WSR 19-17-010
PERMANENT RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 19-141—Filed August 9, 2019, 11:57 a.m., effective January 1, 2020]

Effective Date of Rule: January 1, 2020.

Purpose: Establishing logbook requirements for game fish guides, food fish guides, and combination game fish and food fish guides.

Citation of Rules Affected by this Order: New WAC 220-352-245 Reporting required of licensed food fish, game fish and combination fishing guides.

Statutory Authority for Adoption: RCW 77.04.012, 77.04.013, 77.04.020, 77.04.055.

Adopted under notice filed as WSR 19-04-106 on February 6, 2019.

Changes Other than Editing from Proposed to Adopted Version: The proposed rule had a requirement for licensed commercial fishing guides to report their guided and nonguided fishing activity to the department on a weekly basis. The adopted rule amended the reporting increment to monthly. The amended proposal for the reporting increment states, "require logbook reports to be provided to the department within ten days following any calendar month in which guide activity took place."

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 1, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: August 2, 2019.

Larry M. Carpenter, Chair
Fish and Wildlife Commission

NEW SECTION

WAC 220-352-245 Reporting required of licensed food fish, game fish and combination fishing guides. (1) Licensed food fish, game fish and combination fishing guides shall maintain a daily logbook of guiding activity to include:

(a) Guide name and license No. for the guide leading the trip;

(b) Date that fishing took place. For multiday trips, each day is considered a separate trip;

(c) Specific name of river, stream, or lake fished;

(d) Site code of site fished as referenced within a list provided to each guide. If multiple sites are fished on the same day, each site is considered a separate trip;

(e) Client, "comped angler" and crew current fishing license number (wild ID No.) for each person on board if required to have a license or catch record card. A comped angler is an angler that fishes without charge;

(f) Indicate if person was a crew member or if angler was "comped";

(g) Species kept or released. For salmon and steelhead specify origin (hatchery, wild) and life stage (adult, jack).

(2) Logbooks are required to be completed for each trip before offloading any fish from the vessel or if no fish were kept, complete the logbook before leaving the site.

(3) Report of daily guiding activity shall be made using the department's paper logbook or online reporting application. Logbook pages must be provided to the department or postmarked within ten days following any calendar month in which the guiding activity took place.

(4) Each day of fishing that occurs on a designated WDFW licensed guide fish vessel will be required to be recorded in the logbook. This includes any personal use or nonguided fishing trips that occur.

(5) Information collected under this section may be exempt from public disclosure to the extent provided under RCW 42.56.430.

(6) Failure to report any guiding activity listed in subsections (1) through (4) of this section is an infraction, punishable under RCW 77.15.160.

(7) A fishing guide, or person under the control or direction of a fishing guide, that submits false information is guilty of a gross misdemeanor, punishable under RCW 77.15.270.

WSR 19-17-016
PERMANENT RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 19-188—Filed August 12, 2019, 1:46 p.m., effective September 12, 2019]

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

Purpose: To provide the correct physical address of the southwest Washington - Region 5 office. The southwest Washington Region 5 moved locations from 2108 Grand Boulevard in Vancouver, WA to 5525 11th Street in Ridgefield, WA.

Citation of Rules Affected by this Order: Amending WAC 220-101-030.

Statutory Authority for Adoption: RCW 77.04.012, 77.04.013, 77.04.020, 77.04.055, and 77.12.047.

Adopted under notice filed as WSR 19-05-071 on February 19, 2019.

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

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

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

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

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

Date Adopted: August 12, 2019.

Kelly Susewind
Director

AMENDATORY SECTION (Amending WSR 17-05-112, filed 2/15/17, effective 3/18/17)

WAC 220-101-030 Description of department organization. The department's central office is located at 1111 Washington Street S.E., Olympia, WA 98501-1091. The mailing address of the department's central office is P.O. Box 43200, Olympia, WA 98504-3200. The department's telephone number is 360-902-2200. The fax number is 360-902-2156.

The department has other offices, including six regional offices, as follows:

Eastern Washington - Region 1 Office
2315 North Discovery Place
Spokane Valley, WA 99216-1566
Telephone: 509-892-1001
Fax: 509-921-2440

North Central Washington - Region 2 Office
1550 Alder Street N.W.
Ephrata, WA 98823-9699
Telephone: 509-754-4624
Fax: 509-754-5257

South Central Washington - Region 3 Office
1701 South 24th Avenue
Yakima, WA 98902-5720
Telephone: 509-575-2740
Fax: 509-575-2474

North Puget Sound - Region 4 Office
16018 Mill Creek Boulevard
Mill Creek, WA 98012-1541
Telephone: 425-775-1311
Fax: 425-338-1066

Southwest Washington - Region 5 Office
((~~2108 Grand Boulevard~~
~~Vancouver, WA 98661~~))
5525 S. 11th Street
Ridgefield, WA 98642
Telephone: 360-696-6211
Fax: 360-906-6776

Coastal Washington - Region 6 Office
48 Devonshire Road
Montesano, WA 98563
Telephone: 360-249-4628
Fax: 360-664-0689

Current contact information is also available at the department's web site at http://wdfw.wa.gov.

WSR 19-17-032
PERMANENT RULES
BATES TECHNICAL COLLEGE

[Filed August 14, 2019, 8:54 a.m., effective September 14, 2019]

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

Purpose: Chapter 495A-276 WAC, Public records, is updated to align with current state statutes regarding access to public records.

Citation of Rules Affected by this Order: Amending chapter 495A-276 WAC.

Statutory Authority for Adoption: Chapter 34.05 RCW; RCW 28B.10.140, 42.30.075, 42.17.310.

Adopted under notice filed as WSR 19-13-073 on June 17, 2019.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 1, Amended 0, Repealed 3.

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

Number of Sections Adopted on the Agency's own Initiative: New 1, Amended 11, Repealed 3.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 1, Amended 11, Repealed 3.

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

Date Adopted: August 14, 2019.

Dr. Jean Hernandez
Special Assistant
to the President

Chapter 495A-276 WAC

((~~ACCESS TO~~)) PUBLIC RECORDS

AMENDATORY SECTION (Amending WSR 92-12-017, filed 5/26/92, effective 6/26/92)

WAC 495A-276-010 Purpose. The purpose of this chapter is to ensure that Bates Technical College, District No. 28, complies with the provisions of chapter 42.17 RCW and in particular with those sections of that chapter dealing with public records.

AMENDATORY SECTION (Amending WSR 92-12-017, filed 5/26/92, effective 6/26/92)

WAC 495A-276-020 Definitions. (1) "Public record" includes any writing containing information relating to the conduct or performance of any government ((~~or the performance of any governmental~~)) agency or proprietary function

prepared, owned, used, or retained by any state or local agency regardless of physical form or characteristics.

(2) "Writing" means handwriting, typewriting, printing, ((~~photostating,~~)) photographing, and every other means of recording any form of communication or representation, including letters, words, pictures, sounds or symbols, combination thereof and all papers, maps, magnetic or paper tapes, photographic films and prints, magnetic or punched cards, disks, drums, and other documents.

(3) "Bates Technical College" is an agency organized by statute pursuant to RCW 28B.50.040. Bates Technical College shall hereafter be referred to as the "district." Where appropriate, the term "district" also refers to the staff and employees of the district.

AMENDATORY SECTION (Amending WSR 92-12-017, filed 5/26/92, effective 6/26/92)

WAC 495A-276-030 Description of central and field organization of Bates Technical College, District No. 28. (1) Bates Technical College is a state agency established and organized under the authority of chapter 28B.50 RCW for the purpose of implementing the educational goals established by the legislature in RCW 28B.50.020. The administrative office of the district is located ((~~on~~)) in the downtown campus within the city of Tacoma, Washington. The downtown campus likewise comprises the central headquarters for all operations of the district. Field activities for the south campus((~~, home and family life center, and business and management center branches~~)) and central campus of the district are administered by personnel located at those ((~~branches~~)) campuses in Tacoma, Washington; all other field activities of the district are directed and administered by personnel located on the campus at 1101 South Yakima Avenue, Tacoma, WA 98405.

(2) The district is ((~~operated under the supervision and control of a~~)) governed by the board of trustees. The board of trustees consists of five members appointed by the governor. The board of trustees normally meets at least once each month, as provided in WAC 495A-104-010. The board of trustees employs ((~~a president, an administrative staff, members of the faculty and other employees. The board of trustees takes such actions and promulgates such rules, and policies in harmony with the rules established by the state board for community and technical colleges, as are necessary to the administration and operation of the district.~~

~~(3) The president of the district is responsible to the board of trustees for the operation and administration of the district. A detailed description of the administrative organization of the district is contained within the Policies and Procedures Manual for Bates Technical College, a current copy of which is available for inspection at the administrative office of the district~~)) and delegates to the president authority for all administrative and operational responsibilities.

AMENDATORY SECTION (Amending WSR 92-12-017, filed 5/26/92, effective 6/26/92)

WAC 495A-276-040 Operations and procedures. (1) ((~~Formal decision-making procedures~~)) Board policies are established by the board of trustees through rules promulgated in accordance with the requirements of chapter 34.05 RCW, the Administrative Procedure Act.

(2) ((~~Informal decision-making procedures at the college, as established by the board of trustees, are set forth in the Policies and Procedures Manual of Bates Technical College, a current copy of which is available for inspection at the administrative office of the district.~~)) College policies are established by the president to address all administrative and operational activities.

