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

(((~~(d)~~))) (e) 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)~~))) (f) Subscriber or a subscriber's dependent has a change in enrollment under an employer-based group health plan during its annual open enrollment that does not align with the PEBB program's annual open enrollment;

(((~~(f)~~))) (g) 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;

(((~~(g)~~))) (h) 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);

(((~~(h)~~))) (i) 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;

(((~~(i)~~))) (j) 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). To recertify an enrolled child with a disability, the required forms must be received by the PEBB program or contracted vendor by the child's scheduled PEBB coverage termination date.

(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 16-20-080, filed 10/4/16, effective 1/1/17)

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 required forms to enroll or defer enrollment in PEBB 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. The dependent's first premium payment and applicable premium surcharge is due to the HCA no later than forty-five days after the dependent's election is received by the HCA. Following the dependent's first premium payment, premiums and applicable premium surcharges must be paid as described in WAC 182-08-180 (1)(b).

(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 PEBB retiree insurance coverage provided they immediately begin receiving a monthly retirement benefit from any state of Washington sponsored retirement system. To satisfy the requirement to immediately receive a monthly retirement benefit they must begin receiving monthly benefit payments no later than one hundred twenty days from the date of death of the employee.

(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 as described in WAC 182-12-260.

Notes: 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 PEBB retiree insurance coverage. However, the dependent may continue health plan enrollment as described in WAC 182-12-146.

Eligibility for the surviving spouse, surviving state registered domestic partner, or surviving child of an employee of a participating employer group will cease at the end of the month in which the group's contract with the authority ends unless the employer group is a school district, educational service district, or charter school.

Eligibility for the surviving spouse, surviving state registered domestic partner, or surviving child of an elected or full-time appointed official of the legislative or executive branches of state government is described in WAC 182-12-180.

(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 PEBB 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 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 PEBB retiree insurance coverage. The dependent must submit the 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.

Note: Eligibility for the surviving spouse, surviving state registered domestic partner, or surviving child of an employer group retiree will cease at the end of the month in which the group's contract with the authority ends unless the employer group is a school district, educational service district, or charter school.

(3) The spouse, state registered domestic partner, or child of a deceased school district, educational service district ((~~employee~~)), or a charter school employee 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 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 as described in WAC 182-12-260.

(4) If a premium ((~~or~~)) and applicable premium surcharge ((~~payment~~)) received by the authority is sufficient as described in WAC ((~~180-08-180~~)) 182-08-180 (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 and applicable premium surcharge.

(5) In order to avoid duplication of group medical coverage, surviving dependents may defer enrollment in a PEBB health plan as described in WAC 182-12-200 and 182-12-205.

AMENDATORY SECTION (Amending WSR 16-20-080, filed 10/4/16, effective 1/1/17)

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 premiums and applicable premium surcharges 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's first premium payment and applicable premium surcharge is due to the HCA no later than forty-five days after the dependent's election is received by the HCA. Following the employee's first premium payment, 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 from the original due date, 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 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 as

described in WAC 182-12-180, 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~~)) continuation 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 15-22-099, filed 11/4/15, effective 1/1/16)

WAC 182-12-300 Public employees benefits board (PEBB) wellness incentive program eligibility and procedural requirements. The public employees benefits board (PEBB) annually determines the design of the PEBB wellness incentive program.

(1) All subscribers, except PEBB subscribers who are enrolled in both medicare parts A and B, and in the medicare risk pool, are eligible to participate in the PEBB wellness incentive program.

(2) ((~~To receive a PEBB wellness incentive for the 2016 plan year, eligible subscribers must complete PEBB wellness incentive program requirements during 2015 by the latest date below:~~

~~(a) For subscribers continuing enrollment in PEBB medical and subscribers enrolling in PEBB medical with an effective date in January, February, or March, the deadline is June 30th; or~~

~~(b) For subscribers enrolling in PEBB medical with an effective date in April, May, June, July, or August, the deadline is one hundred twenty days from the subscriber's PEBB medical effective date; or~~

~~(c) For subscribers enrolling in PEBB medical with an effective date in September, October, November, or December, the deadline is December 31st.~~

~~(3)~~)) Effective January 1, 2016, to receive ((~~a~~)) the PEBB wellness incentive of a reduction to the subscriber's medical plan deductible or a deposit to the subscriber's health savings account for the following plan year, eligible subscribers must complete PEBB wellness incentive program requirements during the current plan year by the latest date below:

(a) For subscribers continuing enrollment in PEBB medical and subscribers enrolling in PEBB medical with an effective date in January, February, March, April, May, or June the deadline is September 30th; or

(b) For subscribers enrolling in PEBB medical with an effective date in July or August, the deadline is one hundred twenty days from the subscriber's PEBB medical effective date; or

(c) For subscribers enrolling in PEBB medical with an effective date in September, October, November, or December, the deadline is December 31st.

(((~~4~~))) (3) Subscribers who do not complete the requirements according to subsection (2) ((~~or (3)~~)) of this section, except as noted, within the time frame described are not eligible to receive a PEBB wellness incentive the following plan year.

Note: All eligible subscribers can earn a wellness incentive. Subscribers who cannot complete the wellness incentive program requirements may be able to earn the same incentive by different means. The PEBB program will work with enrollees (and their physician, if they wish) to define an individual wellness program that provides the opportunity to qualify for the same incentive in light of the enrollee's health status.

(4) Effective January 1, 2018, an eligible subscriber will receive a separate PEBB wellness incentive for completing the SmartHealth well-being assessment on or before December 31st, of the current plan year. An eligible subscriber may only earn this separate PEBB wellness incentive once per plan year.

(5) ((~~A~~)) PEBB wellness incentive will be provided only if:

(a) For the wellness incentive described in subsection (2) of this section the subscriber is still eligible for the PEBB wellness incentive program in the year the incentive applies;

(b) The funding rate provided by the legislature is designed to provide a PEBB wellness incentive program or a PEBB wellness incentive, or both; or

(c) Specific appropriations are provided for wellness incentives.

AMENDATORY SECTION (Amending WSR 16-20-080, filed 10/4/16, effective 1/1/17)

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 by the health care authority (HCA) 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((,)) and 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)) HCA program.

(3) The definitions in WAC 182-16-020 apply throughout this chapter.

AMENDATORY SECTION (Amending WSR 16-20-080, filed 10/4/16, effective 1/1/17)

WAC 182-16-020 Definitions. The following definitions apply throughout this chapter unless the context clearly indicates another meaning:

"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)) contracted vendor.

"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((,)) and 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.

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

"Denial" or "denial notice" means an action by, or communication from, either an employing agency, or the PEBB program that aggrieves 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, 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 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)) RCW 41.05.011 or by the authority under this chapter.

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

"Employer 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 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.

"Life insurance" for eligible employees includes basic life insurance and accidental death and dismemberment (AD&D) insurance paid for by the employing agency, as well as optional life insurance and optional AD&D insurance offered to and paid for by employees for themselves and their dependents. Life insurance for eligible retirees includes retiree term life insurance offered to and paid for by retirees.

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

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

"PEBB" means the public employees benefits board.

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

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

"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 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

• When the director has designated the office of administrative hearings (OAH) as a hearing body, an administrative law judge employed by the ((~~office of administrative hearings~~)) OAH.

"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~~)) continuation coverage enrollee, or ((~~eligible~~)) survivor who has been ((~~designated~~)) determined eligible by the ((~~HCA as~~)) PEBB program, employer group, state agency, or charter school and is the individual to whom the ((~~HCA~~)) PEBB program 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.

"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 16-20-080, filed 10/4/16, effective 1/1/17)

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 current or former 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 PEBB 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 current or former 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 current or former employee of an employer group aggrieved by a decision regarding life insurance, long-term disability (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 health plan, life insurance, ((~~or~~)) LTD insurance, long-term care insurance, or property and casualty insurance may appeal that decision by following the appeal provisions of those plans, with the exception of ((~~eligibility, enrollment, and premium payment determinations~~)):

(a) Enrollment decisions;

(b) Premium payment decisions other than life insurance premium payment decisions; and

(c) Eligibility decisions.

(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 contracted vendor 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 16-20-080, filed 10/4/16, effective 1/1/17)

WAC 182-16-030 How can ((~~an~~)) a current or former 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 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 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)~~)) errors made by the employing state agency.

(2) Any current or former 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 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 182-16-032 How can a decision made by the public employees benefits board (PEBB) program regarding eligibility, enrollment, premium payments, premium surcharge, eligibility to participate in the PEBB wellness incentive program or receive a PEBB wellness incentive; or a decision made by an employer group regarding life insurance or LTD insurance be appealed? (1) A decision made by the public employees benefits board (PEBB) program regarding eligibility, enrollment, premium payment, premium surcharge, or eligibility to participate in the PEBB wellness incentive program, or eligibility to receive a PEBB wellness incentive, may be appealed by submitting a notice of appeal to the PEBB appeals committee.

(2) A decision made by an employer group regarding life insurance, LTD insurance, eligibility to participate in the PEBB wellness incentive program, or eligibility to receive a PEBB wellness incentive may be appealed by submitting a notice of appeal to the PEBB appeals committee.

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

(4) The notice of appeal from ((~~an~~)) a current or former employee or employee's dependent must be received by the PEBB appeals manager no later than thirty days after the date of the denial notice.

(5) The notice of appeal from a retiree, self-pay enrollee, or dependent of a retiree or self-pay enrollee must be received by the PEBB appeals manager no later than sixty days after the date of the denial notice.

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

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

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

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-16-035 How can a subscriber appeal a decision regarding the administration of wellness incentive program requirements? (1) Any subscriber aggrieved by a decision regarding the completion of the wellness incentive program requirements or request for a reasonable alternative to a wellness incentive program requirement may appeal that decision to the ((~~third-party administrator contracted to administer the~~)) PEBB wellness incentive program contracted vendor.

(2) Any subscriber who disagrees with a decision in response to an appeal filed with the ((~~third-party administrator that administers the~~)) public employee benefits board (PEBB) wellness incentive program contracted vendor may appeal to the ((~~public employees benefits board (~~))PEBB((~~)~~)) appeals committee.

(a) The notice of appeal from ((~~an~~)) a current or former employee must be received by the PEBB appeals manager 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 WAC 182-16-040.

(b) The notice of appeal from a retiree or self-pay enrollee must be received by the PEBB appeals manager no later than sixty days after the date of the denial notice. The contents of the notice of appeal are to be provided in accordance with WAC 182-16-040.

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

(4) 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.

(5) 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 15-22-099, filed 11/4/15, effective 1/1/16)

WAC 182-16-036 How can an employee who is eligible to participate in the state's salary reduction plan appeal a decision regarding the administration of benefits offered under the state's salary reduction plan? (1) Any employee who is eligible to participate in the state's salary reduction plan who disagrees with a decision that denies eligibility for or enrollment in a benefit offered under the state's salary reduction plan may appeal that decision by submitting a written request for review to his or her state agency. The 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 as described in WAC 182-16-040.

(a) Upon receiving the request for review, the 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 state agency may hold a formal meeting or hearing, but is not required to do so.

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

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

(d) Any employee who disagrees with the 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 state agency's written decision on the request for review.

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

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

(f) 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.

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

(2) Any employee who is eligible to participate in the state's salary reduction plan aggrieved by a decision regarding a claim for benefits under the medical flexible spending arrangement (FSA) and dependent care assistance program (DCAP) offered under the state's salary reduction plan may appeal that decision to the ((~~third-party administrator contracted to administer the plan~~)) plan's contracted vendor by following the appeal process of ((~~the third-party administrator~~)) that contracted vendor.

Any employee who is eligible to participate in the state's salary reduction plan who disagrees with a decision in response to an appeal filed with the ((~~third-party administrator~~)) contracted vendor that administers the medical FSA and DCAP under the state's salary reduction plan may 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 appeal decision by the ((~~third-party administrator~~)) contracted vendor that administers the medical FSA and DCAP. The contents of the notice of appeal are to be provided in accordance with WAC 182-16-040.

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

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

(3) Any employee who is eligible to participate in the state's salary reduction plan aggrieved by a decision regarding the administration of the premium payment plan offered under the state's salary reduction plan may appeal that decision to the PEBB appeals committee. The PEBB appeals manager must receive the notice of appeal no later than thirty days after the date of the denial notice by the PEBB program. The contents of the notice of appeal are to be provided in accordance with WAC 182-16-040.

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

(b) The PEBB appeals committee shall render a written decision to the appellant within thirty days of receiving the notice of appeal. The 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.

WSR 17-16-129

PROPOSED RULES

DEPARTMENT OF HEALTH

(Nursing Care Quality Assurance Commission)

[Filed July 31, 2017, 4:07 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 16-12-037.

Title of Rule and Other Identifying Information: WAC 246-840-015 Collection of demographic data at the time of nursing licensure.

Hearing Location(s): Red Lion River Inn, 700 North Division Street, Spokane, WA 99202, on September 8, 2017, at 2:30 p.m.

Date of Intended Adoption: September 8, 2017.

Submit Written Comments to: Carole Reynolds, Washington State Nursing Commission, P.O. Box 47864, Olympia, WA 98504-7864, email https://fortress.wa.gov/doh/policyreview, fax (360) 236-4738, by August 25, 2017.

Assistance for Persons with Disabilities: Contact Carole Reynolds by September 1, 2017, TTY (800) 833-6388 or 711.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The nursing care quality assurance commission (commission) is proposing new rules to require all nurses to submit demographic data (see below) during licensure. Collection of nationally standardized minimum data set (MDS) elements allows analysis and evaluation of the current nursing workforce composition, and development of plans to address nursing shortages. Currently, less than five percent of Washington nursing professionals voluntarily submit the data during licensure. Requiring licensees to provide standard minimum data as part of licensure allows the commission to fully meet the intent of the law (RCW 18.79.202), which is to safeguard and promote

patient safety and quality of care [by] addressing the nursing shortage.