AMENDATORY SECTION (Amending WSR 92-12-017, filed 5/26/92, effective 6/26/92)

WAC 495A-276-050 Public records available. All public records of the district, as defined in this chapter, are deemed to be available for public inspection and copying pursuant to these rules, except as otherwise provided by RCW 42.17.310 or other statutes.

(1) Records may be reviewed in person at the district office during regular office hours at no charge. Fees for providing copies of records may apply, in accordance with WAC 495A-276-090.

(2) Requestors seeking to review records in person are asked to contact the public records officer by email, phone, or by mail to schedule an appointment. Contact information for the public records officer is as follows:

Public Records Officer
Bates Technical College
1101 South Yakima Avenue
Tacoma, WA 98405
prr@batestech.edu
253-680-7174

(3) The regular business hours of the public records office are from 7:30 a.m. to 4:30 p.m., Monday through Friday, excluding legal holidays and college closures.

AMENDATORY SECTION (Amending WSR 92-12-017, filed 5/26/92, effective 6/26/92)

WAC 495A-276-060 Public records officer. The district's public records shall be in the charge of the public records officer designated by the ((~~chief administrative officer~~)) president of the district. The person so designated shall be located in the district administrative office. The public records officer shall be responsible for the following: Implementation of the district's rules regarding release of public records, coordinating district employees in this regard, and generally ensuring compliance by district employees with the public records disclosure requirements in chapter 42.17 RCW.

AMENDATORY SECTION (Amending WSR 92-12-017, filed 5/26/92, effective 6/26/92)

WAC 495A-276-080 Requests for public records. ((~~In accordance with the requirements of RCW 42.17.290 that agencies prevent unreasonable invasions of privacy, protect public records from damage or disorganization, and prevent excessive interference with essential functions of the agency, public records are only obtainable by members of the public~~

~~when those members of the public comply with the following procedures:~~

~~(1) A request shall be made in writing upon a form prescribed by the district which shall be available at the district administrative office. The form shall be presented to the public records officer or, if the public records officer is not available, to any member of the district's staff at the district administrative office during customary office hours. The request shall include the following information:~~

~~(a) The name of the person requesting the record;~~

~~(b) The time of day and calendar date on which the request was made;~~

~~(c) The nature of the request;~~

~~(d) If the matter requested is referenced within the current index maintained by the public records officer, a reference to the requested record as it is described in such current index;~~

~~(e) If the requested matter is not identifiable by reference to the current index, an appropriate description of the record requested.~~)) (1) The public records officer or designee will provide assistance to any member of the public requesting to inspect the records of the district. However, a person seeking records must make a specific request for identifiable records and must clearly state that the inquiry is a public records request.

(2) In all cases in which a member of the public is making a request, it shall be the obligation of the public records officer((~~,~~)) or person to whom the request is made((~~,~~)) to assist the member of the public in succinctly identifying the public record requested.

(3) The public records officer or designee will take action on a request for public records in a timely manner. In accordance with RCW 42.56.520, the requestor will receive a response within five days of receipt of the request by the district. If the request cannot be completed within five days, the public records officer will provide a reasonable time estimate for a complete response to the request. If the request is particularly large or complex, resulting in a large number of responsive documents or requiring significant redaction, the public records officer and the requestor may enter into an agreement by which the records are made available in installments at specific intervals.

(4) If the requestor fails to respond within fifteen days to a request from the public records officer for clarification of all or part of the public records request, the request or part of the request requiring clarification will be considered withdrawn and no further action will be taken.

(5) The requestor must claim or review the assembled records within thirty days of receiving notification that the records are available for inspection or copying. If the requestor or a representative of the requestor fails to claim or review the records within the thirty-day period or make other arrangements, the district will close the request and refile the assembled records.

AMENDATORY SECTION (Amending WSR 92-12-017, filed 5/26/92, effective 6/26/92)

WAC 495A-276-090 Copying fees—Payments. ((~~No fee shall be charged for the inspection of public records. The district may impose a reasonable charge for providing copies of public records and for the use by any person of agency equipment to copy public records and such charges shall not exceed the amount necessary to reimburse the district for its actual costs incident to such copying. No person shall be released a record so copied until and unless the person requesting the copied public record has tendered payment for such copying to the appropriate district official. All charges must be paid by money order, cashier's check, or cash in advance.~~)) (1) In accordance with RCW 42.56.070(7) and 42.56.120, the district may charge fees for providing copies of public records. The district has determined that calculating the actual costs for providing copies would be unduly burdensome. The determination is based on the large number of factors involved in calculating the actual cost and the frequency with which these factors change. Therefore, the district adopts the schedule of fees provided in RCW 42.56.120 (2).

(2) No fee shall be charged for the inspection of public records; however, in some cases the district will charge a fee for providing copies of public records. These fees are summarized in the fee schedule available on the district's web site at www.batestech.edu.

(a) The district may impose a customized service charge to cover its costs if the request requires the use of information technology or computer-related expertise to prepare data compilations or if such customized access services are not used by the agency for other business purposes.

(b) The district may require a ten percent deposit in advance if the fee for producing copies of responsive records will exceed one hundred dollars.

(c) All fees must be paid by credit or debit card, money order, cashier's check, or cash in advance of receiving the public records.

(d) The charge above may be combined to the extent that more than one type of charge applies to copies produced in response to a particular request.

(e) Upon request, the district will provide a summary of the applicable charges before any copies are made and the requestor may revise the request to reduce the number of copies to be made and reduce the applicable charge.

(3) If the requestor fails to pay fees incurred for copying by the specified payment date, the district will close the request. In such a case, the requestor will receive notification at least ten business days in advance that the request will be closed for nonpayment.

AMENDATORY SECTION (Amending WSR 92-12-017, filed 5/26/92, effective 6/26/92)

WAC 495A-276-100 Determination regarding exempt records. (1) The district reserves the right to determine that a public record requested in accordance with the procedures outlined in WAC 495A-276-080 is exempt pursuant to the provisions set forth in RCW 42.17.310 or other statute. ((~~Such determination may be made in consultation with the public records officer, president of the college district, or an assistant attorney general assigned to the district.~~))

(2) Pursuant to RCW 42.17.260, the district reserves the right to ((~~delete~~)) redact identifying details when it makes

available or publishes any public record when there is reason to believe that disclosure of such details would be an unreasonable invasion of personal privacy ((~~or~~)), impair a vital governmental interest((~~: Provided, however, In each case, the justification for the deletion shall be explained fully in writing~~)), or other applicable statutes.

(3) ((~~Response to requests for a public record must be made promptly. For the purposes of this section, a prompt response occurs if the person requesting the public record is notified within two business days as to whether his request for a public record will be honored.~~

~~(4)~~)) All denials of requests for public records must be accompanied by a written statement, signed by the public records officer or ((~~his/her~~)) designee, specifying the reason for the denial, a statement of the specific exemption authorizing the withholding of the record, and a brief explanation of how the exemption applies to the public record withheld.

AMENDATORY SECTION (Amending WSR 92-12-017, filed 5/26/92, effective 6/26/92)

WAC 495A-276-110 Review of denials of public records requests. (1) Any person who objects to the denial of a request for a public record may petition for ((~~prompt~~)) review of such decision by tendering a written request for review to the public records officer within ten business days. The written request shall specifically refer to the written statement which constituted or accompanied the denial.

(2) ((~~The written request by a person demanding prompt review of a decision denying a public record shall be submitted to the president of the district, or his or her designee.~~

~~(3) Within two business days after receiving the written request by a person petitioning for a prompt review of a decision denying a public record, the president of the district, or his or her designee, shall complete such review.~~

~~(4)~~)) After receiving a written request for review of a decision denying a public record, the public records officer or designee shall refer the request for review to the president of the college. The president or designee shall consider the matter and either affirm or reverse such denial. All requests shall receive a final decision within five business days following receipt of the appeal by the district. The time for review of the denial may be extended by mutual agreement of the district and the requestor.

(3) During the course of the review the president or ((~~his or her~~)) designee shall consider the obligations of the district to comply with the intent of chapter 42.17 RCW ((~~insofar as it requires providing full public access to official records, but shall also consider the~~)) and exemptions provided in RCW 42.17.310 or other pertinent statutes((~~, and the provisions of the statute which require the district to protect public records from damage or disorganization, prevent excessive interference with essential functions of the agency, and prevent any unreasonable invasion of personal privacy by deleting identifying details~~)).

AMENDATORY SECTION (Amending WSR 92-12-017, filed 5/26/92, effective 6/26/92)

WAC 495A-276-130 Records index. (1) The district has available for the use of all persons a current index which provides identifying information as to the following records issued, adopted, or promulgated by the district after September 1, 1991, subject to the limits of the college's retention schedule:

(a) Final opinions, including concurring and dissenting opinions, as well as orders, made in the adjudication of cases;

(b) Those statements of policy and interpretations of policy, statute and the constitution which have been adopted by the agency;

(c) Administrative staff manuals and instructions to staff that affect a member of the public;

(d) Planning policies and goals((~~,~~)) and interim and final planning decisions;

(e) Factual staff reports and studies, factual consultant's reports and studies, scientific reports and studies, and any other factual information derived from tests, studies, reports or surveys, whether conducted by public employees or others; and

(f) Correspondence((~~,~~)) and materials referred to ((~~therein, by and with the agency~~)) in this chapter relating to any regulatory, supervisory, or enforcement responsibilities of the agency((~~, whereby the agency determines, or opines upon, or is asked to determine or opine upon, the rights of the state, the public, a subdivision of state government, or of any private party~~)).

(2) The current index maintained by the district shall be available to all persons under the same rules and on the same conditions as are applied to public records available for inspection.

NEW SECTION

WAC 495A-276-150 Notification of affected persons. If the requested record is not exempt from release and contains information which could identify an individual or agency, the district may notify the individual or agency thus identified that release of the record has been requested. In such cases, the district's initial response to the request will allow a reasonable time for the identified individual or agency to seek court protection from release of the record.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 495A-276-070	Office hours.
WAC 495A-276-120	Protection of public records.
WAC 495A-276-140	Adoption of form.

WSR 19-17-034
PERMANENT RULES
DEPARTMENT OF HEALTH
(Pharmacy Quality Assurance Commission)

[Filed August 14, 2019, 3:48 p.m., effective September 14, 2019]

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

Purpose: WAC 246-901-130 Pharmacist to pharmacy technician ratio, the purpose of the rule is to eliminate a standard ratio for all practice settings. The rule will allow responsible pharmacy managers to use their professional judgment to determine the appropriate staffing levels for their practice setting. Staffing levels must ensure satisfactory supervision of ancillary personnel for the safe and appropriate delivery of patient care.

Citation of Rules Affected by this Order: Amending WAC 246-901-130.

Statutory Authority for Adoption: RCW 18.64A.040.

Adopted under notice filed as WSR 19-04-032 on January 28, 2019.

A final cost-benefit analysis is available by contacting Doreen Beebe, Program Manager, P.O. Box 47852, Olympia, WA 98504-7852, phone 360-236-4834, fax 360-236-2260, TTY 360-833-6388 or 711, email doreen.beebe@doh.wa.gov, web site www.doh.wa.gov.

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

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

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

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

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

Date Adopted: June 21, 2019.

Tim Lynch, PharmD, MS, Chair
Pharmacy Quality Assurance Commission

AMENDATORY SECTION (Amending WSR 00-15-081, filed 7/19/00, effective 8/19/00)

WAC 246-901-130 Pharmacist to pharmacy technician ratio. (((~~(1) A standard ratio of one pharmacist to a maximum of three technicians is established for each licensed pharmacy.~~

~~(2) The pharmacist must be actively practicing pharmacy.~~

~~(3) In determining which pharmacists may be included in the calculation of the ratio, the board will consider approval of pharmacy technician utilization plans which include all pharmacists within the pharmacy who are engaged in the actual practice of pharmacy. When the pharmacy provides service to inpatients of a hospital or extended care facility, pharmacists who are practicing pharmacy outside of the confines of the licensed pharmacy (for example, performing nursing unit inspections, reviewing charts, consulting with health professional staff) may be included in the ratio, if:~~

~~(a) There are sufficient numbers of pharmacists within the pharmacy to properly supervise the work of the pharmacy technicians;~~

~~(b) The pharmacy is not open to the public;~~

~~(c) The medications are being checked by another health professional before being given to the patient;~~

~~(d) Drug orders are not dispensed from the pharmacy without being checked by a licensed pharmacist or pharmacy intern except for board-approved pharmacy technician specialized functions provided a pharmacy technician may check unit-dose medication cassettes.~~)) (1) The ratio of pharmacy technicians to pharmacist(s) on duty is to be determined by the responsible pharmacy manager.

(2) The responsible pharmacy manager will ensure that the number of pharmacy technicians on duty can be satisfactorily supervised by the pharmacist(s) on duty.

WSR 19-17-039
PERMANENT RULES
OFFICE OF FINANCIAL MANAGEMENT

[Filed August 15, 2019, 8:20 a.m., effective September 23, 2019]

Effective Date of Rule: September 23, 2019.

Purpose: To align Title 357 WAC with the changes made to RCW 41.04.674. SSB 5955 addresses various provisions for the department of children, youth, and families (DCYF) effective July 28, 2019. Section 6 of SSB 5955 amends RCW 41.04.674 which removes the requirement for the office of financial management (OFM) to adopt rules and policies governing the donation and use of shared leave from the foster parent shared leave pool (FPSLP) in consultation with the department of social and health services and requires OFM to adopt rules and policies governing the donation and use of shared leave from FPSLP with DCYF.

Citation of Rules Affected by this Order: Amending WAC 357-31-840, 357-31-885, and 357-31-920.

Statutory Authority for Adoption: Chapter 41.06 RCW.

Other Authority: RCW 41.04.674.

Adopted under notice filed as WSR 19-14-028 on June 25, 2019.

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

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

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

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

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 3, Repealed 0.

Date Adopted: August 15, 2019.

Roselyn Marcus
Assistant Director of
Legal and Legislative Affairs

AMENDATORY SECTION (Amending WSR 18-03-081, filed 1/15/18, effective 2/16/18)

WAC 357-31-840 Who shall administer the foster parent shared leave pool? The department of ((~~social and health services~~)) children, youth, and families, in consultation with office of financial management, shall administer the foster parent shared leave pool.

AMENDATORY SECTION (Amending WSR 18-03-081, filed 1/15/18, effective 2/16/18)

WAC 357-31-885 May employees donating leave for the purpose of the foster parent shared leave pool direct the donation to a specific individual? Leave donated under this section is donated to the foster parent shared leave pool and cannot be directed to a specific individual. Foster parent shared leave is withdrawn from the pool by eligible employees according to priorities established by the department of ((~~social and health services~~)) children, youth, and families. All employees who donate must specifically direct their leave donation to the foster parent shared leave pool.

AMENDATORY SECTION (Amending WSR 18-03-081, filed 1/15/18, effective 2/16/18)

WAC 357-31-920 When an employer and/or the department of ((~~social and health services~~)) children, youth, and families has determined that abuse of the foster parent shared leave pool has occurred will the employee be required to repay the shared leave drawn from the pool? Employers and/or the department of ((~~social and health services~~)) children, youth, and families must investigate any alleged abuse of the foster parent shared leave pool and on a finding of wrongdoing the employee may be required to repay all of the shared leave received from the foster parent shared leave pool. The only time an employee will have to repay leave credits is when there is a finding of wrongdoing.

WSR 19-17-040
PERMANENT RULES
OFFICE OF FINANCIAL MANAGEMENT

[Filed August 15, 2019, 8:20 a.m., effective September 23, 2019]

Effective Date of Rule: September 23, 2019.

Purpose: To align Title 357 WAC with the provisions in chapter 415, Laws of 2019, the state operating budget for the 2019-2021 fiscal biennium. Section 207 provides funding for premium pay for those employees who are assigned to work on McNeil Island at the Special Commitment Center. Additionally Section 950 provides funding for a five percent premium pay for employees working in King County.

Citation of Rules Affected by this Order: New WAC 357-28-203 and 357-58-141.

Statutory Authority for Adoption: Chapter 41.06 RCW.

Other Authority: RCW 41.06.133.

Adopted under notice filed as WSR 19-14-027 on June 25, 2019.

Changes Other than Editing from Proposed to Adopted Version: Since the proposed version, WAC 357-28-203 and 357-58-141 were changed. WAC 357-28-203 was changed to clarify that the Special Commitment Center and King County premium pay are location based premium pays. WAC 357-28-203 (2)(a) was also changed to clarify that King County premium pay does not apply to employees who are employed by the University of Washington (UW), not at UW. WAC 357-58-141 was also changed to clarify that the Special Commitment Center and King County premium pay are location based premium pay for Washington management service (WMS) employees. WAC 357-58-141 (2)(a) was removed because there are no WMS employees at UW.

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

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

Number of Sections Adopted on the Agency's own Initiative: New 2, Amended 0, Repealed 0.

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

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

Date Adopted: August 15, 2019.

Roselyn Marcus
Assistant Director of
Legal and Legislative Affairs

NEW SECTION

WAC 357-28-203 When must an employee receive location based premium pay? Location based premium pay at the rate specified in the compensation plan must be paid when an employee is:

(1) Assigned to work on McNeil Island at the special commitment center and for each day the employee is physically working on the island. Days in paid status not working on the island will not qualify for premium pay; and

(2) Assigned to a permanent duty station in King County.

(a) This subsection does not apply to employees who are employed by the University of Washington.

(b) When an employee is no longer permanently assigned to a King County duty station they will not be eligible for location based premium pay.

NEW SECTION

WAC 357-58-141 When must a Washington management service (WMS) employee receive location based premium pay? Location based premium pay at the rate specified

in the compensation plan must be paid when a WMS employee is:

(1) Assigned to work on McNeil Island at the special commitment center and for each day the employee is physically working on the island. Days in paid status not working on the island will not qualify for premium pay; and

(2) Assigned to a permanent duty station in King County. When an employee is no longer permanently assigned to a King County duty station they will not be eligible for location based premium pay.

WSR 19-17-041
PERMANENT RULES
OFFICE OF FINANCIAL MANAGEMENT

[Filed August 15, 2019, 9:08 a.m., effective September 23, 2019]

Effective Date of Rule: September 23, 2019.

Purpose: To align Title 357 WAC with the changes made to RCW 43.10.005. Chapter 134, Laws of 2019 (SHB 1930) was passed during the 2019 legislative session with an effective date of July 28, 2019. This bill amends RCW 43.10.005 adding the requirement for employers to provide reasonable break time for an employee to express breast milk for two years after the child's birth each time the employee has need to express the milk and provide a private location, other than a bathroom, if such a location exists at the place of business or worksite, which may be used for this purpose.

Citation of Rules Affected by this Order: Amending WAC 357-26-035.

Statutory Authority for Adoption: Chapter 43.01 RCW.