Minimum Nurse Supply Dataset

Initial Rationale for Selection and Measurement of Minimum Dataset Items

The National Forum of State Nursing Workforce Centers collected Nurse Supply Survey instruments from all Forum subscriber states as well as non-subscriber states participating in the 2008 Education Capacity Summit hosted by AARP's Center to Champion Nursing in America. The instruments were compiled into a spreadsheet showing the number of states collecting data on each variable along with their method of measurement. In addition to state-level instruments, the Minimum Supply Dataset recommended by Colleagues in Caring in 1995 was described on the spreadsheet. Using this spreadsheet, a survey was developed that identified the items collected and asked respondents to rate the importance of each for 1) supply forecasting and 2) policy issues. The survey was fielded to each Forum subscriber or Education Capacity state.

The Minimum Supply Dataset Drafting Workgroup reviewed data collection strategies reported in the scientific literature, the spreadsheet, and survey results to identify the most critical items for the minimum dataset and the appropriate measurement approach for each.

2016 Revisions to the Supply Minimum Dataset

In 2015, because of the evolution and transformation of healthcare and nursing that has taken place since 2009 when the original Supply MDS was adopted, the Forum made the decision to revisit the Supply MDS. Throughout 2015, the National Forum's Research Committee undertook the task of reviewing the Supply MDS to ensure that the elements included are still relevant. This review included an assessment of items currently being collected by states and national organizations in their supply data collection efforts.

The revised elements below are a result of this assessment and lengthy discussions by members of the research committee as well as review and approval of all Forum member executive directors. Additionally, the National Forum solicited comment on the proposed changes to the Supply MDS from national organizations and researchers that work with nursing workforce data. Feedback received was incorporated into the final draft of this revision.

Instructions for Collecting the Minimum Dataset

This document is intended to guide states in assembling the standardized nurse supply dataset recommended by the National Forum of State Nursing Workforce Centers. Words written in RED are defined in the glossary accompanying this dataset.

We recommend that states collect the Minimum Nurse Supply Dataset at initial nurse licensure and license renewal from all licensed nurses (LPN/LVN, RN, APRN) in the state. This design generates a complete set of updated data for an individual nurse every time his or her license is renewed (in most states, every two years). We recognize, however, that states may vary in their capacity to implement such a study design. In lieu of continuous data collection from all licensees, we recommend that the Minimum Nurse Supply Dataset be collected from random or representative samples as often as possible. We anticipate that states will work towards and eventually achieve collection of data on the entire licensed nurse population for submission to the national nurse supply dataset.

This Minimum Nurse Supply Dataset is intended to be a data standardization model and in no way is meant to limit data collection in your state.

Essential Elements

The National Forum's Research Committee identified the following 6 variables as being the most essential data elements a state could collect. These variables are already being collected by a majority of states and standardizing the collection of these elements among all states would be the most paramount to workforce analyses.

- Variable 1: Gender
- Variable 2: Ethnicity
- Variable 3: Race
- Variable 4: Year of birth
- Variable 6: Highest level of nursing education
- Variable 12: Employment status
- Variable 17: Employer's zip code

Demographics

Variable 1: Gender

Stem (example): What is your gender?

Response Categories: Male, Female

Variable 2: Ethnicity

Stem (example): Are you of Hispanic or Latino origin?

Response Categories: Yes, No

Variable 3: Race

Stem (example): What is your race? (Mark all that apply)

Response Categories: American Indian or Alaska Native Asian, Black/African American, Native Hawaiian or Other Pacific Islander, White/Caucasian, Other

Variable 4: Year of birth

Stem (example): In what year were you born?

Response Categories: Open ended field

Variable 5: Entry level education

Stem (example): What type of nursing degree/credential qualified you for your first U.S. nursing license?

Response Categories: Vocational/Practical certificate-nursing, Diploma-nursing, Associate degree-nursing, Baccalaureate degree-nursing, Master's degree-nursing, Doctoral degree-nursing (PhD), Doctoral degree-nursing (DNP)

Variable 6: Highest level of nursing education

Stem (example): What is your highest level of nursing education?

Response Categories: Vocational/Practical certificate-Nursing, Diploma-Nursing, Associate degree-Nursing, Baccalaureate degree-Nursing, Master's degree-Nursing, Doctoral degree-Nursing (PhD), Doctoral degree-Nursing Practice (DNP), Doctoral degree-Nursing other

Variable 7: Highest level of education in another field

Stem (example): What is your highest level of non-nursing education?

Response Categories: Associate degree-Non nursing, Baccalaureate degree-Non-nursing, Master's degree-Non-nursing, Doctoral degree-Non-nursing, Not applicable

License/Certification Information

Variable 8: License type

Stem (example): What type of license do you currently hold? (Mark all that apply.)

Response Categories: RN, LPN, APRN

Variable 9: Year of Initial U.S. licensure

Stem (example): Year of Initial U.S. Licensure

Minimum Response Categories: Open-ended field or drop-down menu

Variable 10: Country of Initial RN/LPN licensure

Stem (example): In what country were you initially licensed as RN or LPN

Minimum Response Categories: Open-ended field

Variable 11: License status

Stem (example): What is the status of the license currently held?

Response Categories: Active or Inactive

Variable 12: Advanced Practice Registered Nurse License/Certification

Stem (example): Indicate whether you are credentialed in your state to practice as any of the following: (Select all that apply.)

Response Categories: Certified Nurse Practitioner, Clinical Nurse Specialist, Certified Registered Nurse Anesthetist, Certified Nurse Midwife, Not credentialed as any of the above

Employment Information

Variable Group 13: Employment status

Stem (example): What is your employment status? (Mark all that apply)

Response Categories: Actively employed in nursing or in a position that requires a nurse license full-time, Actively employed in nursing or in a position that requires a nurse license part-time, Actively employed in nursing or in a position that requires a nurse license on a per-diem basis, Actively employed in a field other than nursing full-time, Actively employed in a field other than nursing part-time, Actively employed in a field other than nursing on a per-diem basis, Working in nursing only as a volunteer, Unemployed, seeking work as a nurse, Unemployed, not seeking work as a nurse, Retired

Variable Group 14: Reason for being unemployed

Stem (example): If unemployed, please indicate the reasons.

Response Categories: Taking care of home and family, Disabled, Inadequate Salary, School, Difficulty in finding a nursing position, other

Variables 15-19 intended only if individual is actively employed in nursing

Variable 15: Number of positions employed in

Stem (example): In how many positions are you currently employed as a nurse?

Response Categories: 1, 2, 3 or more

Variable 16: Hours worked per week

Stem (example): How many hours do you work during a typical week in all your nursing positions?

Response Categories: Open-ended field

Variable 17: Employer's address

Stem (example): Please indicate the state and zip code of your primary employer.

Response Categories: Open-ended field

It is recommended that information for both primary and secondary positions be collected for variables 18-20.

Variable 18: Employment Setting*

Stem (example): Please identify the type of setting that most closely corresponds to your nursing practice position.

Response Categories: Hospital, Nursing Home/Extended Care, Assisted Living Facility, Home Health Hospice, Correctional Facility, School of Nursing, Public Health, Dialysis Center, Community Health, School Health Service, Occupational Health, Ambulatory Care Setting, Insurance Claims/Benefits, Policy/Planning/Regulatory/Licensing Agency, Other (Please specify) _

Variable 19: Employment Position*

Stem (example): Please identify the position title that most closely corresponds to your nursing practice position.

Response Categories: Consultant, Nurse Researcher, Nurse Executive, Nurse Manager, Nurse Faculty/Educator, Advanced Practice Registered, Nurse Staff Nurse, Case Manager, Other-Health Related (Please specify), Other-Not Health Related (Please specify)

Variable 20: Employment Specialty*

Stem (example): Please identify the employment specialty that most closely corresponds to your nursing practice position.

Response Categories: Acute care/Critical Care, Adult Health, Family Health, Anesthesia, Cardiology, Community, Geriatric/Gerontology, Home Health, Maternal-Child Health/Obstetrics, Medical Surgical, Nephrology, Occupational health, Oncology, Palliative Care/Hospice, Pediatrics, Neonatal, Perioperative, Public Health, Psychiatric/Mental Health/Substance Abuse, Rehabilitation, School Health, Emergency/Trauma, Women's Health, Other-Clinical specialties (Please specify), Other-Non-clinical specialties (Please specify)

*** The response options for these variables were derived from the response options to similar questions in HRSA's National Sample Survey of Registered Nurses. After discussion among work group members and Forum members who participated in the initial data summit, we felt that by collapsing some of the response options we would have a better opportunity of meeting our Minimum Data Set goals of capturing data that is already being collected instead of asking for an exhaustive and very detailed list of settings, positions, and specialties.**

Glossary of Operational Definitions

Active - a license that is up to date on all licensure and/or renewal requirements

Advanced Practice Registered Nurse - is a nurse who has obtained a license to practice as an APRN in one of the four APRN roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS), or certified nurse practitioner (CNP). 2

Certified Nurse Midwife (CNM) - provides a full range of primary health care services to women throughout the lifespan, including gynecologic care, family planning services, preconception care, prenatal and postpartum care, childbirth, and care of the newborn. The practice includes treating the male partner of their female clients for sexually transmitted disease and reproductive health. This care is pro-

vided in diverse settings, which may include home, hospital, birth center, and a variety of ambulatory care settings including private offices and community and public health clinics. 2

Certified Nurse Practitioner (CNP) - For the certified nurse practitioner (CNP), care along the wellness-illness continuum is a dynamic process in which direct primary and acute care is provided across settings. CNPs are members of the health delivery system, practicing autonomously in areas as diverse as family practice, pediatrics, internal medicine, geriatrics, and women's health care. CNPs are prepared to diagnose and treat patients with undifferentiated symptoms as well as those with established diagnoses. Both primary and acute care CNPs provide initial, ongoing, and comprehensive care, includes taking comprehensive histories, providing physical examinations and other health assessment and screening activities, and diagnosing, treating, and managing patients with acute and chronic illnesses and diseases. This includes ordering, performing, supervising, and interpreting laboratory and imaging studies; prescribing medication and durable medical equipment; and making appropriate referrals for patients and families. Clinical CNP care includes health promotion, disease prevention, health education, and counseling as well as the diagnosis and management of acute and chronic diseases. Certified nurse practitioners are prepared to practice as primary care CNPs and acute care CNPs, which have separate national consensus-based competencies and separate certification processes 2

Certified Registered Nurse Anesthetist (CRNA) - is prepared to provide the full spectrum of patients' anesthesia care and anesthesia-related care for individuals across the lifespan, whose health status may range from healthy through all recognized levels of acuity, including persons with immediate, severe, or life-threatening illnesses or injury. This care is provided in diverse settings, including hospital surgical suites and obstetrical delivery rooms; critical access hospitals, acute care; paint [pain] management centers, ambulatory surgical centers; and the offices of dentists, podiatrists, ophthalmologists, and plastic surgeons. 2

Clinical Nurse Specialist (CNS) - has a unique APRN role to integrate care across the continuum and through three spheres of influence: patient, nurse, system. The three spheres are overlapping and interrelated but each sphere possesses a distinctive focus. In each of the spheres of influence, the primary goal of the CNS is continuous improvement of patient outcomes and nursing care. Key elements of CNS practice are to create environments through mentoring and system changes that empower nurses to develop caring, evidence-based practices to alleviate patient distress, facilitate ethical decision-making, and respond to diversity. The CNS is responsible and accountable for diagnosis and treatment of health/illness states, disease management, health promotion, and prevention of illness and risk behaviors among individuals, families, groups, and communities. 2

Employed in nursing - A nurse who receives compensation for work that requires licensure and/or educational preparation as a nurse. 1

Full-time - An individual employed for a full work week as defined by the employer. 1

Highest level of education in nursing - the highest degree obtained in nursing

Highest level of education in other field - highest non-nursing degree obtained

Inactive (in regard to licensure) - A license that was not renewed or a license placed on inactive status at the request of the licensee. 1

LPN - (or LVN) Licensed Practical Nurse or Licensed Vocational Nurse - An individual who holds a current license to practice as a practical or vocational nurse in at least one jurisdiction of the United States. 1

Part-time - An individual employed less than full time or less than a full work week, as defined by the employer. 1

Per diem - an arrangement wherein a nurse is employed directly on an as needed basis and usually has no benefits.

Primary Position - The position at which you work the most hours during your regular work year.

RN - Registered Nurse (RN) An individual who holds a current license to practice within the scope of professional nursing in at least one jurisdiction of the United States. 1

Secondary Position - The position at which you work the second greatest number of hours during your regular work year.

Employment Setting - The setting in which nursing personnel provide nursing services 1 See examples below:

Hospital (Exclude nursing home units in hospitals but include all clinics and other services of the hospital)
Non-federal, short-term hospital (for example, acute care hospital) Non-federal, long-term hospital
Non-federal psychiatric hospital (for example, state mental hospital) Federal government hospital
Other type of hospital

Nursing Home/Extended Care Facility
Nursing home unit in hospital
Freestanding skilled nursing facility (nursing home)
Facility for people with intellectual disabilities
Other type of extended care facility

Home Health
Health care provided in the patient's home

Hospice
In-home and facility based hospice care

Correctional Facility
Jail or prisons

School of Nursing
LPN/LVN program
Diploma program (RN)
Associate degree program (RN)
Baccalaureate and/or higher degree nursing program (RN)
Other

Public Health
Official state health department
Official state mental health agency
Official city or county health department

Community Health
Combination (official/voluntary) nursing service
Community mental health center
Community/neighborhood health center

Planned parenthood/family planning center
Day care center
Rural health center
Retirement community center

School Health Service
Board of education (public school system)
Private or parochial elementary or secondary school
College or university
Other

Occupational Health (Employee Health Service)
Private industry
Government
Other

Ambulatory Care Setting Employee (e.g., Physician/Dentist office)
Solo practice (physician)
Solo practice (nurse)
Partnership (one or more physicians)
Partnership (one or more nurses)
Group practice (physicians)
Group practice (nurses)
Partnership or group practice (mixed group of professionals)
Freestanding clinic (physicians)
Freestanding clinic (nurses)
Ambulatory surgical center (non-hospital-based)
Dental practice
Health Maintenance Organization (HMO)
Urgent care clinic

Dialysis Center
Free standing and hospital based

Insurance Claims/Benefits
Insurance Company

Policy/Planning/Regulatory/Licensing Agency
Central or regional office of Federal agency
State Board of Nursing
Health planning agency
Nurse Workforce Center

Other
Nursing or health professional membership association
Medical supplier (e.g., Drug Company, equipment, etc.)
Other

Employment position/position title - the position an individual holds at their place of employment

Advanced Practice Registered Nurse - is a nurse who has obtained a license to practice as an APRN in one of the four APRN roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS), or certified nurse practitioner (CNP). 2

Nurse Consultant - A professional who provides advice or expertise in the field of nursing regarding such issues as nursing education, nurse staffing, nurse policy, etc.