Other Authority: RCW 43.10.005.

Adopted under notice filed as WSR 19-14-029 on June 25, 2019.

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

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

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

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

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

Date Adopted: August 15, 2019.

Roselyn Marcus
Assistant Director of
Legal and Legislative Affairs

AMENDATORY SECTION (Amending WSR 19-05-056, filed 2/15/19, effective 3/29/19)

WAC 357-26-035 What actions must an employer take to provide reasonable pregnancy accommodations? (1) An employer must provide employees who are pregnant or have a pregnancy-related health condition a reasonable pregnancy accommodation((~~, which includes the following:~~

~~(a) Providing more frequent, longer, or flexible restroom breaks;~~

~~(b) Modifying a no food or drink policy;~~

~~(c) Providing seating or allowing an employee to sit more frequently if the job requires standing;~~

~~(d) Job restructuring, part-time or modified work schedules, reassignment to a vacant position, or acquiring or modifying equipment, devices, or an employee's work station;~~

~~(e) Providing a temporary transfer to a less strenuous or less hazardous position;~~

~~(f) Providing assistance with manual labor and limits on lifting;~~

~~(g) Scheduling flexibility for prenatal visits; and~~

~~(h) Any further pregnancy accommodation an employee may request and to which an employer must give reasonable consideration in consultation with information provided on pregnancy accommodation by the department of labor and industries or the employee's attending health care provider~~)) for reasons as required in RCW 43.10.005.

(2) An employer cannot require an employee who is pregnant or has a pregnancy-related health condition to take leave if another reasonable pregnancy accommodation can be provided.

(3) The employer is not required to create additional employment that the employer would not otherwise have created, unless the employer does so or would do so for other classes of employees who need accommodation.

WSR 19-17-042
PERMANENT RULES
BOARD OF TAX APPEALS

[Filed August 15, 2019, 12:55 p.m., effective September 15, 2019]

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

Purpose: Amending WAC 456-09-120, 456-12-045 and 456-10-140, to reflect new office location and contact information.

Citation of Rules Affected by this Order: Amending WAC 456-09-120, 456-10-140, and 456-12-045.

Statutory Authority for Adoption: RCW 82.03.170.

Adopted under notice filed as WSR 19-12-034 on May 29, 2019.

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

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

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

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 3, Repealed 0.

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

Date Adopted: August 6, 2019.

Kate Adams
Executive Director

AMENDATORY SECTION (Amending WSR 05-13-141, filed 6/21/05, effective 8/1/05)

WAC 456-09-120 Organization and office. The board consists of three members, one of whom is elected chair. Members of the board are appointed by the governor with the consent of the senate and serve on a full-time basis.

The board offices are open each day for the transaction of business from 8:00 a.m. to 5:00 p.m., excluding Saturdays, Sundays, and legal holidays. All submissions, requests, and communications shall be sent to the board at its ((~~principal office at 910 5th Avenue S.E.,~~)) main office. The main office of the board is located at 1110 Capitol Way S., Suite 300, Olympia, WA 98501-2251. The mailing address is Post Office Box 40915, Olympia, Washington 98504-0915. The phone number of the board office is 360-753-5446; its fax number is 360-586-9020; its electronic mail address is ((~~bta@bta.state.wa.us~~)) bta@bta.wa.gov. Information about the board is available at its web site at ((~~http://bta.state.wa.us~~)) http://bta.wa.gov.

AMENDATORY SECTION (Amending WSR 05-13-141, filed 6/21/05, effective 8/1/05)

WAC 456-10-140 Organization and office. The board consists of three members, one of whom is elected chair. Members of the board are appointed by the governor with the consent of the senate and serve on a full-time basis.

The board offices are open each day for the transaction of business from 8:00 a.m. to 5:00 p.m., excluding Saturdays, Sundays, and legal holidays. All submissions, requests, and communications shall be sent to the board at its ((~~principal office at 910 5th Avenue S.E.,~~)) main office. The main office is located at 1110 Capitol Way S., Suite 300, Olympia, WA 98501-2251. The mailing address is Post Office Box 40915, Olympia, Washington 98504-0915. The phone number of the board office is 360-753-5446; its fax number is 360-586-9020; its electronic mail address is ((~~bta@bta.state.wa.us~~)) bta@bta.wa.gov. Information about the board is available at its web site at ((~~http://bta.state.wa.us~~)) http://bta.wa.gov.

AMENDATORY SECTION (Amending WSR 99-13-098, filed 6/15/99, effective 7/16/99)

WAC 456-12-045 Public records available. Unless exempt under chapter 42.17 RCW or other law, all public records and indexes of the board are available for public inspection and copying at the board's ((~~office from 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding legal holidays. The board's office is located at 910 5th Avenue S.E., Olympia, WA 98504-0915~~)) main office during customary office hours.

WSR 19-17-062
PERMANENT RULES
DEPARTMENT OF TRANSPORTATION

[Filed August 20, 2019, 8:12 a.m., effective September 20, 2019]

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

Purpose: The authority needs to be corrected. The incorrect authority was cited. The change will cite the correct authority of RCW 47.01.101 which provides that the department may adopt rules that are subject to the adoption procedures contained in the state Administrative Procedure Act.

Citation of Rules Affected by this Order: Amending WAC 468-17-010.

Statutory Authority for Adoption: RCW 47.01.101.

Adopted under notice filed as WSR 19-13-012 on June 7, 2019.

Changes Other than Editing from Proposed to Adopted Version: No other changes of substance.

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

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

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

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

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

Date Adopted: August 20, 2019.

Kara Larsen, Director
Risk Management and
Legal Services Division

AMENDATORY SECTION (Amending WSR 19-12-026, filed 5/29/19, effective 6/29/19)

WAC 468-17-010 Authority. RCW ~~47.28.030~~ 47.01.101 provides that the Washington state department of transportation (WSDOT) may adopt rules ~~to enable a larger number of small businesses and veteran contractors to compete for department contracts~~ that are subject to the adoption procedures contained in the state administrative procedure act.

Reviser's note: The typographical errors in 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 19-17-067
PERMANENT RULES
DEPARTMENT OF LABOR AND INDUSTRIES

[Filed August 20, 2019, 10:14 a.m., effective January 1, 2020]

Effective Date of Rule: January 1, 2020.

Purpose: The department is adopting one new rule. This rule making involves significant legislative changes. The goals of the new rule are to create standardized medical bill reporting expectations for self-insured employers, to support the collection of quality data, and to create a reporting exemption for qualifying employers.

This rule making will ensure:

- Self-insured employers are required to report medical bills through the medical bill electronic data interchange.
- Self-insured employers are required to report bills accurately and timely.
- Under limited circumstances, self-insured employers can be provided an exception, which means that they are exempt from reporting.

Standardized reporting will build data integrity, improve industry benchmarking, and inform and support policy conversations and decisions.

Citation of Rules Affected by this Order: New WAC 296-15-232.

Statutory Authority for Adoption: RCW 51.04.020, 51.14.110(3).

Adopted under notice filed as WSR 19-12-087 on June 4, 2019.

A final cost-benefit analysis is available by contacting K. C. Wilkerson, P.O. Box 44890, Olympia, WA 98504-4890, phone 360-902-6851, fax 360-902-6977, email kc.wilkerson@Lni.wa.gov, web site http://www.Lni.wa.gov/LawRule.

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

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

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

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

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

Date Adopted: August 20, 2019.

Joel Sacks
Director

NEW SECTION

WAC 296-15-232 Self-insurance medical bill electronic data interchange. (1) Self-insurers are required to report medical bills incurred from their workers' compensation claims according to department guidelines.

(a) All bills associated with qualifying claims must be reported, and the department will establish a minimum threshold percentage for reporting of bill to claims to monitor compliance.

(b) Qualifying claims include claims for which:

(i) The date of injury (DOI) was on or after January 1, 2020.

(ii) The claim was initiated during a time that the employer was self-insured, and the liability for that claim remains with the employer.

(2) Self-insurers must submit complete and accurate reports based on standards set forth by the International Association of Industrial Accident Boards and Commissions (IAIABC).

(a) The department will systematically monitor report data for quality and timeliness, and establish objective performance standards based on the overall reporting of data.

(b) The department will establish a maximum threshold percentage for errors or untimely submittals.

(c) The department will provide notification to submitters if performance measures are below the standard set by the department.

(d) Submitters will have thirty days from the date of notification to make corrections to errors and resubmit, or request an extension in writing to the department.

(e) The department will review errors that remain uncorrected after thirty days. Uncorrected errors may result in training, audit, rule violation penalties, and/or a corrective action process.

(3) New self-insurers may apply for an exemption to reporting medical bills with their application for certification as a self-insured employer.

(a) To qualify for the exemption, the employer must have had one or fewer claims filed in the state of Washington in the last three years, and the employer must have fewer than five employees in the state.

(b) The department may deny any request for exemption.

(c) Authority to grant or deny exemptions belongs to the supervisor of industrial insurance, or designee.

(d) If granted, the exemption expires after three years. The employer may apply for another exemption at that time.

WSR 19-17-068
PERMANENT RULES
DEPARTMENT OF LABOR AND INDUSTRIES

[Filed August 20, 2019, 10:16 a.m., effective January 1, 2020]

Effective Date of Rule: January 1, 2020.