Nurse Researcher - An individual who conducts research in the field of nursing

Nurse Executive - involved with management and administration concerns. They provide leadership roles in the designing of care, the planning and developing of procedures and policies, and administration of budgets in hospitals, health clinics, nursing homes, and ambulatory care centers. 3

Nurse Manager - An individual who has line management position with 24-hour accountability for a designated patient care services which may include operational responsibility for patient care delivery, fiscal and quality outcomes. 1

Nurse Faculty/Educator - Nurse faculty are individuals employed by a school of nursing or other type of nursing education program and are generally involved in teaching, research and service. Nurse educators provide education to nurses and other healthcare professionals in non- academic settings such as hospitals

Staff Nurse - a nurse in direct patient care who is responsible for the treatment and well-being of patients

Case Manager - Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost-effective outcomes. 4

Employment Specialty - the specific area in which a nurse is specialized or practices

Acute care/Critical Care - acute care nurses provide care to patients with acute conditions. Critical care nurses deal specifically with human responses to life threatening problems. 8

Adult Health - nurses in this specialty provide general care for adult patients, including adult primary care, adult pathophysiology, clinical management of medication and treatments, patient assessment and education, patient referral, and planning adult health maintenance programs. 5

Anesthesia - nurses in this specialty provide anesthesia and anesthesia-related care upon request, assignment, or referral by the patient's physician or other healthcare provider authorized by law, most often to facilitate diagnostic, therapeutic, and surgical procedures. In other instances, the referral or request for consultation or assistance may be for management of pain associated with obstetrical labor and delivery, management of acute and chronic ventilatory problems, or management of acute and chronic pain through the performance of selected diagnostic and therapeutic blocks or other forms of pain management care to patients receiving anesthesia during operative procedures. 6

Cardiology - nurses in this specialty treat patients suffering from heart diseases and conditions 3

Community - is a systematic process of delivering nursing care to improve the health of an entire community (Nehls et al, 2001, pg. 305). It is a synthesis of nursing knowledge and practice and the science and practice of public health, implemented via systematic

use of the nursing process and other processes to promote health and prevent illness in population groups. (Community Health Nursing 2008, Clark, Pg. 5). 7

Family Health - nurses in this specialty meet the healthcare needs of the individual and family by providing comprehensive primary care through the lifespan 9

Geriatric/Gerontology - nurses in this specialty provide the special care needed in rehabilitating and maintaining the mental and physical health of the elderly. 3

Home Health - nurses in this specialty provide care for people in their homes, such as those recovering from illness, an accident, or childbirth 3

Maternal-Child Health/Obstetrics - nurses in this specialty provide medical and surgical treatment to pregnant women and to mother and baby following delivery

Medical/Surgical - nurses in this specialty provide diagnostic and therapeutic services to acutely ill patients for a variety of medical conditions, both surgical and non-surgical

Occupational health - nurses in this specialty provide on-the-job health care for the nation's workforce, striving to ensure workers' health, safety, and productivity 3

Oncology - nurses in this specialty provide care and support for patients diagnosed with cancer. 3

Palliative Care/Hospice - Palliative care is patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information and choice. Hospice care focuses on caring, not curing.

Hospice care manages patient's pain and symptoms, provides emotional, psychosocial, and spiritual support to patients and families during end of life care. 10

Pediatrics - nurses in this specialty provide care and treatment to young patients ranging in age from infancy to late teens

Neonatal - provide care and support for very sick or premature newborn babies 3

Perioperative - perioperative nurses are registered nurses (RNs) who work in hospital surgical departments, day-surgery units (also called ambulatory surgery units), clinics, and physicians' offices. They help plan, implement, and evaluate treatment of the surgical patient before, during, and after operation. Perioperative nurses may work closely with the patient, family members, and other health care professionals. 11

Public Health - the practice of promoting and protecting the health of populations using knowledge from nursing, social, and public health sciences. Public health nursing practice focuses on population health, with the goal of promoting health, and preventing disease and disability 12

Psychiatric/Mental Health/Substance Abuse - nurses in this specialty aid and support the mental health of patients with acute or chronic psychiatric needs.; pain management nurses who help regulate medications and provide care for those addicted to drugs or alcohol, or who are suffering from other types of substance abuse. 3

Rehabilitation - nurses in this specialty provide physical and emotional support to patients and the families of patients with illnesses or disabilities that affect their ability to function normally and that may alter their lifestyle. 3

School Health - nurses in this specialty are dedicated to promoting the health and well being of children of all ages in an academic environment. 3

Trauma - nurses in this specialty provide emergency care to patients of all ages. These nurses work to maintain vital signs and prevent complications and death. 3

Women's Health - nurses in this specialty provided care for women across the life cycle with emphasis on conditions that are particular to women

1 Source: "Definitions" Interagency Collaborative on Nursing Statistics (ICONS) http://www.iconsdata.org/definitions.htm

2 Source: "Consensus Model for APRN Regulation" National Council of State Boards of Nursing

3 Source: "Nursing Careers" Discover Nursing. http://www.discovernursing.com/nursing-careers

4 Source: "Standards of Practice for Case Management" Case Management Society of America

5 Source: National Center for Education Statistics http://nces.ed.gov/ipeds/cipcode/cipdetail.aspx?y=55&cipid=88816

6 Source: "CRNA Scope of Practice" American Nurses Association. http://www.aana.com/aboutus/Documents/scopeofpractice.pdf

7 Source: Community Health Nursing: Advocacy for Population health - Mary Jo Clark. http://www.cmsa.org/portals/0/pdf/memberonly/standardsofpractice.pdf

8 Source: American Association of Critical-Care Nurses - About Critical Care Nursing http://www.aacn.org/wd/publishing/content/pressroom/aboutcriticalcarenursing.pcms?menu=

9 Source: University of California San Francisco http://nursing.ucsf.edu/about/departments/family-health-care-nursing

10 Source: National Hospice and Palliative Care Organization definitions of Hospice and Palliative care. http://www.nhpco.org/palliative-care-4 http://www.nhpco.org/about/hospice-care

11 Source: "AORN" Association of perioperative Registered Nurses. http://www.aorn.org/Career_Center/Explore_Careers/Consider_a_Career_in_the_OR.aspx

12 Source: What is PHN? - Association of Public Health Nurses http://phnurse.org/What-is-Public-Health

13 Source: American Nurses Association, Public Health Nursing Scope and Standards of Practice, 2007

Reasons Supporting Proposal: The rule will allow a mechanism for the commission to obtain uniform, complete, accurate and current information to provide to the Washington Center for Nursing (WCN), the designated central nursing resource center, for analysis, monitoring and trend validation to fulfill their statutory requirements. In turn, the commission intends to use the WCN information as the basis for strategic decisions regarding the need for changes in nursing

education and training, diversity, mobility, leadership and work environment policies.

Statutory Authority for Adoption: RCW 18.79.110, 18.79.160, 18.79.202.

Statute Being Implemented: RCW 18.79.110, 18.79.160, 18.79.202.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Nursing care quality assurance commission, governmental.

Name of Agency Personnel Responsible for Drafting: Carole Reynolds, 111 Israel Road S.E., Tumwater, WA, (360) 236-4785; Implementation and Enforcement: Teresa Corrado, 111 Israel Road S.E., Tumwater, WA, (360) 236-4708.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The proposed rule would not impose more than minor costs on businesses in an industry.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Carole Reynolds, Washington State Nursing Commission, P.O. Box 47864, Olympia, WA 98504-7864, phone (360) 236-4785, fax (360) 236-4738, email Carole.Reynolds@doh.wa.gov.

July 28, 2017
Paula R. Meyer, MSN, RN, FRE
Executive Director
Nursing Care Quality Assurance Commission

NEW SECTION

WAC 246-840-015 Requirement to submit demographic data. Collecting and supplying demographic data for the nursing profession in Washington state is essential to answering the fundamental questions on supply, demand, and distribution of the nursing workforce.

(1) Applicants and licensees must complete all demographic data elements and attest to the completion of the data elements as part of their licensure requirements for:

(a) Licensed practical nurse as defined under WAC 246-840-010(22); or

(b) Registered nurse as defined under WAC 246-840-010(33).

(2) Advanced practice nurses do not have to complete additional demographic data. The demographic data is collected on their RN license.

(3) The commission shall verify compliance with this section during the continued competency audit process in WAC 246-840-230.

WSR 17-16-138
PROPOSED RULES
SUPERINTENDENT OF PUBLIC INSTRUCTION

[Filed August 1, 2017, 10:07 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 16-18-093.

Title of Rule and Other Identifying Information: Chapter 392-725 WAC, College in the high school rules; and WAC 392-725-235 Co-delivery of college in the high school courses.

Hearing Location(s): Office of Superintendent of Public Instruction (OSPI), Old Capitol Building, 600 South Washington Street, Olympia, WA 98501, on September 5, 2017, at 1:00 p.m.

Date of Intended Adoption: September 8, 2017.

Submit Written Comments to: Kim Reykdal, OSPI, P.O. Box 47200, Olympia, WA 98504-7200, email Kim.Reykdal@k12.wa.us, fax (360) 664-3683, by September 5, 2017.

Assistance for Persons with Disabilities: Contact Kristin Murphy by August 29, 2017, TTY (360) 664-3631 or (360) 725-6133.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose of these proposed rules is to implement section 3 of E2SHB 1546 (2015), which authorizes OSPI to adopt rules administering Washington's college in the high school program. The rules were jointly developed by OSPI, the state board of community and technical colleges, the student achievement council, and public baccalaureate institutions. The Association of Washington School Principals and Council of Presidents was consulted during the rules development.

Working with these agencies, including the Council of Presidents representing the public baccalaureate institutions, OSPI convened a workgroup that reviewed and jointly developed rules that, among other things, would remove OSPI from its current role overseeing the high school standards report review committee and provide for co-delivery of college in the high school courses with other dual credit programs.

Reasons Supporting Proposal: The workgroup members anticipate that these proposed rules will provide clarity to school districts regarding how to enroll students and transcribe courses that incorporate more than one dual credit option.

Statutory Authority for Adoption: RCW 28A.600.290.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: OSPI.

Name of Agency Personnel Responsible for Drafting: Kim Reykdal and Barbara Dittrich, Old Capitol Building, 600 South Washington Street, Olympia, WA, (360) 725-6168/725-6097; Implementation: Dixie Grunenfelder, Old Capitol Building, 600 South Washington Street, Olympia, WA, (360) 725-0415; and Enforcement: Tennille Jeffries-Simmons, Old Capitol Building, 600 South Washington Street, Olympia, WA, (360) 725-6380.

No small business economic impact statement has been prepared under chapter 19.85 RCW. Not applicable - no small business impact nor school district fiscal impact.

A cost-benefit analysis is not required under RCW 34.05.328. OSPI is not subject to RCW 34.05.328 per subsection (5)(a)(i). Additionally, this rule is not a significant legislative rule per subsection (5)(c)(iii).

July 28, 2017
Chris P. S. Reykdal
State Superintendent
of Public Instruction

AMENDATORY SECTION (Amending WSR 16-14-030, filed 6/27/16, effective 7/28/16)

WAC 392-725-015 Definitions. The following definitions in this section apply throughout this chapter.

(1) **"College in the high school course"** means a dual credit course provided on a high school campus or in a high school environment in which an eligible student is given the opportunity to earn high school credit to be awarded by a district, charter school, or tribal compact school and college credit awarded by the participating institution of higher education by completing a college level course with a passing grade. College in the high school courses may be either academic or career and technical (vocational) education.

(2) **"Eligible student"** means any student who meets the following conditions:

(a) The student meets the definition of an enrolled student pursuant to WAC 392-121-106.

(b) The student under the grade placement policies of the district, charter school, or tribal compact school through which the high school credits will be awarded has been deemed to be a tenth, eleventh, or twelfth grade student.

(c) The student has met the student standards pursuant to WAC 392-725-130 and the general requirements and conditions pursuant to WAC 392-725-225(2).

(3) **"Participating institution of higher education"** means an institution of higher education that:

(a) A district, charter school, or tribal compact school has contracted with to provide the college in the high school courses;

(b) Meets the definition in RCW 28B.10.016, is authorized or exempt under the requirements of chapter 28B.85 RCW, or is a public tribal college located in Washington as noted in RCW 28A.600.290 (7)(a);

(c) Meets the college in the high school program standards outlined in WAC 392-725-130 through 392-725-150; and

(d) Is accredited by National Alliance of Concurrent Enrollment Partnerships or commits to the annual reporting of evidence requirement outlined in WAC 392-725-120.

(4) **"National Alliance of Concurrent Enrollment Partnerships"** is the professional organization that works to ensure that college in the high school courses are as rigorous as courses offered on the sponsoring college campuses. National Alliance of Concurrent Enrollment Partnerships has defined a set of quality standards that is the basis of their accreditation process.

(5) **"Council of presidents"** is defined throughout this chapter as the organization representing the interest of public baccalaureate institutions, specific to RCW 28A.600.290(6).

(6) **"Provisional status"** is the status that a college in the high school program may be assigned after the program's evidence of meeting the standards submitted in the annual report was found to be unsatisfactory by the review committee. A program is in provisional status up to six months after the review of the annual report.

(7) **"Fees."**

(a) **"College in the high school fees"** means the per credit fee charged by the participating institution of higher education for the registration for the college course.

(i) The maximum dual credit fee shall not exceed the college in the high school state-funded subsidies allocated in the current Omnibus Appropriations Act.

(ii) The dual credit fee may be less than the college in the high school state-funded subsidies allocation.

(iii) The institution of higher education must receive the corresponding fee for any student seeking to earn college credit from the college in the high school course in accordance with the general requirements identified in WAC 392-725-225 (2)(a) unless the student qualifies for the state-funded subsidies in accordance with WAC 392-725-325(4).