Purpose: The department of labor and industries (L&I) is adopting updates to certain sections of chapter 296-27 WAC, Recordkeeping and reporting, to make sure we are at-least-as-effective-as the Occupational Safety and Health Administration (OSHA). Over the past few years, federal OSHA made multiple updates, with the latest changes occurring in

January 2019. OSHA's multiple rule-making projects impacted these specific sections:

- 29 C.F.R. 1904.35 Employee Involvement. (WAC 296-27-02111)
- 29 C.F.R. 1904.36 Prohibition against discrimination. (WAC 296-27-02113)
- 29 C.F.R. 1904.40 Providing records to government representatives. (WAC 296-27-03101)
- 29 C.F.R. 1904.41 Annual Electronic Submission of occupational injury and illness records; which now applies to all state plan states. (WAC 296-27-03103)

One of the most significant changes federal OSHA made was to now require all establishments/employers operating in state plan states (and who meet the specified criteria) to comply with the annual electronic records submission requirements. Other housekeeping amendments were also adopted in this chapter. Please see below for what was adopted in this rule making:

AMENDED SECTIONS

WAC 296-27-01103 through 296-27-03101.

- Housekeeping changes through the chapter that did not change the effect of the rule. These changes included updating "you," "you are" or "you have" to "the employer," "the employer is" or "the employer has" where applicable for consistency purposes across all WAC, as well as clarification for users of this chapter.

WAC 296-27-01101 Recording criteria.

- The adoption corrected an inadvertent error from past rule making that references recordkeeping criteria under WAC 296-27-01109 through 296-27-01115 for specific cases related to needlestick and sharps injuries, medical removal cases, occupational hearing loss cases, and work-related tuberculous cases. The adopted rule updated the reference to "musculoskeletal disorder" with the correct reference to "tuberculosis" in subsection (2).

WAC 296-27-02111 Employee involvement.

- Revised the existing requirement that employers establish procedures for employees to report occupational injuries and illness, to clarify that these procedures must be "reasonable" and not deter or discourage reporting.
- Required employers to inform employees of their right to report work-related injuries and illnesses free from retaliation.
- Incorporated the existing statutory prohibition on retaliating against employees for reporting work-related injuries or illnesses.
- Updated existing language to clarify the rights of employees and their representatives to access the injury and illness records.

WAC 296-27-02113 Prohibition against discrimination.

- Updated the existing language to clarify that the WISH Act prohibits employers from discriminating against an employee for reporting a work-related fatality, injury or illness, as well as protects the employee who files a safety and health complaint, or asks for access to the chapter 296-27 WAC records, or otherwise exercises any rights afforded under the WISH Act.

WAC 296-27-03103 Annual OSHA injury and illness survey.

- Updated title of this WAC section to "Electronic submission of injury and illness records to OSHA."
- Added new note at the beginning of the section that reads: Note: The information required by this section is reported and tracked by OSHA for their own injury and illness data analysis. The division of occupational safety and health is not notified when employers submit this information to OSHA.
- Updated existing requirements requiring certain employers to submit injury and illness data to OSHA to address electronic submission. Removed all original language from this section and replaced it with new language from OSHA, in a new format, outlining the requirements of electronic submission. The latest OSHA updates from January 2019 are represented in our updates. The new language will be at-least-as-effective-as OSHA.

NEW SECTIONS

WAC 296-27-001 Definitions.

- Moved the definitions section from the end of the chapter to the beginning for clarification purposes, as well as to align with the changes being made for the eRules rule-making project.

WAC 296-27-071 Appendix B Annual Electronic Submission of OSHA Form 300A; Table 3: Designated Industries.

- Added an OSHA identical table to this new section. Please see the adopted language for Table 3.

REPEALED SECTIONS

WAC 296-27-051 Definitions and 296-27-05101 Definitions.

Citation of Rules Affected by this Order: New WAC 296-27-001 and 296-27-071; repealing WAC 296-27-051 and 296-27-05101; and amending WAC 296-27-01101, 296-27-01103, 296-27-01105, 296-27-01107, 296-27-01109, 296-27-01111, 296-27-01113, 296-27-01115, 296-27-01119, 296-27-02101, 296-27-02103, 296-27-02105, 296-27-02107, 296-27-02111, 296-27-02113, 296-27-02117, 296-27-031, 296-27-03101, and 296-27-03103.

Statutory Authority for Adoption: RCW 49.17.010, 49.17.040, and 49.17.050.

Adopted under notice filed as WSR 19-10-062 on April 30, 2019.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 2, Amended 19, Repealed 2; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

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

Number of Sections Adopted on the Agency's own Initiative: New 2, Amended 19, Repealed 2.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 2, Amended 19, Repealed 2.

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

Date Adopted: August 20, 2019.

Joel Sacks
Director

NEW SECTION

WAC 296-27-001 Definitions. Amputation. The traumatic loss of an appendage, such as an upper or lower limb (or part of the limb) or other external body part that has been severed or cut off either completely or partially at the time of the injury, or is surgically removed due to irreparable damage. Amputations may or may not include bone loss.

Note: Amputations include fingertips and amputations of body parts that have since been reattached. Amputations do not include loss of an eye, broken or chipped teeth, scalpings, or avulsions, such as deglovings, where the skin and tissue have been torn away from the underlying subcutaneous tissue, tendons, muscle, or bone.

Authorized employee representative. An authorized collective bargaining agent of employees.

Authorized government representative. A representative of the Secretary of Labor, conducting an inspection or investigation under the act, a representative of the Secretary of Health and Human Services (including the National Institute for Occupational Safety and Health (NIOSH)) conducting an investigation under section 20(b) of the act, or a division of occupational safety and health (DOSH) representative of the state department of labor and industries.

Department. The Washington state department of labor and industries.

Employer. A person, firm, corporation, partnership, business trust, legal representative, or other business entity which engages in any business, industry, profession, or activity in this state and employs one or more employees or who contracts with one or more persons, the essence of which is the personal labor of such person or persons and includes the state, counties, cities, and all municipal corporations, public corporations, political subdivisions of the state, and charitable organizations. Provided that any persons, partnership, or business entity not having employees, and who is covered by the Industrial Insurance Act, must be considered both an employer and employee.

Establishment. A single physical location where business is conducted or where services or industrial operations are performed. For activities where employees do not work at a single physical location, such as construction; transportation; communications, electric, gas and sanitary services; and similar operations, the establishment is represented by main or branch offices, terminals, stations, etc., that either supervise such activities or are the base from which personnel carry out these activities.

(a) Normally, one business location has only one establishment. Under limited conditions, the employer may consider two or more separate businesses that share a single location to be separate establishments. You may divide one location into two or more establishments only when:

(i) Each of the establishments represents a distinctly separate business;

(ii) Each business is engaged in a different economic activity;

(iii) No one industry description in the North American Industrial Classification System applies to the joint activities of the establishments; and

(iv) Separate reports are routinely prepared for each establishment on the number of employees, their wages and salaries, sales or receipts, and other business information. For example, if an employer operates a construction company at the same location as a lumber yard, the employer may consider each business to be a separate establishment.

(b) You may combine two or more physical locations into a single establishment only when:

(i) You operate the locations as a single business operation under common management;

(ii) The locations are all located in close proximity to each other; and

(iii) You keep one set of business records for the locations, such as records on the number of employees, their wages and salaries, sales or receipts, and other kinds of business information. For example, one manufacturing establishment might include the main plant, a warehouse a few blocks away, and an administrative services building across the street.

(c) For employees who telecommute from home, the employee's home is not a business establishment, and a separate OSHA 300 Log is not required. Employees who telecommute must be linked to one of your establishments under WAC 296-27-02101(4).

First aid. For the purpose of this chapter, first aid only includes the following:

(a) Using a nonprescription medication at nonprescription strength (for medications available in both prescription and nonprescription form, a recommendation by a physician or other licensed health care professional to use a nonprescription medication at prescription strength is considered medical treatment for recordkeeping purposes);

(b) Administering tetanus immunizations (other immunizations, such as Hepatitis B vaccine or rabies vaccine, are considered medical treatment);

(c) Cleaning, flushing, or soaking wounds on the surface of the skin;

(d) Using wound coverings such as bandages, Band-Aids™, gauze pads, etc., or using butterfly bandages or Steri-Strips™ (other wound closing devices such as sutures, staples, etc., are considered medical treatment);

(e) Using hot or cold therapy;

(f) Using any nonrigid means of support, such as elastic bandages, wraps, nonrigid back belts, etc., (devices with rigid stays or other systems designed to immobilize parts of the body are considered medical treatment for recordkeeping purposes);

(g) Using temporary immobilization devices while transporting an accident victim (e.g., splints, slings, neck collars, back boards, etc.);

(h) Drilling of a fingernail or toenail to relieve pressure, or draining fluid from a blister;

(i) Using eye patches;

(j) Removing foreign bodies from the eye using only irrigation or a cotton swab;

(k) Removing splinters or foreign material from areas other than the eye by irrigation, tweezers, cotton swabs, or other simple means;

(l) Using finger guards;

(m) Using massages (physical therapy or chiropractic treatment are considered medical treatment for recordkeeping purposes); or

(n) Drinking fluids for relief of heat stress.

Injury or illness. An abnormal condition or disorder. Injuries include cases such as, but not limited to, a cut, fracture, sprain, or amputation. Illnesses include both acute and chronic illnesses, such as, but not limited to, a skin disease, respiratory disorder, or poisoning. Injuries and illness are recordable only if they are new, work-related cases that meet one or more of this section's recording criteria.

Inpatient hospitalization. To be admitted into a hospital or equivalent facility for medical treatment.

Loss of an eye(s). The physical removal of an eye occurring either at the time of injury or is surgically removed due to irreparable damage. The loss of sight without the removal is not reportable, unless the worker is admitted as an inpatient hospitalization after losing sight as a result of a worker-related incident, then it is reportable within the eight-hour time frame specified in WAC 296-27-031(1).

Medical treatment. The management and care of a patient to com-bat disease or disorder. For the purposes of this section, medical treatment does not include:

(a) Visits to a physician or other licensed health care professional solely for observation or counseling;

(b) The conduct of diagnostic procedures, such as X rays and blood tests, including the administration of prescription medications used solely for diagnostic purposes (e.g., eye drops to dilate pupils); or

(c) First aid (see definition of first aid).

OSHA. Occupational Safety and Health Administration.

Other potentially infectious materials. Includes all of the following:

(a) The following human body fluids: Semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids;

(b) Any unfixed tissue or organ (other than intact skin) from a human (living or dead);

(c) HIV-containing cell or tissue cultures, organ cultures, and HIV- or HBV-containing culture medium or other solutions; and blood, organs, or other tissues from experimental animals infected with HIV or HBV; and

(d) Blood and tissues of experimental animals infected with bloodborne pathogens.

Personal representative. Any person that the employee or former employee designates as such in writing, or the legal representative of a deceased or legally incapacitated employee or former employee.

Physician or other licensed health care professional. A physician or other licensed health care professional whose legally permitted scope of practice (i.e., license, registration, or certification) allows them to independently perform, or be delegated the responsibility to perform, the activities described by this regulation.

Preexisting condition. An injury or illness that resulted solely from a nonwork-related event or exposure.

Routine functions. For recordkeeping purposes, routine functions are those work activities the employee regularly performs at least once per week.

WISHA (WISH Act). The Washington Industrial Safety and Health Act.

Work environment. The establishment and other locations where one or more employees are working or are present as a condition of their employment. The work environment includes not only physical locations, but also the equipment or materials used by the employee during the course of their work.

You. An employer (see definition of employer).

AMENDATORY SECTION (Amending WSR 15-11-066, filed 5/19/15, effective 7/1/15)

WAC 296-27-01101 Recording criteria. (1) Employers required to keep records by this chapter must record each fatality, injury and illness that:

(a) Is work-related, see WAC 296-27-01103;

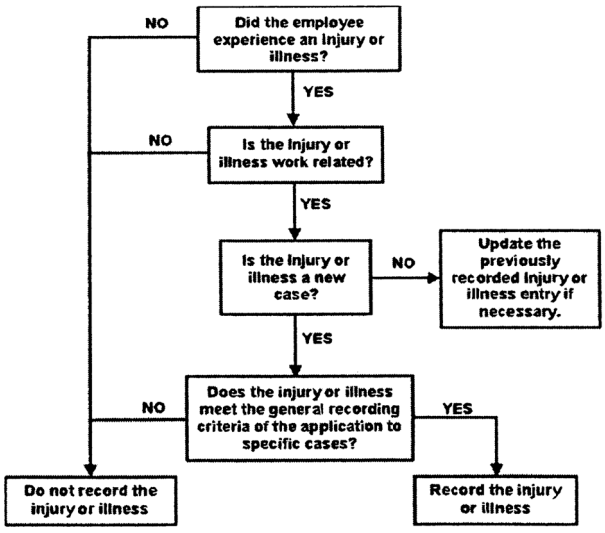
(b) Is a new case, see WAC 296-27-01105; and

(c) Meets one or more of the general recording criteria of WAC 296-27-01107.

(2) Additional criteria for specific cases such as needlestick and sharps injury cases, hearing loss cases, medical removal cases, and ((~~musculoskeletal disorder~~)) tuberculosis cases are located in WAC 296-27-01109 through 296-27-01115.

Note: The decision tree for recording work-related injuries and illnesses below shows the steps involved in determining whether a particular injury or illness is reportable.

Decision Tree



AMENDATORY SECTION (Amending WSR 15-11-066, filed 5/19/15, effective 7/1/15)

WAC 296-27-01103 Determination of work-relatedness. (1) ((~~You~~)) The employer must consider an injury or illness to be work-related if an event or exposure in the work environment either caused or contributed to the resulting condition or significantly aggravated a preexisting injury or illness. Work-relatedness is presumed for injuries and illnesses resulting from events or exposures occurring in the work environment, unless an exception in subsection (2)(a) through (i) of this section specifically applies.

(2) An injury or illness occurring in the work environment is not recordable or considered work-related if it meets one of the following exceptions:

(a) At the time of the injury or illness, the employee was present in the work environment as a member of the public rather than as an employee.

(b) The injury or illness involves signs or symptoms that surface at work but result solely from a nonwork-related event or exposure that occurs outside the work environment.

(c) The injury or illness results solely from voluntary participation in a wellness program or in a medical, fitness, or recreational activity such as blood donation, physical examination, flu shot, exercise class, racquetball, or baseball.

(d) The injury or illness is solely the result of an employee eating, drinking, or preparing food or drink for personal consumption (whether bought on the employer's premises or brought in). For example, if the employee is injured by choking on a sandwich while in the employer's establishment, the case would not be considered work-related.

(e) The injury or illness is solely the result of an employee doing personal tasks (unrelated to their employment) at the establishment outside of the employee's assigned working hours.

(f) The injury or illness is solely the result of personal grooming, self-medication for a nonwork-related condition, or is intentionally self-inflicted.

(g) The injury or illness is caused by a motor vehicle accident and occurs on a company parking lot or company access road while the employee is commuting to or from work.

(h) The illness is the common cold or flu.

(i) The illness is a mental illness. Mental illness will not be considered work-related unless the employee voluntarily provides the employer with an opinion from a physician or other licensed health care professional with appropriate training and experience (psychiatrist, psychologist, psychiatric nurse practitioner, etc.) stating that the employee has a mental illness that is work-related.

Notes:

1. If the employee is made ill by ingesting food contaminated by workplace contaminants (such as lead), or gets food poisoning from food supplied by the employer, the case would be considered work-related.

2. Contagious diseases such as tuberculosis, brucellosis, hepatitis A, or plague are considered work-related if the employee is infected at work.

(3) If it is not obvious whether an event or exposure was work-related, ((~~you~~)) the employer must evaluate the employee's work duties and work environment to determine if the event or exposure was work-related and resulted in either a new injury or illness or it significantly aggravated a preexisting condition. A preexisting condition is an injury or illness that is significantly aggravated by the event or exposure occurring in the work environment if it results in any of the following:

(a) Death, provided that the preexisting injury or illness would likely not have resulted in death but for the occupational event or exposure.

(b) Loss of consciousness, provided that the preexisting injury or illness would likely not have resulted in loss of consciousness but for the occupational event or exposure.

(c) One or more days away from work, or days of restricted work, or days of job transfer that otherwise would not have occurred but for the occupational event or exposure.

(d) Medical treatment in a case where no medical treatment was needed for the injury or illness before the workplace event or exposure, or a change in medical treatment was necessitated by the workplace event or exposure.

(4) Injuries and illnesses that occur while an employee is on travel status are work-related if, at the time of the injury or illness, the employee was engaged in work activities "in the interest of the employer." Examples include travel to and from customer contacts, conducting job tasks, and entertaining or being entertained to transact, discuss, or promote business (work-related entertainment includes only entertainment activities being engaged in at the direction of the employer). Injuries or illnesses that occur when the employee is on travel status do not have to be recorded if they meet one of the exceptions listed in Table 2 of this subsection:

Table 2

Determining Work-Related Injuries or Illnesses During Travel Status

If the employee has:	**((~~You~~)) The employer may use the following to determine if an injury or illness is work-related.**
Checked into a hotel or motel for one or more days	When a traveling employee checks into a hotel, motel, or into another temporary residence, they establish a "home away from home." ((~~You~~)) The employer must evaluate the employee's activities after they check into the hotel, motel, or other temporary residence for their work-relatedness in the same manner as you evaluate the activities of a nontraveling employee. When the employee checks into the temporary residence, they are considered to have left the work environment. When the employee begins work each day, they reenter the work environment. If the employee has established a "home away from home" and is reporting to a fixed worksite each day, ((~~you also do~~)) the employer also does not consider injuries or illnesses work-related if they occur while the employee is commuting between the temporary residence and the job location.
Taken a detour for personal reasons	Injuries or illnesses are not considered work-related if they occur while the employee is on a personal detour from a reasonably direct route of travel (e.g., has taken a side trip for personal reasons).

(5) Injuries and illnesses that occur while an employee is working at home are considered work-related if the injury or illness occurs while the employee is performing work for pay or compensation in the home, and the injury or illness is directly related to the performance of work and not to the home environment.

Note: Examples of recordable injury and illnesses that occur when an employee works at home:

1. If an employee drops a box of work documents and injures their foot, the case is considered work-related.

2. If an employee's fingernail is punctured by a needle from a sewing machine used to perform garment work at home, becomes infected and requires medical treatment, the injury is considered work-related.

3. If an employee is injured because they trip on the family dog while rushing to answer a work phone call, the case is not considered work-related.

4. If an employee working at home is electrocuted because of faulty home wiring, the injury is not considered work-related.

AMENDATORY SECTION (Amending WSR 15-11-066, filed 5/19/15, effective 7/1/15)

WAC 296-27-01105 Determination of new cases. (1) ((~~You~~)) The employer must consider an injury or illness to be a "new case" if:

(a) The employee has not previously experienced a recorded injury or illness of the same type that affects the same part of the body; or

(b) The employee previously experienced a recorded injury or illness of the same type that affected the same part of the body but had recovered completely (all signs and symptoms had disappeared) from the previous injury or illness, and an event or exposure in the work environment caused the signs or symptoms to reappear.