(b) **"Other associated college in the high school fees"** means additional fees required to fully participate in the college in the high school course charged by the participating institution of higher education such as registration fees and fees for consumables.

(8) **"College in the high school state-funded subsidies"** means the amount provided in the Omnibus Appropriations Act that pays the dual credit fee for specific eligible eleventh or twelfth grade students pursuant to RCW 28A.600.290 (1)(b)(i) only and for the limited amount provided in WAC 392-725-325(2).

AMENDATORY SECTION (Amending WSR 16-14-030, filed 6/27/16, effective 7/28/16)

WAC 392-725-120 Demonstration and reporting of evidence of required college in the high school standards. (1) Participating institutions of higher education shall provide evidence that they meet the most recent National Alliance of Concurrent Enrollment Partnerships student standards, curriculum and assessment standards, faculty standards and evaluation standards unless recommended differently in WAC 392-725-130 through 392-725-160. National Alliance of Concurrent Enrollment Partnerships accreditation is recommended.

(2) As a condition of eligibility pursuant to WAC 392-725-015(3), after the college in the high school course concludes, institutions of higher education shall provide an annual report consisting of evidence that the required standards were met, consistent with the evidence National Alliance of Concurrent Enrollment Partnerships requires to meet standards. The annual report shall be submitted no later than July 1st for review by the college in the high school standards report review committee. Participating institutions of higher education that are accredited by the National Alliance of Concurrent Enrollment Partnerships for the current year of enrollment will be exempt from this requirement.

(3) The ((~~office of superintendent of public instruction~~)) Washington student achievement council shall ((~~convene~~)) be the convener of a college in the high school standards report review committee. This review committee will consist of a representative ((~~of~~)) from the state board of community and technical colleges, ((~~a representative of~~)) the council of

presidents, ((~~a representative of~~)) and the student achievement council((~~, and a representative from the office of superintendent of public instruction~~)). Additional members may be included at the discretion of college in the high school standards report review committee.

(4) The review committee will no later than August 15th advise the institution of higher education whether the required standards have been met.

(5) If the review committee finds that the institution of higher education's evidence of meeting the required standards is not satisfactory, the institution of higher education will have no more than six months to make any necessary reporting corrections and/or program adjustments to provide satisfactory evidence. During this period, the program will be under provisional status until evidence shows the program has met the standards or the program is made ineligible.

(6) If after review of the additional evidence, the review committee deems that the standards ((~~are~~)) were not ((~~being~~)) met, then the institution of higher education is ineligible and may not offer the college in the high school program ((~~for~~)) starting with the following ((~~school year~~)) fall term. To regain eligibility, the institution of higher education must, by July 1, submit an updated plan for how the standards will be met.

(7) If the institution of higher education is deemed ineligible, the institution of higher education can appeal to a three person appeals committee convened by the student achievement council, and including representatives from the student achievement council, state board of community and technical colleges and council of presidents. The original review committee members would be excluded from the appellate process.

(8) The review committee will review the National Alliance of Concurrent Enrollment Partnerships standards beginning in 2019 and every three years thereafter, and update the college in the high school standards in WAC 392-725-130 through 392-725-160 as informed by the current National Alliance of Concurrent Enrollment Partnerships standards and feedback from participating school districts, charter schools, tribal compact schools, and institutions of higher education.

AMENDATORY SECTION (Amending WSR 16-14-030, filed 6/27/16, effective 7/28/16)

WAC 392-725-200 Prior confirmation of high school credit. As a condition to an eligible student's enrollment in college courses, the eligibility of the college in the high school courses which the student intends to take for the award of high school credit and the amount of such credit shall first be established, as follows:

(1) The district, charter school, or tribal compact school shall establish on a course by course basis the amount of high school required or elective credit, or combination thereof, that shall be awarded for each college in the high school course successfully completed by the student based upon the conversion rate set forth in WAC 180-51-050.

(2) If a college in the high school course is not comparable to a district, charter school, or tribal compact school course required for high school graduation, the district, charter school, or tribal compact school superintendent shall determine the amount of required high school credit which shall be awarded following consultation with a representative of the institution of higher education designated for that purpose. The difference between the amount of ((~~required~~)) credit required and the amount of credit earned at the conversion rate set forth in WAC 180-51-050 shall be awarded as elective credit.

(3) Within five school days of a student's request for confirmation of credit, the district, charter school, or tribal compact school superintendent or other designated representative shall confirm in writing the amount of high school required or elective credit, or combination thereof, which shall be awarded upon successful completion of the courses.

(4) Upon confirmation by the college in the high school instructor of a student's successful completion of a college in the high school course under this chapter, the district, charter school, or tribal compact school shall record on the student's secondary school records and transcript the high school credit previously confirmed under the section with a notation that the courses were taken at an institution of higher education pursuant to WAC 392-415-070.

(5) Each district, charter school, or tribal compact school and institution of higher education shall independently have and exercise exclusive jurisdiction over academic and discipline matters involving a student's enrollment and participation in courses of, and the receipt of services and benefits from the district, charter school, tribal compact school or the institution of higher education.

AMENDATORY SECTION (Amending WSR 16-14-030, filed 6/27/16, effective 7/28/16)

WAC 392-725-225 College in the high school general requirements. (1) Participating districts, charter schools, or tribal compact schools must provide general information about the college in the high school program to all students in grades nine through twelve and to the parents and guardians of those students.

(2) The enrollment of a student who meets the definition of WAC 392-725-015(2) in the college in the high school program shall be governed as follows:

(a) An eligible student seeking to earn college credit is responsible for enrolling into an institution of higher education on or before the deadline established by the institution of higher education.

(b) An eligible student is entitled to enroll in an institution of higher education for college in the high school program purposes subject to each of the following conditions and limitations:

(i) Enrollment is limited to college level courses.

(ii) Prior confirmation pursuant to WAC 392-725-200 by the district, charter school, or tribal compact school of the amount of high school credit to be awarded for a college in the high school course on or before the deadline for enrollment established by the institution of higher education.

(iii) Acceptance of the student by the institution of higher education subject to enrollment requirements and limitations established by the institution((~~, including a determi-~~

~~nation that the student is competent to profit from the college level course(s) in which the student seeks to enroll~~)).

NEW SECTION

WAC 392-725-235 Co-delivery of college in the high school courses. (1) In cases where a college in the high school course is co-delivered with another dual credit course, such as advanced placement, international baccalaureate, or Cambridge international, the participating institution of higher education, in coordination with the institution's academic department, shall assess curriculum alignment and approve the option to provide a co-delivered course.

(2) In cases where a college in the high school course is co-delivered with another dual credit course, the high school transcript shall reflect the co-delivered courses as follows:

(a) The course title as listed on the high school transcript shall begin with the institute of higher education's curriculum and course number, as described in the office of superintendent of public instruction CEDARS manual.

(b) Any additional course title description for a co-delivered college in the high school course title shall be included pursuant to WAC 392-415-070.

Official course abbreviations for advanced placement, international baccalaureate and Cambridge international shall be included on the high school transcript as listed in appendix Q of the office of superintendent of public instruction CEDARS manual.

(c) For approved co-delivered courses, as provided in subsection (1) of this section, the high school transcript course title and course designators may reflect two dual credit programs in cases where students have met any required prerequisites or other entrance requirements for both programs.

(3) Students choosing to enroll in a co-delivered college in the high school course for the purpose of earning college credit must meet the college in the high school enrollment requirements outlined in WAC 392-725-225(2).

AMENDATORY SECTION (Amending WSR 16-14-030, filed 6/27/16, effective 7/28/16)

WAC 392-725-325 College in the high school state funded subsidies. Pursuant to RCW 28A.600.290 and subject to the amount ((~~provided~~)) appropriated for such purposes in the Omnibus Appropriations Act, state funded subsidies may be available to pay the cost of college in the high school fees for specific eligible eleventh or twelfth grade students only enrolled in college in the high school courses provided by institutions of higher education that meet the definition in RCW 28B.10.016, or a public tribal college located in Washington as noted in RCW 28A.600.290 (7)(a), and for the limited amount provided in subsection (2) of this section. Public institutions of higher education that are outside of the state of Washington or private institutions of higher education do not qualify for the state funded subsidies.

(1) Prioritization of the available college in the high school state-funded subsidies will be allocated in the following method:

(a) High schools that are and students that reside twenty driving miles or more as measured by the most direct route from the nearest institution of higher education offering running start.

(b) High schools who receive small high school funding enhancement as provided in the Omnibus Appropriations Act.

(c) For the remaining high schools, eligible students who qualify for the new school year for free and reduced price lunch.

(2) Limitation of college in the high school state-funded subsidies are as follows:

(a) For each eligible eleventh and twelfth grade student, the annual credit amounts for subsection (1)(a) through (b) of this section are limited to the annual credit amounts provided in the Omnibus Appropriations Act but may not exceed ten credits for any school year.

(b) The annual credit amounts for subsection (1)(c) of this section are limited to the annual credit amounts provided in the Omnibus Appropriations Act but may not exceed five credits for any school year.

(3) The office of superintendent of public instruction will provide an application process that districts, charter schools, and tribal compact schools will use to apply annually for the college in the high school state-funded subsidies.

(a) Districts, charter schools, and tribal compact schools will apply by July 1st for the new school year's subsidies.

(b) The office of superintendent of public instruction will notify districts, charter schools, and tribal compact schools by September 1st the amount of subsidies awarded for the new school year.

(c) Through the application process, districts, charter schools, and tribal compact schools will provide a list of college in the high school courses per high school for the new school year. The award of subsidies will be limited to the courses provided in the application process.

(d) The list of college in the high school courses will contain the amount of college quarter credits awarded for each course. For this section only, college semester credits will be converted into quarter credits by multiplying the semester credits by 1.5 and rounding up to the nearest whole credit.

(e) Districts, charter schools, and tribal compact schools will provide an estimate of eligible students expected to receive the subsidies within the per student credit limitation provided in the Omnibus Appropriations Act.

(i) For high schools that qualify for the priorities according to subsection (1)(a) and (b) of this section, applicant will provide an estimate of eligible eleventh and twelfth grade students.

(ii) For high schools that qualify for the priorities according to subsection (1)(b) and (c) of this section, applicant will provide an estimate of eligible eleventh and twelfth grade students that live more than twenty miles from a college offering running start.

(iii) For high schools that qualify for subsection (1)(c) of this section, applicant will provide an estimate of eligible eleventh and twelfth grade students that are expected to qualify for free and reduced price lunch.

(4) Reimbursement of the college in the high school state-funded subsidies will occur as follows:

(a) Beginning with the 2015-16 school year, the college in the high school state-funded subsidies for college in the high school will be allocated at minimum sixty-five dollars per quarter credits.

(b) Starting with the 2017 calendar year, and for every four years after, the funding level for the college in the high school state-funded subsidies will be reviewed by the office of superintendent of public instruction, the student achievement council, the state board for community and technical colleges, and the council of presidents representing the public baccalaureate institutions and make recommendation to the legislature for an increase to the funding level of the college in the high school state funded subsidies.

(c) The college in the high school state-funded subsidies will be paid after the completion of the course.

(d) Districts, charter schools, and tribal compact schools with high schools eligible for the college in the high school state-funded subsidies will submit a request for payment of subsidies form to the office of the superintendent of public instruction. The request for payment will include the actual number of completed credits for eligible eleventh and twelfth grade students who have not exceeded the credit limitation pursuant to subsection (2) of this section.

(e) The office of the superintendent of public instruction will review the request for payment of subsidies form and fund the reporting district, charter school, and tribal compact school one hundred percent of the approved college in the high school subsidies on the following monthly apportionment payment.

(f) One hundred percent of the subsidies generated will be forwarded to the participating institution of higher education that provided the college in the high school program.

WSR 17-16-140
PROPOSED RULES
BOARD OF PILOTAGE COMMISSIONERS

[Filed August 1, 2017, 10:37 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 17-11-125.

Title of Rule and Other Identifying Information: WAC 363-116-301 New revenue collection.

Hearing Location(s): 2901 Third Avenue, 1st Floor, Agate Conference Room, Seattle, WA 98121, on September 21, 2017, at 10:00 a.m.

Date of Intended Adoption: September 21, 2017.

Submit Written Comments to: Sheri J. Tonn, Chair, 2901 Third Avenue, Suite 500, Seattle, WA 98121, email BeverJ@wsdot.wa.gov, fax (206) 515-3906, by September 18, 2017.

Assistance for Persons with Disabilities: Contact Shawna Erickson by September 18, 2017, (206) 515-3647.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose of this filing is to comply with legislative intent, through the passage of ESB 5096, by establishing new WAC 363-116-301 New revenue collection. ESB 5096 stipulates certain conditions in order for the board to receive a transfer of funds from the state multimodal transportation account solely for self-insurance liability premium expenditures. The new WAC outlines those conditions and directives.

Reasons Supporting Proposal: Putting the mechanisms in place to collect the revenue needed to pay the self-insurance liability premium expenditures is necessary in order for the board to show compliance with legislative intent thus prompting the state to transfer the funds from the multimodal transportation account. Without the fund sources allocated by ESB 5069, the agency would be in financial crisis, putting the board's mission to ensure against the loss of lives, loss of or damage to property and vessels, and to protect the marine environment by maintaining efficient and competent pilotage services in jeopardy.

Statutory Authority for Adoption: Chapter 88.16 RCW.

Rule is necessary because of state court decision, *Katharine Sweeney vs. Board of Pilotage Commissioners* Cause Number 11-2-36792-4SEA in King County Superior Court and Joint Motion to Dismiss the Appeal in Cause No. 72664-1 in the Washington County of Appeals.

Agency Comments or Recommendations, if any, as to Statutory Language, Implementation, Enforcement, and Fiscal Matters: The board's self-insurance liability premium is comprised of monetary contributions from the Board of Pilotage Commissioners (BPC), Puget Sound Pilots and those vessels taking pilots in the Puget Sound pilotage district. This new rule enforces the collection of revenue from all participants.

Name of Proponent: BPC, governmental.

Name of Agency Personnel Responsible for Drafting and Implementation: Jaimie C. Bever, Seattle, Washington, (206) 515-3887; and Enforcement: BPC, Seattle, Washington, (206) 515-3904.

No small business economic impact statement has been prepared under chapter 19.85 RCW. This was a legislative mandate. The application of the proposed language is clear in the description of the proposal and its anticipated effects and as well as the WAC language shown below.

A cost-benefit analysis is not required under RCW 34.05.328. RCW 34.05.328 does not apply to the adoption of these rules. The Washington state BPC is not a listed agency in RCW 34.05.328 (5)(a)(i).

August 1, 2017
Jaimie C. Bever
Executive Director (Interim)

NEW SECTION

WAC 363-116-301 New revenue collection. With respect to the passage of Engrossed Senate Bill No. 5096 Section 108, the board of pilotage commissioners is appropriated one million one hundred thousand dollars from the multimodal transportation account solely for self-insurance liability premium expenditures. This appropriation is contingent upon three stipulated conditions:

(1) The Puget Sound pilots shall pay to the board, from its tariffs, one hundred fifty thousand dollars annually on July 1, 2017, and July 1, 2018. These amounts shall be deposited

by the board into the pilotage account and used solely for the expenditure of self-insurance premiums;

(2) The board shall maintain the Puget Sound pilotage district pilotage tariff at the rate which became effective on January 1, 2017; and

(3) A self-insurance premium surcharge of sixteen dollars shall be added to each Puget Sound pilotage assignment on all vessels requiring pilotage in the Puget Sound pilotage district. The Puget Sound pilots shall remit the total amount of such surcharges generated to the board by the tenth of each month. The surcharge shall be in effect from July 1, 2017, through June 30, 2019. These amounts shall be in addition to those fees to be paid to the board pursuant to subsection (1) of this section and shall be deposited by the board into the pilotage account solely for the expenditure of self-insurance premiums.

These three directives are in effect beginning May 18, 2017, through June 30, 2019.

WSR 17-16-143
PROPOSED RULES
DEPARTMENT OF HEALTH
(Dental Quality Assurance Commission)

[Filed August 1, 2017, 11:22 a.m.]

Original Notice.

Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1).

Title of Rule and Other Identifying Information: WAC 246-817-110, 246-817-155, 246-817-160, and 246-817-220 dental licensure rules. SHB 1411 (chapter 100, Laws of 2017) modified RCW 18.32.040 to allow completion of a qualifying Washington state dental residency to qualify an applicant for dental licensure by residency in lieu of practical examination.

Hearing Location(s): Department of Health, Point Plaza East, Room 152/153, 310 Israel Road S.E., Tumwater, WA 98501, on October 27, 2017, at 8:05 a.m.

Date of Intended Adoption: October 27, 2017.

Submit Written Comments to: Jennifer Santiago, P.O. Box 47852, Olympia, WA 98504, email https://fortress.wa.gov/doh/policyreview, fax (360) 236-2901, by October 23, 2017.

Assistance for Persons with Disabilities: Contact Jennifer Santiago by October 23, 2017, TTY (800) 833-6388 or 711.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: SHB 1411 (chapter 100, Laws of 2017) modified RCW 18.32.040 regarding dental licensure by residency in lieu of practical examination. The proposed rule amendment deletes reference to approved by or administered by the direction of dental quality assurance commission (DQAC) in WAC 246-817-110, 246-817-160, and 246-817-220. The proposed rule amendments update dentist licensure eligibility [to] obtain a dentist license through residency in lieu of examination. The repeal of WAC 246-817-155 is proposed as the rule is no longer necessary.

Reasons Supporting Proposal: The rules amendments are necessary to implement SHB 1411. SHB 1411 (chapter 100, Laws of 2017) modifies RCW 18.32.040 (3)(c) to allow any ADA accredited general practice residency, advanced education in general practice residency, and pediatric residency graduates to be eligible for license [licensure] by residency in lieu of clinical examination. The residency must be at least one year in length and must be in a setting that serves predominantly low-income patients in Washington state.

Statutory Authority for Adoption: RCW 18.32.002 and 18.32.0365.

Statute Being Implemented: RCW 18.32.040.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: DQAC, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Jennifer Santiago, 111 Israel Road S.E., Tumwater, WA 98501, (360) 236-4893.

No small business economic impact statement has been prepared under chapter 19.85 RCW. Under RCW 19.85.025 and 34.05.310 (4)(c), a small business economic impact statement is not required for proposed rules adopting or incorporating by reference, without material change, federal statutes or regulations, Washington state statutes, rules of other Washington state agencies, shoreline master programs other than those programs governing shorelines of statewide significance, or, as referenced by Washington state law, national consensus codes that generally establish industry standards, if the material adopted or incorporated regulates the same subject matter and conduct as the adopting or incorporating rule.

A cost-benefit analysis is not required under RCW 34.05.328. The agency did not complete a cost-benefit analysis under RCW 34.05.328. RCW 34.05.328 (5)(b)(iii) exempts rules adopting or incorporating by reference, without material change, federal statutes or regulations, Washington state statutes, rules of other Washington state agencies, shoreline master programs other than those programs governing shorelines of statewide significance, or, as referenced by Washington state law, national consensus codes that generally establish industry standards, if the material adopted or incorporated regulates the same subject matter and conduct as the adopting or incorporating rule.

August 1, 2017
John Carbery, DMD, Chairperson
Dental Quality Assurance Commission

AMENDATORY SECTION (Amending WSR 16-05-083, filed 2/16/16, effective 3/18/16)

WAC 246-817-110 Dental licensure—Initial eligibility and application requirements. To be eligible for Washington state dental licensure, the applicant must provide:

(1) A completed application and fee. The applicant must submit a signed application and required fee as defined in WAC 246-817-990;

(2) Proof of graduation from a dental school approved by the DQAC:

(a) DQAC recognizes only those applicants who are students or graduates of dental schools in the United States or

Canada, approved, conditionally or provisionally, by the Commission on Dental Accreditation of the American Dental Association. The applicant must have received, or will receive, a Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) degree from that school;

(b) Other dental schools which apply for DQAC approval and which meet these adopted standards to the DQAC's satisfaction may be approved, but it is the responsibility of a school to apply for approval and of a student to ascertain whether or not a school has been approved;

(3) Proof of successful completion of the National Board Dental Examination Parts I and II, or the Canadian National Dental Examining Board Examination. An original scorecard or a certified copy of the scorecard shall be accepted. Exception: Dentists who obtained initial licensure in a state prior to that state's requirement for successful completion of the national boards, may be licensed in Washington, provided that the applicant provide proof that their original state of licensure did not require passage of the national boards at the time they were initially licensed. Applicants need to meet all other requirements for licensure;

(4) Proof of graduation from an approved dental school. The only acceptable proof is an official, posted transcript sent directly from such school, or in the case of recent graduates, a verified list of graduating students submitted directly from the dean of the dental school. Graduates of nonaccredited dental schools must also meet the requirements outlined in WAC 246-817-160;

(5) A complete listing of professional education and experience including college or university (predental), and a complete chronology of practice history from the date of dental school graduation to present, whether or not engaged in activities related to dentistry;

(6) Proof of completion of seven clock hours of AIDS education as required in chapter 246-12 WAC, Part 8;

(7) Proof of malpractice insurance if available, including dates of coverage and any claims history;

(8) Written certification of any licenses held, submitted directly from another licensing entity, and including license number, issue date, expiration date and whether applicant has been the subject of final or pending disciplinary action;

(9) Proof of successful completion of ((~~an approved~~)):

(a) An approved practical/clinical examination under WAC 246-817-120; or

(b) A qualifying ((~~postgraduate~~)) residency program((~~, approved by or administered under the direction of the DQAC~~)) under RCW 18.32.040 (3)(c);

(10) Proof of successful completion of an approved written jurisprudence examination;

(11) A recent 2" x 2" photograph, signed, dated, and attached to the application;

(12) Authorization for background inquiries to other sources may be conducted as determined by the DQAC, including but not limited to the national practitioner data bank and drug enforcement agency. Applicants are responsible for any fees incurred in obtaining verification of requirements;

(13) Any other information for each license type as determined by the DQAC.

AMENDATORY SECTION (Amending WSR 16-17-104, filed 8/19/16, effective 9/19/16)

WAC 246-817-160 Graduates of nonaccredited schools. (1) An applicant for Washington state dental licensure, who is a graduate of a dental school or college not accredited by the Commission on Dental Accreditation shall provide to the Dental Quality Assurance Commission (commission):

(a) Materials listed in WAC 246-817-110 (1), (3), (5) through (8), and (10) through (13);

(b) Official school transcript or diploma with dental degree listed transcribed to English if necessary;

(c) Evidence of successful completion of at least two additional predoctoral or postdoctoral academic years of dental education.

(i) Additional predoctoral or postdoctoral dental education completed prior to July 1, 2018, must be obtained at a dental school in the United States or Canada, approved, conditionally or provisionally, by the Commission on Dental Accreditation.

(ii) Additional predoctoral or postdoctoral dental education completed after July 1, 2018, must be obtained in a dental program in the United States or Canada, approved, conditionally or provisionally, by the Commission on Dental Accreditation and include clinical training; and

(d) An applicant for Washington state dental licensure must provide proof of successful completion of ((~~an approved~~)):

(i) An approved practical/clinical examination under WAC 246-817-120; or

(ii) A qualifying ((~~postgraduate~~)) residency program((~~, approved by or administered under the direction of the commission authorized in~~)) under RCW 18.32.040 (3)(c).

(2) Upon completion of the requirements in subsection (1)(a) through (c) of this section, an applicant may be eligible to take the practical examination as approved in WAC 246-817-120 (2) through (4).

(a) The commission may issue examination approval up to six months before an applicant has completed the two additional predoctoral or postdoctoral academic years of dental education.

(b) An applicant must provide a letter from the school where the two additional predoctoral or postdoctoral academic years is being obtained indicating expected date of education completion.

AMENDATORY SECTION (Amending WSR 11-07-052, filed 3/17/11, effective 4/17/11)

WAC 246-817-220 Inactive license. (1) A dentist may obtain an inactive license by meeting the requirements of WAC 246-12-090 and RCW 18.32.185.

(2) An inactive license must be renewed every year on or before the practitioner's birthday according to WAC 246-12-100 and 246-817-990.

(3) If a license is inactive for three years or less, to return to active status a dentist must meet the requirements of WAC 246-12-110, 246-817-440, and 246-817-990.

(4) If a license is inactive for more than three years, and the dentist has been actively practicing in another United States jurisdiction, to return to active status the dentist must:

(a) Provide certification of an active dentist license, submitted directly from another licensing entity. The certification shall include the license number, issue date, expiration date and whether the applicant has been the subject of final or pending disciplinary action;

(b) Provide verification of active practice in another United States jurisdiction within the last three years; and

(c) Meet the requirements of WAC 246-12-110, 246-817-440, and 246-817-990.

(5) If a license is inactive for more than three years, and the dentist has not been actively practicing in another United States jurisdiction, to return to active status the dentist must provide:

(a) A written request to change licensure status;

(b) The applicable fees according to WAC 246-817-990;

(c) Proof of successful completion of ((~~an approved~~)):

(i) An approved practical/practice examination ((~~according to~~)) under WAC 246-817-120; or

(ii) A qualifying ((~~postgraduate~~)) residency program((~~, approved by or administered under the direction of the DQAC~~)) under RCW 18.32.040 (3)(c);

(d) Written certification of all dental or health care licenses held, submitted directly from the licensing entity. The certification shall include the license number, issue date, expiration date and whether the applicant has been the subject of final or pending disciplinary action;

(e) Written declaration that continuing education and competency requirements for the two most recent years have been met according to WAC 246-817-440;

(f) Proof of successful completion of an approved written jurisprudence examination within the past year;

(g) Proof of malpractice insurance if available, including dates of coverage and any claims history; and

(h) Proof of AIDS education according to WAC 246-817-110, if not previously provided.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 246-817-155	Dental resident license to full dental license—Conditions.

WSR 17-16-158
PROPOSED RULES
OFFICE OF INSURANCE COMMISSIONER

[Insurance Commissioner Matter No. R 2017-01—Filed August 1, 2017, 4:29 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 17-02-062.

Title of Rule and Other Identifying Information: Creating a safe harbor for the use of the federal model privacy form.

Hearing Location(s): Office of the Insurance Commissioner, 302 Sid Snyder Avenue S.W., Suite 200, Olympia, WA 98504, on September 5, 2017, at 1:00 p.m.

Date of Intended Adoption: September 5, 2017.

Submit Written Comments to: Jim Freeburg, P.O. Box 40258, Olympia, WA 98504, email rulescoordinator@oic.wa.gov, fax (360) 586-3109, by September 5, 2017.

Assistance for Persons with Disabilities: Contact Lorie Villaflores by September 1, 2017, TTY (360) 586-0241 or (360) 725-7087.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The rules will create a safe harbor of compliance for insurers who use the federal model privacy form.

Reasons Supporting Proposal: The federal model privacy form is easier for consumers to understand than existing sample disclosures. Recent changes to NAIC model law on privacy notices encourages insurers to use the federal model privacy form by creating a safe harbor for its use.

Statutory Authority for Adoption: RCW 48.02.060, 48.43.505, Gramm-Leach-Bliley Act, Public Law 102-106, Sections 501(b), 503 (b)(2).

Statute Being Implemented: RCW 48.43.505, Financial Services Regulatory Relief Act of 2006, Public Law 109-351, Section 728.

Rule is necessary because of federal law, Financial Services Regulatory Relief Act of 2006, Public Law 109-351, Section 728.

Name of Proponent: Mike Kreidler, insurance commissioner, governmental.

Name of Agency Personnel Responsible for Drafting: Jim Freeburg, P.O. Box 40258, Olympia, WA 98504, (360) 725-7170; Implementation: John Haworth, P.O. Box 40255, Olympia, WA 98504, (360) 725-7223; and Enforcement: AnnaLisa Gellerman [Gellermann], P.O. Box 40255, Olympia, WA 98504, (360) 725-7037.