(2) For occupational illnesses where the signs or symptoms may recur or continue in the absence of an exposure in the workplace, the case must only be recorded once. Examples may include occupational cancer, asbestosis, byssinosis and silicosis.

(3) When an employee experiences the signs or symptoms of an injury or illness as a result of an event or exposure in the workplace, such as an episode of occupational asthma, ((~~you~~)) the employer must treat the episode (even if the episode is a recurrence) as a new case.

(4) ((~~You are~~)) The employer is not required to seek the advice of a physician or other licensed health care professional. However, if ((~~you do~~)) the employer does seek such advice, ((~~you~~)) they must follow the physician's or other licensed health care professional's recommendation about whether the case is a new case or a recurrence. If ((~~you~~)) the employer receives recommendations from two or more physicians or other licensed health care professionals, ((~~you~~)) the employer must make a decision as to which recommendation is the most authoritative (best documented, best reasoned, or most authoritative), and record the case based upon that recommendation.

AMENDATORY SECTION (Amending WSR 15-11-066, filed 5/19/15, effective 7/1/15)

WAC 296-27-01107 General recording criteria. (1) ((~~You~~)) The employer must consider an injury or illness to meet the general recording criteria, and therefore to be recordable, if it results in any of the following:

(a) Death;

(b) Days away from work;

(c) Restricted work or transfer to another job;

(d) Medical treatment beyond first aid;

(e) Loss of consciousness for any length of time.

(2) ((~~You~~)) The employer must also record any case that involves a **significant injury or illness** (see WAC 296-27-01107(21)) diagnosed by a physician or other licensed health care professional, even if it does not result in death, days away from work, restricted work, job transfer, medical treatment beyond first aid, or loss of consciousness.

(3) ((~~You~~)) The employer must record an injury or illness that results in death by entering a check mark on the OSHA 300 Log in the space for cases resulting in death.

(4) When an injury or illness involves one or more days away from work, ((~~you~~)) the employer must record the injury or illness on the OSHA 300 Log with a check mark in the space for cases involving days away and an entry for the number of calendar days away from work in the number of days column. If the employee is out for an extended period, ((~~you~~)) the employer must enter an estimate for the number of days that the employee will be away, and update the day count when the actual number of days is known.

(5) ((~~You~~)) The employer begins counting days away on the day after the injury occurred or the illness began.

(6) To record an injury or illness for which the employee comes to work against the physician's or other licensed health care professional's recommendation, ((~~you~~)) the employer must do the following:

(a) Record these injuries and illnesses on the OSHA 300 Log using the check box for cases with days away from work and enter the number of calendar days away recommended by the physician or other licensed health care professional.

(b) Record the days away whether the injured or ill employee follows the physician or licensed health care professional's recommendation or not.

Notes: 1. If ((~~you~~)) the employer receives recommendations from two or more physicians or other licensed health care professionals, ((~~you~~)) the employer may make a decision as to which recommendation is the most authoritative and record the case based upon that recommendation.

2. Encourage your employee to follow the recommendation.

(7) When an employee decides to stay at home after the date a physician or other licensed health care professional recommends that the employee return to work, ((~~you~~)) the employer must end the count of days away from work on the date the physician or other licensed health care professional recommends that the employee return to work.

(8) ((~~You~~)) The employer must count the number of calendar days the employee was unable to work as a result of the injury or illness, regardless of whether or not the employee was scheduled to work on those day(s). Weekend days, holidays, vacation days or other days off are included in the total

number of days recorded if the employee would not have been able to work on those days because of a work-related injury or illness.

(9) When a worker is injured or becomes ill on a Friday and reports to work on a Monday, and was not scheduled to work on the weekend, ((~~you~~)) the employer only needs to record this case if ((~~you~~)) they receive information from a physician or other licensed health care professional indicating that the employee should not have worked, or should have performed only restricted work, during the weekend. If so, ((~~you~~)) the employer must record the injury or illness as a case with days away from work or restricted work and enter the day counts as appropriate.

(10) If a worker is injured or becomes ill on the day before scheduled time off such as a holiday, a planned vacation, or a temporary plant closing, ((~~you~~)) the employer only needs to record the case if ((~~you~~)) they receive information from a physician or other licensed health care professional indicating that the employee should not have worked, or should have performed only restricted work, during the scheduled time off. If so, ((~~you~~)) the employer must record the injury or illness as a case with days away from work or restricted work and enter the day counts as appropriate.

(11) ((~~You are~~)) The employer is not required to keep track of the number of calendar days away from work if the injury or illness resulted in more than one hundred eighty calendar days away from work or days of job transfer or restriction. In such a case, entering one hundred eighty in the total days away column will be considered adequate.

(12) If the employee leaves your company for some reason unrelated to the injury or illness, such as retirement, a plant closing, or to take another job, ((~~you~~)) the employer may stop counting days away from work, days of restriction, or days of job transfer. If the employee leaves your company because of the injury or illness, ((~~you~~)) the employer must estimate the total number of days away, days of restriction, or days of job transfer and enter the day count on the OSHA 300 Log.

(13) If a case occurs in one calendar year but results in days away during the next calendar year, ((~~you~~)) the employer only records the injury or illness once. ((~~You~~)) The employer must enter the number of calendar days away for the injury or illness on the OSHA 300 Log for the year in which the injury or illness occurred. If the employee is still away from work because of the injury or illness when you prepare the annual summary, estimate the total number of calendar days you expect the employee to be away from work. Then use this number to calculate the total for the annual summary. Update the initial log entry later when the day count is known or reaches the one hundred eighty day cap.

(14) ((~~You~~)) The employer must meet the following requirements for recording restricted work or job transfer.

(a) When an injury or illness involves restricted work or job transfer but does not involve death or days away from work, ((~~you~~)) the employer must record the injury or illness on the OSHA 300 Log by placing a check mark in the space for job transfer or restriction and enter the number of restricted or transferred days in the restricted workdays column.

(b) Restricted work occurs when, as the result of a work-related injury or illness:

(i) ((~~You~~)) The employer keeps the employee from performing one or more of the routine functions of their job, or from working the full workday that they would otherwise have been scheduled to work; or

(ii) A physician or other licensed health care professional recommends that the employee not perform one or more of the routine functions of their job, or not work the full workday that they would otherwise have been scheduled to work.

(c) ((~~You do~~)) The employer does not have to record restricted work or job transfers if you, the physician, or other licensed health care professional impose the restriction or transfer only for the day on which the injury occurred or the illness began.

(d) A recommended work restriction is recordable only if it affects one or more of the employee's routine job functions. To determine whether this is the case, ((~~you~~)) the employer must evaluate the restriction in light of the routine functions of the injured or ill employee's job. If the restriction from you, the physician, or other licensed health care professional keeps the employee from performing one or more of their routine job functions, or from working the full workday the injured or ill employee would otherwise have worked, the employee's work has been restricted and you must record the case.

(e) If an employee works only for a partial work shift because of the work-related injury or illness, ((~~you~~)) the employer must record the partial day of work as a day of job transfer or restriction. However, ((~~you~~)) the employer need not record the partial day of work if it is the same day the injury occurred or the illness began.

Note: The case is considered restricted work only if the worker does not perform all of the routine functions (see definition in this chapter) of their job or does not work the full shift that they would otherwise have worked.

(15) If ((~~you are~~)) the employer is not clear about the physician or other licensed health care professional's recommendation (i.e., engage only in "light duty" or "take it easy for the week"), ((~~you~~)) the employer may ask the physician or other licensed health care professional:

(a) "Can the employee do all of their routine job functions?"

(b) "Can the employee work all of their normally assigned work shift?"

(i) If the answer to both of these questions is "Yes," then the case does not involve a work restriction and does not have to be recorded.

(ii) If the answer to one or both of these questions is "No," the case involves restricted work and must be recorded as a restricted work case.

(iii) If ((~~you are~~)) the employer is unable to obtain this additional information from the physician or other licensed health care professional who recommended the restriction, record the injury or illness as a case involving restricted work.

(16) To record an injury or illness for which a physician or other licensed health care professional recommends a job restriction, but the employee does all of their routine job functions, ((~~you~~)) the employer must do the following:

(a) Record the injury or illness on the OSHA 300 Log as a restricted work case.

(b) Record this job restriction even if the employee chooses to do all of their routine job functions.

Notes: 1. If you receive recommendations from two or more physicians or other licensed health care professionals, you may make a decision as to which recommendation is the most authoritative and record the case based upon that recommendation.

2. If a physician or other licensed health care professional recommends a job restriction, you should ensure that the employee complies with that restriction.

(17) If ((~~you~~)) the employer assigns an injured or ill employee to a job other than their regular job for part of the day, ((~~you~~)) the employer must record the case as a job transfer.

Notes: 1. This does not include the day on which the injury or illness occurred.

2. Transfers to another job are recorded in the same way as restricted work cases on the OSHA 300 Log. Example: If you assign, or a physician or other licensed health care professional recommends that you assign, an injured or ill worker to their routine job duties for part of the day and to another job for the rest of the day, the injury or illness involves a job transfer. You must record an injury or illness that involves a job transfer by placing a check in the box for job transfer.