No small business economic impact statement has been prepared under chapter 19.85 RCW. This rule proposal, or portions of the proposal, is exempt under RCW 19.85.061 because this rule making is being adopted solely to conform and/or comply with federal statute or regulations. Citation: Financial Services Regulatory Relief Act of 2006, Public Law 109-351, Section 728 creates a federal model privacy form for use by financial companies (including insurers and insurance agents). If the state does not adopt the rule, insurers may lose the opportunity to be more efficient in giving privacy notices to their enrollees.

In addition, because the proposed rule allows but does not require use of the federal model privacy form it is permissive in nature and does not impose any costs on small businesses; it is therefore also exempt under the provisions of RCW 19.85.030.

A cost-benefit analysis is not required under RCW 34.05.328. Per RCW 34.05.328 (5)(b)(iii), the rules adopt federal regulations without material change. In addition the proposed rule is permissive in nature, allowing use of the new federal form but not requiring it.

August 1, 2017
Mike Kreidler
Insurance Commissioner

AMENDATORY SECTION (Amending WSR 01-03-034, filed 1/9/01, effective 2/9/01)

WAC 284-04-210 Information to be included in privacy notices. (1) General rule. The initial, annual and revised privacy notices that a licensee provides under WAC 284-04-200, 284-04-205, and 284-04-220 shall include each of the following items of information, in addition to any other information the licensee wishes to provide, that applies to the licensee and to the consumers to whom the licensee sends its privacy notice:

(a) The categories of nonpublic personal financial information that the licensee collects;

(b) The categories of nonpublic personal financial information that the licensee discloses;

(c) The categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information, other than those parties to whom the licensee discloses information under WAC 284-04-405 and 284-04-410;

(d) The categories of nonpublic personal financial information about the licensee's former customers that the licensee discloses and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information about the licensee's former customers, other than those parties to whom the licensee discloses information under WAC 284-04-405 and 284-04-410;

(e) If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under WAC 284-04-400 (and no other exception in WAC 284-04-405 and 284-04-410 applies to that disclosure), a separate description of the categories of information the licensee discloses and the categories of third parties with whom the licensee has contracted;

(f) An explanation of the consumer's right under WAC 284-04-300(1) to opt out of the disclosure of nonpublic personal financial information to nonaffiliated third parties, including the methods by which the consumer may exercise that right at that time;

(g) Any disclosures that the licensee makes under section 603 (d)(2)(A)(iii) of the Federal Fair Credit Reporting Act (15 U.S.C. 1681a (d)(2)(A)(iii)) (that is, notices regarding the ability to opt out of disclosures of information among affiliates);

(h) The licensee's policies and practices with respect to protecting the confidentiality and security of nonpublic personal information; and

(i) Any disclosure that the licensee makes under subsection (2) of this section.

(2) Description of parties subject to exceptions. If a licensee discloses nonpublic personal financial information as authorized under WAC 284-04-405 and 284-04-410, the licensee is not required to list those exceptions in the initial or annual privacy notices required by WAC 284-04-200 and 284-04-205. When describing the categories of parties to whom disclosure is made, the licensee is required to state only that it makes disclosures to other affiliated or nonaffiliated third parties, as applicable, as permitted by law.

(3) Examples.

(a) Categories of nonpublic personal financial information that the licensee collects. A licensee satisfies the requirement to categorize the nonpublic personal financial information it collects if the licensee categorizes it according to the source of the information, as applicable:

(i) Information from the consumer;

(ii) Information about the consumer's transactions with the licensee or its affiliates;

(iii) Information about the consumer's transactions with nonaffiliated third parties; and

(iv) Information from a consumer reporting agency.

(b) Categories of nonpublic personal financial information a licensee discloses.

(i) A licensee satisfies the requirement to categorize nonpublic personal financial information it discloses if the licensee categorizes the information according to source, as described in (a) of this subsection, as applicable, and provides a few examples to illustrate the types of information in each category. These might include:

(A) Information from the consumer, including application information, such as assets and income and identifying information, such as name, address, and Social Security number;

(B) Transaction information, such as information about balances, payment history, and parties to the transaction; and

(C) Information from consumer reports, such as a consumer's creditworthiness and credit history.

(ii) A licensee does not adequately categorize the information that it discloses if the licensee uses only general terms, such as transaction information about the consumer.

(iii) If a licensee reserves the right to disclose all of the nonpublic personal financial information about consumers that it collects, the licensee may simply state that fact without describing the categories or examples of nonpublic personal information that the licensee discloses.

(c) Categories of affiliates and nonaffiliated third parties to whom the licensee discloses.

(i) A licensee satisfies the requirement to categorize the affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information about consumers if the licensee identifies the types of businesses in which they engage.

(ii) Types of businesses may be described by general terms only if the licensee uses a few illustrative examples of significant lines of business. For example, a licensee may use the term financial products or services if it includes appropriate examples of significant lines of businesses, such as life insurer, automobile insurer, consumer banking or securities brokerage.

(iii) A licensee also may categorize the affiliates and nonaffiliated third parties to whom it discloses nonpublic personal financial information about consumers using more detailed categories.

(d) Disclosures under exception for service providers and joint marketers. If a licensee discloses nonpublic personal financial information under the exception in WAC 284-04-400 to a nonaffiliated third party to market products or

services that it offers alone or jointly with another financial institution, the licensee satisfies the disclosure requirement of subsection (1)(e) of this section if it:

(i) Lists the categories of nonpublic personal financial information it discloses, using the same categories and examples the licensee used to meet the requirements of subsection (1)(b) of this section, as applicable; and

(ii) States whether the third party is:

(A) A service provider that performs marketing services on the licensee's behalf or on behalf of the licensee and another financial institution; or

(B) A financial institution with whom the licensee has a joint marketing agreement.

(e) Simplified notices. If a licensee does not disclose, and does not wish to reserve the right to disclose, nonpublic personal financial information about customers or former customers to affiliates or nonaffiliated third parties except as authorized under WAC 284-04-405 and 284-04-410, the licensee may simply state that fact, in addition to the information it shall provide under subsections (1)(h), (i) and (2) of this section.

(f) Confidentiality and security. A licensee describes its policies and practices with respect to protecting the confidentiality and security of nonpublic personal financial information if it does both of the following:

(i) Describes in general terms who is authorized to have access to the information; and

(ii) States whether the licensee has security practices and procedures in place to ensure the confidentiality of the information in accordance with the licensee's policy. The licensee is not required to describe technical information about the safeguards it uses.

(4) Short-form initial notice with opt out notice for noncustomers.

(a) A licensee may satisfy the initial notice requirements in WAC 284-04-200 (1)(b) for a consumer who is not a customer by providing a short-form initial notice at the same time as the licensee delivers an opt out notice as required in WAC 284-04-215.

(b) A short-form initial notice shall:

(i) Be clear and conspicuous;

(ii) State that the licensee's privacy notice is available upon request; and

(iii) Explain a reasonable means by which the consumer may obtain that notice.

(c) The licensee shall deliver its short-form initial notice according to WAC 284-04-225. The licensee is not required to deliver its privacy notice with its short-form initial notice. The licensee instead may simply provide the consumer a reasonable means to obtain its privacy notice. If a consumer who receives the licensee's short-form notice requests the licensee's privacy notice, the licensee shall deliver its privacy notice according to WAC 284-04-225.

(d) Examples of obtaining privacy notice. The licensee provides a reasonable means by which a consumer may obtain a copy of its privacy notice if the licensee:

(i) Provides a toll-free telephone number that the consumer may call to request the notice; or

(ii) For a consumer who conducts business in person at the licensee's office, maintain copies of the notice on hand that the licensee provides to the consumer immediately upon request.

(5) Future disclosures. The licensee's notice may include:

(a) Categories of nonpublic personal financial information that the licensee reserves the right to disclose in the future, but do not currently disclose; and

(b) Categories of affiliates or nonaffiliated third parties to whom the licensee reserves the right in the future to disclose, but to whom the licensee does not currently disclose, nonpublic personal financial information.

(6) Sample Clauses and Federal Model Privacy Form. Sample clauses illustrating some of the notice content required by this section and the Federal Model Privacy Form are included in Appendix A and Appendix B of this regulation.

NEW SECTION

WAC 284-04-910 Appendix B—Federal Model Privacy Form. Licensees, including a group of financial holding company affiliates that use a common privacy notice, may use the federal Model Privacy Form, if the form is accurate for each institution that uses the form. (Note that disclosure of certain information, such as assets, income and information from a consumer reporting agency, may give rise to obligations under the federal Fair Credit Reporting Act, such as a requirement to permit a consumer to opt out of disclosures to affiliates or designation as a consumer reporting agency if disclosures are made to nonaffiliated third parties.)

(1) **General instructions.**

(a) How the Model Privacy Form is used.

(i) The model form may be used, (at the option of a "licensee"), including a group of licensees or other financial institutions that use a common privacy notice, to meet the content requirements of the privacy notice and opt-out notice set forth in WAC 284-04-210 and 284-04-215.

(ii) The model form is a standardized form, including page layout, content, format, style, pagination, and shading. Licensees seeking to obtain the safe harbor through use of the model form may modify it only as described in these instructions.

(iii) Note that disclosure of certain information, such as assets, income, and information from a consumer reporting agency, may give rise to obligations under the federal Fair Credit Reporting Act (FCRA), codified at 15 U.S.C. §§ 1681-1681x, such as a requirement to permit a consumer to opt out of disclosures to affiliates, or designation as a consumer reporting agency if disclosures are made to nonaffiliated third parties.

(iv) The word "customer" may be replaced by the word "member," whenever it appears in the model form, as appropriate.

(b) The contents of the Model Privacy Form. The model form consists of two pages, which may be printed on both sides of a single sheet of paper or may appear on two separate pages. Where a licensee provides a long list of licensees or financial institutions at the end of the model form in accordance with subsection (2)(c)(i)(A) of this instruction, or provides additional information in accordance with subsection

(2)(c)(iii) of this instruction and such list or additional information exceeds the space available on page two of the model form, such list or additional information may extend to a third page.

(i) Page one. The first page consists of the following components:

(A) Date last revised (upper right-hand corner)

(B) Title

(C) Key frame (Why? What? How?)

(D) Disclosure table ("Reasons we can share your personal information")

(E) "To limit our sharing" box, as needed, for the licensee's opt-out information

(F) "Questions" box, for customer service contact information

(G) Mail-in opt-out form, as needed

(ii) Page two. The second page consists of the following components:

(A) Heading (Page two)

(B) Frequently asked questions ("Who we are" and "What we do")

(C) Definitions

(D) "Other important information" box, as needed

(c) The format of the Model Privacy Form. The format of the model form may be modified only as described below.

(i) Easily readable type font. Licensees that use the model form must use an easily readable type font. While a number of factors together produce easily readable font, licensees are required to use a minimum of 10-point font (unless otherwise expressly permitted in these instructions) and sufficient spacing between lines.

(ii) Logo. A licensee may include a corporate logo on any page of the notice, so long as it does not interfere with the readability of the model form or the space constraints of each page.

(iii) Page size and orientation. Each page of the model form must be printed in portrait orientation, the size of which must be sufficient to meet the layout and minimum font size requirements, with sufficient white space on the top, bottom, and sides of the content.

(iv) Color. The model form must be printed on white or light color paper (such as cream) with black or other contrasting ink color. Spot color may be used to achieve visual interest, so long as the color contrast is distinctive and the color does not detract from the readability of the model form. Logos may also be printed in color.

(v) Languages. The model form may be translated into languages other than English.

(2) **Information required in the Model Privacy Form.** The information in the model form may be modified only as described below:

(a) Name of licensee or group of affiliated licensees or institutions providing the notice: Insert the name of the licensee providing the notice, or a common identity of the affiliated licensees or financial institutions jointly providing the notice on the form, wherever [name of licensee] appears.

(b) Page one

(i) Last revised date. The licensee must insert in the upper right-hand corner the date on which the notice was last revised. The information shall appear in minimum eight-point font as "rev. [month/year]" using either the name or number of the month, such as "rev. July 2016" or "rev. 7/16."

(ii) General instructions for the "What?" box

(A) The bulleted list identifies the types of personal information that the licensee collects and shares. All licensees must use the term "Social Security number" in the first bullet.

(B) A licensee must use five of the following terms, to complete the bulleted list: Income; account balances; payment history; transaction history; transaction or loss history; credit history; credit scores; assets; investment experience; credit-based insurance scores; insurance claim history; medical information; overdraft history; purchase history; account transactions; risk tolerance; medical-related debts; credit card or other debt; mortgage rates and payments; retirement assets; checking account information; employment information; wire transfer instructions.

(iii) General instructions for the disclosure table. The left column lists reasons for sharing or using personal information. Each reason correlates to a specific legal provision described in subsection (2)(b)(iv) of this instruction. In the middle column, each licensee must provide a "Yes" or "No" response that accurately reflects its information-sharing policies and practices with respect to the reason listed on the left. In the right column, each licensee must provide in each box one of the following three responses, as applicable, that reflects whether a consumer can limit such sharing: "Yes," if it is required to or voluntarily provides an opt-out; "No," if it does not provide an opt-out; or "We don't share," if it answers "No" in the middle column. Only the sixth row ("For our affiliates to market to you") may be omitted at the option of the licensee. See subsection (2)(b)(iv)(F) of this instruction.

(iv) Specific disclosures and corresponding legal provisions.

(A) For our everyday business purposes. This reason incorporates sharing information under WAC 284-04-405 and 284-04-410 and with service providers pursuant to WAC 284-04-400 other than the disclosures described in subsection (2)(b)(iv)(B) or (C) of this instruction.

(B) For our marketing purposes. This reason incorporates sharing information with service providers by a licensee for its own marketing pursuant to WAC 284-04-400. A licensee that shares for this reason may choose to provide an opt-out.

(C) For joint marketing with other financial companies. This reason incorporates sharing information under joint marketing agreements between two or more licensees or financial institutions and with any service provider used in conjunction with such agreement pursuant to WAC 284-04-400. A licensee that shares for this reason may choose to provide an opt-out.

(D) For our affiliates' everyday business purposes - Information about transactions and experiences. This reason incorporates sharing information specified in sections 603(d)(2)(A)(i) and (ii) of the FCRA. A licensee that shares information for this reason may choose to provide an opt-out.

(E) For our affiliates' everyday business purposes - Information about creditworthiness. This reason incorporates sharing information pursuant to section 603 (d)(2)

(A)(iii) of the FCRA. A licensee that shares information for this reason must provide an opt-out.

(F) For our affiliates to market to you. This reason incorporates sharing information specified in section 624 of the FCRA. This reason may be omitted from the disclosure table when: The licensee does not have affiliates (or does not disclose personal information to its affiliates); the licensee's affiliates do not use personal information in a manner that requires an opt-out; or the licensee provides the affiliate marketing notice separately. Licensees that include this reason must provide an opt-out of indefinite duration. A licensee that is required to provide an affiliate marketing opt-out, but does not include that opt-out in the model form under this part, must comply with section 624 of the FCRA and WAC 284-04-200 and 284-04-215, with respect to the initial notice and opt-out and any subsequent renewal notice and opt-out. A licensee not required to provide an opt-out under this subparagraph may elect to include this reason in the model form.

(G) For nonaffiliates to market to you. This reason incorporates sharing described in WAC 284-04-215 and 284-04-300. A licensee that shares personal information for this reason must provide an opt-out.

(v) To limit our sharing. A licensee must include this section of the model form only if it provides an opt-out. The word "choice" may be written in either the singular or plural, as appropriate. Licensees must select one or more of the applicable opt-out methods described: Telephone, such as by a toll-free number; a web site; or use of a mail-in opt-out form. Licensees may include the word "toll-free" before telephone, as appropriate. A licensee that allows consumers to opt out online must provide either a specific web address that takes consumers directly to the opt out page or a general web address that provides a clear and conspicuous direct link to the opt-out page. The opt-out choices made available to the consumer who contacts the licensee through these methods must correspond accurately to the "Yes" responses in the third column of the disclosure table. In the part entitled "Please note," licensees may insert a number that is thirty days or greater in the space marked "[30]." Instructions on voluntary or state privacy law opt-out information are in subsection (2)(b)(vii)(E) of these instructions.

(vi) Questions box. Customer service contact information must be inserted as appropriate where [phone number] or [web site] appear. Licensees may elect to provide either a phone number, such as a toll-free number, or a web address, or both. Licensees may include the words "toll-free" before the telephone number, as appropriate.

(vii) Mail-in opt-out form. Licensees must include this mail-in form only if they state in the "To limit our sharing" box that consumers can opt out by mail. The mail-in form must provide opt-out options that correspond accurately to the "Yes" responses in the third column of the disclosure table. Licensees that require consumers to provide only name and address may omit the section identified as "[account #]." Licensees that require additional or different information, such as a random opt-out number or a truncated account number to implement an opt-out election should modify the "[account #]" reference accordingly. This includes licensees that require customers with multiple accounts to identify each account to which the opt-out should apply. A licensee must enter its opt-out mailing address in the far right of this form (see version three); or below the form (see version four). The reverse side of the mail-in opt-out form must not include any content of the model form.

(A) Joint accountholder. Only licensees that provide their joint accountholders the choice to opt out for only one accountholder, in accordance with subsection (2)(c)(i)(E) of these instructions, must include in the far left column of the mail-in form the following statement:

"If you have a joint account, your choice(s) will apply to everyone on your account unless you mark below.

□ Apply my choice(s) only to me."

The word "choice" may be written in either the singular or plural, as appropriate. Licensees that provide insurance products or services, provide this option, and elect to use the model form may substitute the word "policy" for "account" in this statement. Licensees that do not provide this option may eliminate this left column from the mail-in form.

(B) FCRA section 603 (d)(2)(A)(iii) opt-out. If the licensee shares personal information pursuant to section 603 (d)(2)(A)(iii) of the FCRA, it must include in the mail-in opt-out form the following statement:

"Do not share information about my creditworthiness with your affiliates for their everyday business purposes."

(C) FCRA section 624 opt-out. If the licensee uses section 624 of the FCRA, in accord with subsection (2)(b)(iv)(F) of these instructions, it must include in the mail-in opt-out form the following statement:

"Do not allow your affiliates to use my personal information to market to me."

(D) Nonaffiliate opt-out. If the licensee shares personal information pursuant to WAC 284-04-300, it must include in the mail-in opt-out form the following statement:

"Do not share my personal information with nonaffiliates to market their products and services to me."

(E) Additional opt-outs. Licensees that use the disclosure table to provide opt-out options beyond those required by federal law must provide those opt-outs in this section of the model form. A licensee that chooses to offer an opt-out for its own marketing in the mail-in opt-out form must include one of the two following statements:

"Do not share my personal information to market to me."; or

"Do not use my personal information to market to me."

A licensee that chooses to offer an opt-out for joint marketing must include the following statement:

"Do not share my personal information with other financial institutions to jointly market to me."

(viii) Barcodes. A licensee may elect to include a barcode and/or "tagline" (an internal identifier) in six-point type at the bottom of page one, as needed for information internal to the licensee, so long as these do not interfere with the clarity or text of the form.

(c) Page two

(i) General instructions for the questions. Certain questions on the model form may be customized as follows:

(A) "Who is providing this notice?" This question may be omitted where only one licensee provides the model form and that licensee is clearly identified in the title on page one. Two or more licensees or financial institutions that jointly provide the model form must use this question to identify themselves as required by WAC 284-04-225. Where the list of licensees or financial institutions exceeds four lines, the licensee must describe in the response to this question the general types of licensees or financial institutions jointly providing the notice and must separately identify those licensees or financial institutions, in minimum 8-point font, directly following the "Other important information" box, or, if that box is not included in the licensee's form, directly following the "Definitions." The list may appear in a multi- column format.

(B) "How does [name of licensee] protect my personal information?" The licensee may only provide additional information pertaining to its safeguards practices following the designated response to this question. Such information may include information about the licensee's use of cookies or other measures it uses to safeguard personal information. Licensees are limited to a maximum of thirty additional words.

(C) "How does [name of licensee] collect my personal information?" Licensees must use five of the following terms to complete the bulleted list for this question: Open an account; deposit money; pay your bills; apply for a loan; use your credit or debit card; seek financial or tax advice; apply for insurance; pay insurance premiums; file an insurance claim; seek advice about your investments; buy securities from us; sell securities to us; direct us to buy securities; direct us to sell your securities; make deposits or withdrawals from your account; enter into an investment advisory contract; give us your income information; provide employment information; give us your employment history; tell us about your investment or retirement portfolio; tell us about your investment or retirement earnings; apply for financing; apply for a lease; provide account information; give us your contact information; pay us by check; give us your wage statements; provide your mortgage information; make a wire transfer; tell us who receives the money; tell us where to send the money; show your government-issued ID; show your driver's license; order a commodity futures or option trade. Licensees that collect personal information from their affiliates and/or credit bureaus must include the following statement after the bulleted list: "We also collect your personal information from others, such as credit bureaus, affiliates, or other companies." Licensees that do not collect personal information from their affiliates or credit bureaus but do collect information from other companies must include the following statement instead: "We also collect your personal information from other companies." Only licensees that do not collect any personal information from affiliates, credit bureaus, or other companies can omit both statements.

(D) "Why can't I limit all sharing?" Licensees that describe state privacy law provisions in the "Other important information" box must use the bracketed sentence: "See below for more on your rights under state law." Other licensees must omit this sentence.

(E) "What happens when I limit sharing for an account I hold jointly with someone else?" Only licensees that provide opt-out options must use this question. Other licensees must omit this question. Licensees must choose one of the following two statements to respond to this question:

"Your choices will apply to everyone on your account."; or

"Your choices will apply to everyone on your account—unless you tell us otherwise." Licensees may substitute the word "policy" for "account" in these statements.

(ii) General instructions for the definitions. The licensee must customize the space below the responses to the three definitions in this section. This specific information must be in italicized lettering to set off the information from the standardized definitions.

(A) Affiliates. As required by WAC 284-04-210, where [affiliate information] appears, the licensee must:

(I) If it has no affiliates, state: "[name of licensee] has no affiliates";

(II) If it has affiliates but does not share personal information with them, state: "[name of licensee] does not share with our affiliates"; or

(III) If it shares with its affiliates, state, as applicable: "Our affiliates include companies with a [common corporate identity of licensee] name; financial companies such as [insert illustrative list of companies]; nonfinancial companies, such as [insert illustrative list of companies]; and others, such as [insert illustrative list]."

(B) Nonaffiliates. As required by WAC 284-04-210, where [nonaffiliate information] appears, the licensee must:

(I) If it does not share with nonaffiliated third parties, state: "[name of licensee] does not share with nonaffiliates so they can market to you"; or

(II) If it shares with nonaffiliated third parties, state, as applicable: "Nonaffiliates we share with can include [list categories of companies such as mortgage companies, insurance companies, direct marketing companies, and nonprofit organizations]."

(C) Joint marketing. As required by WAC 284-04-400, where [joint marketing] appears, the licensee must:

(I) If it does not engage in joint marketing, state: "[name of licensee] doesn't jointly market"; or

(II) If it shares personal information for joint marketing, state, as applicable:

"Our joint marketing partners include [list categories of companies such as credit card companies]."

(iii) General instructions for the "Other important information" box. This box is optional. The space provided for information in this box is not limited, and an additional page may be used if necessary. Only the following types of information can appear in this box:

(A) State and/or international privacy law information; and/or

(B) A form by which the consumer may acknowledge receipt of the notice.

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency and appear in the Register pursuant to the requirements of RCW 34.08.040.

WSR 17-16-159
PROPOSED RULES
OFFICE OF INSURANCE COMMISSIONER

[Insurance Commissioner Matter No. R 2017-03—Filed August 1, 2017, 4:33 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 17-12-064.

Title of Rule and Other Identifying Information: Interest rate pursuant to RCW 87.03.810.

Hearing Location(s): Office of the Insurance Commissioner, 302 Sid Snyder Avenue S.W., Suite 200, Olympia, WA 98504, on September 5, 2017, at 11:00 a.m.

Date of Intended Adoption: September 5, 2017.

Submit Written Comments to: Jim Freeburg, P.O. Box 40258, Olympia, WA 98504, email rulescoordinator@oic.wa.gov, fax (360) 586-3109, by September 5, 2017.

Assistance for Persons with Disabilities: Contact Lorie Villaflores by September 1, 2017, TTY (360) 586-0241 or (360) 725-7087.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: RCW 87.03.810 sets forth a process for the Washington state department of transportation (WSDOT) to acquire land from irrigation districts for highway purposes. The statute references interest rate tables issued by the office of the insurance commissioner. The rule sets forth the interest rate to be used by WSDOT for purposes of this section - the local government investment pool daily yield.

Reasons Supporting Proposal: The local government investment pool daily yield has been agreed upon by both parties as the proper interest rate to be used in this scenario.

Statutory Authority for Adoption: RCW 48.02.060, 87.03.810.

Statute Being Implemented: RCW 87.03.810.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Mike Kreidler, governmental.

Name of Agency Personnel Responsible for Drafting: Jim Freeburg, P.O. Box 40260 [40258], Olympia, WA 98504, (360) 725-7170; Implementation: John Haworth, P.O. Box 40255, Olympia, WA 98504, (360) 725-7223; and Enforcement: AnnaLisa Gellermann, P.O. Box 40255, Olympia, WA 98504, (360) 725-7037.

No small business economic impact statement has been prepared under chapter 19.85 RCW. This rule proposal is exempt under RCW 19.85.025(3) because these rules only relate to internal governmental operations that are not subject to violation by a nongovernment party, as described in RCW 34.05.328 (5)(b)(ii).

A cost-benefit analysis is not required under RCW 34.05.328. Per RCW 34.05.328 (5)(b)(ii), these rules only relate to internal governmental operations that are not subject to violation by a nongovernment party.

August 1, 2017
Mike Kreidler
Insurance Commissioner

SUBCHAPTER B: ALTERNATIVE USES OF INTEREST RATE TABLES

NEW SECTION

WAC 284-74-700 Acquiring irrigation district lands. The local government investment pool (LGIP) daily yield, as calculated by the state treasurer, is the proper interest rate to be used as the annual rate of interest for the purpose of calculating a lump sum payment to irrigation districts for lands acquired by the Washington state department of transportation per RCW 87.03.810. The last published daily yield prior to the official transfer of property should be used for the calculation. The last published daily yield means the day prior to the day that the deed is recorded.

WSR 17-16-161
PROPOSED RULES
OFFICE OF INSURANCE COMMISSIONER

[Insurance Commissioner Matter No. R 2017-02—Filed August 1, 2017, 4:44 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 17-12-063.

Title of Rule and Other Identifying Information: Obsolete citations to insurer investments under chapter 48.13 RCW.

Hearing Location(s): Office of the Insurance Commissioner, 301 Sid Snyder Avenue S.W., Olympia, WA 98501, on September 7, 2017, at 10:00 a.m.

Date of Intended Adoption: September 8, 2017.

Submit Written Comments to: Jim Tompkins, P.O. Box 40260, Olympia, WA 98504-0260, email rulescoordinator@oic.wa.gov, fax (360) 586-3109, by September 6, 2017.

Assistance for Persons with Disabilities: Contact Lorie Villaflores by September 6, 2017, TTY (360) 586-0241 or (360) 725-7087.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The commissioner will consider adopting rules to amend/repeal obsolete statutory citations to domestic insurer investments.

Reasons Supporting Proposal: In 2011 chapter 188, Laws of 2011 (SHB 1257) was enacted repealing the then existing chapter 48.13 RCW and replaced [replacing] it with new sections. As a result there are several sections in Title 284 WAC that contain statutory citations to sections in chapter 48.13 RCW that were repealed.

Statutory Authority for Adoption: RCW 48.02.060 and 48.13.171(1).

Statute Being Implemented: Chapter 48.13 RCW.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Mike Kreidler, insurance commissioner, governmental.

Name of Agency Personnel Responsible for Drafting: Jim Tompkins, P.O. Box 40260, Olympia, WA 98504-0260, (360) 725-7036; Implementation: Steve Drutz, P.O. Box 40255, Olympia, WA 98504-0255, (360) 725-7209; and Enforcement: Doug Hartz, P.O. Box 40255, Olympia, WA 98504-0255, (360) 725-7214.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The proposed rule acts to update WAC references, standardize wording, and remove redundant language. Because it does not impose any new requirements on the businesses being regulated no small business economic impact statement is required.

A cost-benefit analysis is not required under RCW 34.05.328. This proposed rule acts to update WAC language to conform to statute and clarify/correct portions of existing rules. No new burdens/benefits are imposed by the rule. In accordance with RCW 34.05.328 (5)(b)(iii), (iv) and (v) no cost-benefit analysis is required.

August 1, 2017
Mike Kreidler
Insurance Commissioner

AMENDATORY SECTION (Amending WSR 93-19-010, filed 9/1/93, effective 10/2/93)

WAC 284-13-280 Real estate appraisals. ((~~(1) Except as provided in subsection (2) of this section, for purposes of RCW 48.13.120(1) and 48.13.140, an insurer may rely on an appraisal that is less than one year old.~~

~~(2)~~)) An insurer may not rely on an appraisal if the insurer knows or should know that the appraisal is not reliable. An appraisal may be "not reliable" because it was incorrect when done, because conditions affecting the property have changed, or for other reasons.

AMENDATORY SECTION (Amending WSR 82-23-010, filed 11/5/82, effective 1/1/83)

WAC 284-44-330 Agreement guaranteed by a deposit of cash or securities. (1) If, pursuant to RCW 48.44.030, the agreement is guaranteed by a deposit of cash or securities, ((~~such~~)) the deposit ((~~shall~~)) must be in an amount equal to the greater of (i) one hundred fifty thousand dollars, or (ii) one-twelfth of the total sum of money received during the preceding calendar year as prepayment for health care services, except as provided by WAC 284-44-340.

(2) Securities eligible for ((~~such~~)) the deposit ((~~shall be~~)) are those set forth in RCW ((~~48.13.040, 48.13.050, 48.13.080, 48.13.100, 48.13.200, and 48.13.220. The commissioner may, upon advance approval, allow other securities to be included as deposits pursuant to RCW 48.13.250~~)) 48.13.009 (12), (14), and 48.13.061 (2) and (4).

(3) In determining the value to be assigned to securities for compliance with the depository requirements, market value ((~~shall be~~)) is the measurement.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 284-16-100	Investments—Encumbrance—Interpretation of RCW 48.13.130.
WAC 284-16-110	F.H.A. mortgage loans and investments.

WSR 17-16-175
PROPOSED RULES
DEPARTMENT OF FISH AND WILDLIFE

[Filed August 2, 2017, 11:50 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 17-12-115 on June 7, 2017.

Title of Rule and Other Identifying Information: WAC 220-440-170 Payment for livestock damage and other domestic animals—Limitations and 220-440-180 Application for cash compensation for livestock damage or domestic animal—Procedure.

Hearing Location(s): Red Lion Hotel, 221 North Lincoln Street, Port Angeles, WA 98362, on September 8-9, 2017, at 8:00 a.m.

Date of Intended Adoption: On or after October 27, 2017.

Submit Written Comments to: Wildlife Program, Commission Meeting Public Comments, P.O. Box 43200, Olympia, WA 98504, fax (360) 902-2162, by August 23, 2017, online https://www.surveymonkey.com/r/29ZPM7V.

Assistance for Persons with Disabilities: Contact Tami Lininger by September 1, 2017, TTY (800) 833-6388 or (360) 902-2267.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: WAC 220-440-170, the purpose of the proposal is to align WAC 220-440-170 with RCW 77.36.110, so that a livestock producer must exhaust all available compensation from nonprofit organizations before receiving payment from the Washington department of fish and wildlife (WDFW). The anticipated effect is that the language between law and rule will be more consistent and allow for a more streamlined process for assessing claims.

WAC 220-440-180, the purpose of the proposal is to clarify that a livestock producer can use an independent assessor or market sales receipts from last sale or the next upcoming sale to estimate the value of their damaged livestock. The changes would also align WAC 220-440-180 with the payment schedule in the 2011 wolf conservation and management plan.

Reasons Supporting Proposal: WAC 220-440-170, the proposal makes the rule consistent with state law and produces a more streamlined process for assessing claims.

WAC 220-440-180, the proposal makes the rule consistent with WDFW's 2011 wolf conservation and management plan and produces a more streamlined process for assessing claims.

Statutory Authority for Adoption: RCW 77.04.012, 77.04.020, 77.04.055, 77.12.047, 77.36.170, and 77.36.180.

Statute Being Implemented: RCW 77.04.012, 77.04.020, 77.04.055, 77.12.047, 77.36.170, and 77.36.180.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: WDFW, governmental.

Name of Agency Personnel Responsible for Drafting and Implementation: Eric Gardner, Natural Resources Building, (360) 902-2515; and Enforcement: Chris Anderson, Natural Resources Building, (360) 902-2373.

No small business economic impact statement has been prepared under chapter 19.85 RCW. These rule changes do not impact small businesses.

A cost-benefit analysis is not required under RCW 34.05.328. These rule proposals do not affect hydraulics.

August 2, 2017
Scott Bird
Rules Coordinator

AMENDATORY SECTION (Amending WSR 17-05-112, filed 2/15/17, effective 3/18/17)

WAC 220-440-170 Payment for livestock damage and other domestic animals—Limitations. Commercial livestock owners who have worked with the department to prevent depredation but continue to experience losses, or who experience unforeseen losses, may be eligible to file a damage claim and receive cash compensation. Cash compensation will only be provided to livestock owners by the department when specifically appropriated by the legislature or other funding entity. Damages payable under this section are limited to the lost or diminished value of livestock caused by wild bears, cougars, or wolves and shall be paid only to the owner of the livestock, without assignment. Cash compensation for livestock losses from bears, cougars, and wolves shall not include damage to other real or personal property, including other vegetation or animals, consequential damages, or any other damages except veterinarian services may be eligible. However, livestock owners under written agreement with the department will be compensated consistent with their agreement which may extend beyond the limitations in this section. The department is authorized to pay the market value for the eligible livestock or guard dog lost((,)) or the market value of indirect livestock losses as a result of harassment by wolves, including reduced weight gains for livestock, and no more than ten thousand dollars to the livestock owner per claim.

Claims for cash compensation will be denied when:

(1) Funds for livestock compensation have not been specifically appropriated by the legislature or other funding entity;

(2) The claim is for livestock other than sheep, cattle, or horses, when only state funds are available; or any domestic animals not allowed by the funding entity;

(3) The owner fails to provide the department with an approved checklist of the preventative and nonlethal means that have been employed, or the owner failed to comply with the terms and conditions of his or her agreement(s) with the department;

(4) The owner has accepted noncash compensation to offset livestock losses in lieu of cash. Acceptance of noncash compensation will constitute full and final payment for livestock losses within a fiscal year;

(5) Damages to the livestock or other domestic animals claimed are covered by insurance or are eligible for payment from ((~~other entities~~)) nonprofit organizations. However, any portion of the damage not covered by ((~~others~~)) nonprofit organizations is eligible for filing a claim with the department;

(6) The owner fails to provide on-site access to the department or designee for inspection and investigation of alleged attack or to verify eligibility for claim;

(7) The owner has not provided a completed written claim form and all other required information, or met required timelines prescribed within this chapter;

(8) No claim will be processed if the owner fails to sign a statement affirming that the facts and supporting documents are truthful to the best of the owner's knowledge; or

(9) The owner or designee has salvaged or rendered the carcass or allowed it to be scavenged without an investigation completed under the direction of the department.

AMENDATORY SECTION (Amending WSR 17-05-112, filed 2/15/17, effective 3/18/17)

WAC 220-440-180 Application for cash compensation for livestock damage or domestic animal—Procedure. Pursuant to this section, the department may distribute money specifically appropriated by the legislature or other funding entity to pay commercial livestock or guard dog losses caused by wild bear, cougar, or wolves in the amount of up to ten thousand dollars per claim unless, following an appeal, the department is ordered to pay more (see RCW 77.36.130(2)). The department will develop claim procedures and application forms consistent with this section for cash compensation of commercial livestock or guard dog losses. Partnerships with other public and private organizations to assist with completion of applications, assessment of losses, and to provide funding for compensation are encouraged.

Filing a claim:

(1) Claimant must notify the department within twenty-four hours of discovery of livestock or other domestic animal attack or as soon as feasible.

(2) Damage claim assessment of amount and value of ((~~domestic animal~~)) eligible livestock or guard dog loss is the primary responsibility of the claimant.

(3) Investigation of the loss and review and approval of the assessment will be conducted by the department:

(a) The claimant must provide access to department staff or designees to investigate the cause of death or injury to ((~~domestic animals~~)) eligible livestock or guard dogs and use reasonable measures to protect evidence at the depredation site.

(b) Federal officials may be responsible for the investigation when it is suspected that the attack was by a federally listed species.

(4) To be eligible a claimant must submit a written statement, electronic or hard copy, within thirty days of discovery of a loss to indicate his or her intent to file a claim.

(5) A complete((~~, written~~)) claim package must be submitted to the department within ninety days of a discovery of an attack on ((~~domestic animals or~~)) livestock or guard dogs to be eligible for compensation.

(6) A claim form declaration must be signed, affirming that the information provided is factual and truthful, per the certification set out in RCW 9A.72.085 before the department will process the claim.

(7) In addition to a completed claim form, a claimant must provide:

(a) Proof of legal ownership or contractual lease of claimed livestock.

(b) Records documenting the value of the ((~~domestic animal based on either market price or value at the time of loss~~)) livestock or guard dog depending upon the determination for cause of loss.

(c) Declaration signed under penalty of perjury indicating that the claimant is eligible for the claim, meets eligibility requirements listed under this chapter and in RCW 77.36.-100, 77.36.110, and 77.36.120, and all claim evaluation and assessment information in the claim application is to the best knowledge of the claimant true and accurate.

(d) A copy of any insurance policy covering loss claimed.

(e) Copies of applications for other sources of loss compensation and any payment or denial documentation.

(f) The department approved checklist of preventative measures that have been deployed, or documented compliance with the terms and conditions of the claimant's agreement with the department, or the director approved waiver.

Settlement of claims:

(8) Subject to funds appropriated to pay for ((~~domestic animal~~)) livestock or guard dog losses, undisputed claims will be paid up to ten thousand dollars.

(9) Valuation of the lost livestock;

(a) ((~~For losses caused by wolves, livestock~~)) The department may utilize the services of an independent certified appraiser to assist in the evaluation of livestock or guard dog claims.

(b) For losses caused by wolves, the compensation value for livestock or guard dogs will be based on the value at the time the animal would normally be sold at market or the cost to replace the animal, and based on comparable types and/or weight of livestock or guard dogs, such as comparable calves, steers, cows, ewes, and lambs; except bulls will be replaced based on the actual purchase price prorated on a four-year depreciation cycle minus salvage value. The market or replacement value will be determined by ((~~the market at the time the animals would normally be sold. Livestock will be valued based on the average weight of herd mates at the time of sale multiplied by the cash market price received and depredated cows or ewes will be replaced based on the value of a bred animal of the same age and type as the one lost. Bulls will be replaced using actual purchase price prorated based on a four-year depreciation cycle minus salvage value.~~

(~~b~~))) an independent certified appraiser, the sales receipts from the most recent sale of comparable animals by the owner, or the sales receipts from the next sale of comparable animals by the owner.

(c) The payment amount for wolf depredations to livestock will be:

(i) Twice the full market value for each commercial livestock loss for a confirmed wolf depredation, or full market value for each probable wolf depredation, where the livestock grazing site was greater or equal to one hundred acres. Payments will be reduced by half if all the remaining livestock are accounted for.

(ii) The full market value for each commercial livestock loss for a confirmed wolf depredation, or half the full market value for each probable wolf depredation, where the livestock grazing site was less than one hundred acres.

(d) For losses caused by bear or cougar, livestock value will be determined by the market value((~~s~~)) for an animal of the same breed, sex, and average weight at the time the animal((~~s are~~)) is lost.

(((~~(e) The department may utilize the services of a certified livestock appraiser to assist in the evaluation of livestock claims.~~)))

(10) Claims for higher than normal livestock losses, reduced weight gains, or reduced pregnancy rates due to harassment of livestock caused by wolves must include:

(a) At least three consecutive years of records ((~~prior to~~)) preceding the year of the claim. Claims will be assessed for losses in excess of the ((~~previous~~)) preceding three-year running average;

(b) The losses must occur on large pastures or range land used for grazing, lambing, or calving where regular monitoring of livestock is impractical (and therefore discovery of carcasses infeasible) as determined by the department;

(c) Verification by the department that wolves are occupying the area;

(d) The losses cannot be reasonably explained by other causes;

(e) Compliance with the department's preventative measures checklist, or damage prevention cooperative agreement, or a waiver signed by the director.

(11) Compensation paid by the department combined with any other compensation may not exceed the total assessed value of the ((~~assessed~~)) loss.

(12) Upon completion of an evaluation, the department will notify the claimant of its decision to either deny the claim or make a settlement offer (order). The claimant has sixty days from the date received to accept ((~~the department's~~)), sign, and mail to the department the original offer for settlement of the claim. If the claimant wishes to appeal the offer, they must request an informal resolution or adjudicative proceeding as described in WAC 220-440-230. ((~~The acceptance must be in writing and the signed originals must be mailed in to the department.~~)) The appeal must be in writing and may be mailed or submitted by email. If no written acceptance or request for appeal is received within sixty days of receipt of the settlement offer, the offer is considered rejected and not subject to appeal.

(13) If the claimant accepts the department's offer, the department will ((~~send~~)) provide payment to the claimant within thirty days from receipt of the written acceptance document(s).

(14) The department will prioritize payment for livestock losses in the order the claims were received or upon

final adjudication of an appeal. If the department is unable to make a payment for livestock losses during the current fiscal year, the claim shall be held over until the following fiscal year when funds become available. As funding becomes available to the department under this section, RCW 77.36.170, or any other source, the department must pay claims in ((~~the chronologic~~)) chronological order. Claims that are carried over will take first priority and receive payment before any new claims are paid. The payment of a claim included on the list maintained by the department under this section is conditional on the availability of specific funding for this purpose and is not a guarantee of reimbursement.