(18) ((~~You~~)) The employer counts days of job transfer or restriction in the same way ((~~you~~)) they count days away from work. The only difference is that, if ((~~you~~)) the employer permanently assigns the injured or ill employee to a job that has been modified or permanently changed in a manner that eliminates the routine functions the employee was restricted from performing, ((~~you~~)) the employer may stop the day count when the modification or change is made permanent. ((~~You~~)) The employer must count at least one day of restricted work or job transfer for such cases.

(19) If a work-related injury or illness results in medical treatment beyond first aid, ((~~you~~)) the employer must record the case on the OSHA 300 Log. If the injury or illness did not involve death, one or more days away from work, one or more days of restricted work, or one or more days of job transfer, ((~~you~~)) the employer enters a check mark in the box for cases where the employee received medical treatment but remained at work and was not transferred or restricted.

Note: The professional status of the person providing treatment has no effect on what is considered first aid or medical treatment as defined in WAC 296-27-051.

(20) ((~~You~~)) The employer must record a case even if the injured or ill employee does not follow the physician or other licensed health care professional's recommendation for medical treatment.

(21) ((~~You~~)) The employer must record "significant" diagnosed injuries or illnesses, such as work-related cases involving cancer, chronic irreversible disease, a fractured or cracked bone, or a punctured eardrum at the time of diagnosis by a physician or other licensed health care professional even if it does not result in death, days away from work, restricted work or job transfer, medical treatment beyond first aid, or loss of consciousness.

Note: OSHA believes that most significant injuries and illnesses will result in one of the criteria listed in WAC 296-27-01107(1): Death, days away from work, restricted work or job transfer, medical treatment beyond first aid, or loss of consciousness. However, there are some significant injuries, such as a punctured eardrum or a fractured toe or rib, for which neither medical treatment nor work restrictions may be recommended. In addition, there are some significant progressive diseases, such as byssinosis, silicosis, and some types of cancer, for which medical treatment or work restrictions may not be recommended at the time of diagnosis but are likely to be recommended as the disease progresses. Cancer, chronic irreversible diseases, fractured or cracked bones, and punctured eardrums are generally considered significant injuries and illnesses, and must be recorded at the initial diagnosis, even if medical treatment or work restrictions are not recommended, or are postponed, in a particular case.

AMENDATORY SECTION (Amending WSR 15-11-066, filed 5/19/15, effective 7/1/15)

WAC 296-27-01109 Recording criteria for needlestick and sharps injuries. (1) ((~~You~~)) The employer must record all work-related needlestick injuries and cuts from sharp objects that are contaminated with another person's blood or other potentially infectious material (as defined in this chapter and by chapter 296-823 WAC, Occupational exposure to bloodborne pathogens). ((~~You~~)) The employer must enter the case on the OSHA 300 Log as an injury. To protect the employee's privacy, ((~~you~~)) the employer may not enter the employee's name on the OSHA 300 Log (see the requirements for privacy concern cases in WAC 296-27-01119 (3) and (4)).

(2) ((~~You~~)) The employer must record cuts, lacerations, punctures, and scratches only if they are work-related and involve contamination with another person's blood or other potentially infectious material. If the cut, laceration, or scratch involves a clean object, or a contaminant other than blood or other potentially infectious material, ((~~you~~)) the employer needs to record the case only if it meets one or more of the general recording criteria in WAC 296-27-01107.

(3) If after recording the initial injury, the employee is later diagnosed with an infectious bloodborne disease, ((~~you~~)) the employer must update both of the following on the OSHA 300 Log if it resulted in death, days away from work, restricted work, or job transfer:

(a) The classification of the case from an injury to an illness; and

(b) The description to identify the infectious disease.

(4) ((~~You~~)) The employer must record incidents where an employee is splashed or exposed to blood or other potentially infectious material without being cut or scratched on the OSHA 300 Log as an illness if:

(a) It results in the diagnosis of a bloodborne illness, such as HIV, hepatitis B, or hepatitis C; or

(b) It meets one or more of the general recording criteria in WAC 296-27-01107.

AMENDATORY SECTION (Amending WSR 15-11-066, filed 5/19/15, effective 7/1/15)

WAC 296-27-01111 Recording criteria for medical removal cases. (1) ((~~Under the medical surveillance requirements, you~~)) The employer must record any case that involves the medical removal of an employee on the OSHA 300 Log under the medical surveillance requirements.

(2) ((~~You~~)) The employer must enter each medical removal case as either a case involving days away from work or a case involving restricted work activity. For medical removal cases that resulted from chemical exposure, you must check the "poisoning" column.

Notes: 1. Standards that do not include medical removal provisions include bloodborne pathogens and noise.

2. Standards that cover specific chemical substances have medical removal provisions. These standards include, but are not limited to, lead, cadmium, methylene chloride, formaldehyde, and benzene.

3. If you voluntarily remove an employee from exposure before the medical removal criteria are met, you do not have to record the case.

AMENDATORY SECTION (Amending WSR 15-11-066, filed 5/19/15, effective 7/1/15)

WAC 296-27-01113 Recording criteria for occupational hearing loss cases. (1) ((~~You~~)) The employer must record a hearing loss case on the OSHA 300 Log by checking the column for hearing loss if an employee's hearing test (audiogram) reveals that a recordable threshold shift (RTS) in one or both ears has occurred.

(2) ((~~To determine whether a RTS has occurred, you~~)) The employer must evaluate the employee's current audiogram with their baseline audiogram to determine whether a RTS has occurred. If the employee has previously experienced a recorded hearing loss, you must compare the employee's current audiogram with the audiogram reflecting the employee's previously recorded hearing loss case.

Note: Audiometric test results reflect the employee's overall hearing ability in comparison to audiometric zero. Therefore, using the employee's current audiogram, you must use the average hearing level at 2000, 3000, and 4000 Hz to determine whether or not the employee's total hearing level is 25 dB or more.

(3) To determine whether RTS has occurred, ((~~you~~)) the employer may age adjust the employee's current audiogram results by using Tables A-1 or A-2 in Appendix A of this chapter. ((~~You~~)) The employer may not use an age adjustment when determining whether the employee's total hearing level is 25 dB or more above audiometric zero.

(4) ((~~You are~~)) The employer is not required to record the hearing loss case on the OSHA 300 Log if ((~~you~~)) they retest the employee's hearing within thirty days of the first test, and the retest does not confirm the RTS. If the retest confirms the RTS, ((~~you~~)) the employer must record the hearing loss illness within seven calendar days of the retest. If subsequent audiometric testing indicates that an RTS is not persistent, ((~~you~~)) the employer may erase or line-out the recorded entry.

(5) ((~~You~~)) The employer must consider the case to be work-related if an event or exposure in the work environment either caused or contributed to the hearing loss or significantly aggravated a preexisting hearing loss.

(6) ((~~You are~~)) The employer is not required to consider the case work-related or recordable if a physician or other licensed health care professional determines that the hearing loss is not work-related or has not been significantly aggravated by occupational noise exposure.

AMENDATORY SECTION (Amending WSR 15-11-066, filed 5/19/15, effective 7/1/15)

WAC 296-27-01115 Recording criteria for work-related tuberculosis cases. ((~~You~~)) The employer must record a tuberculosis (TB) case on the OSHA 300 Log by checking the "respiratory condition" column if any employee has been occupationally exposed to anyone with a known case of active TB, and that employee subsequently develops a TB infection that is confirmed by a positive skin test or diagnosis by a physician or other licensed health care professional.

Notes: 1. ((~~You do~~)) The employer does not have to record a positive TB skin test result obtained at a preemployment physical because the employee was not occupationally exposed to a known case of active TB in your workplace.

2. ((~~You~~)) The employer may line-out or erase a TB case from the log under the following circumstances:

a. The worker contracted TB while living in a household with a person who had been previously diagnosed with active TB;

b. The public health department has identified the worker as a contact of an individual with a case of active TB unrelated to the workplace; or

c. A medical investigation shows that the employee's infection was caused by exposure to TB away from work, or proves that the case was not related to the workplace TB exposure.

AMENDATORY SECTION (Amending WSR 15-11-066, filed 5/19/15, effective 7/1/15)

WAC 296-27-01119 Forms. (1) ((~~You~~)) The employer must use the following OSHA forms (or equivalent forms), for recording work-related injuries and illnesses:

(a) OSHA 300, Log of Work-Related Injuries and Illnesses;

(b) OSHA 300-A, Summary of Work-Related Injuries and Illnesses; and

(c) OSHA 301, Injury and Illness Incident Report.

(2) ((~~You~~)) The employer must complete the OSHA forms as follows:

(a) At the top of the OSHA 300 Log, enter your business information and enter a one or two line description for each recordable injury or illness. Summarize this information on the OSHA 300-A form at the end of the year.

(b) Complete an OSHA 301 Incident Report form, or an equivalent form, for each recordable injury or illness entered on the OSHA 300 Log.

(c) Enter each recordable injury or illness on the OSHA 300 Log and 301 Incident Report within seven calendar days of receiving information that a recordable injury or illness has occurred.

Note: You may keep your injury and illness forms on a computer if you can produce equivalent forms when they are needed, as described under WAC 296-27-02111, 296-27-03101(1), and 296-27-03103.

(3) ((~~For **privacy concern cases,** you~~)) The employer must follow these requirements for **privacy concern cases** when filling out the OSHA 300 Log:

(a) ((~~You~~)) The employer may not enter the employee's name on the OSHA 300 Log. Instead, enter "privacy case" in the space normally used for the employee's name in order to protect the identity of the injured or ill employee when another employee, a former employee, or an authorized employee representative is provided access to the OSHA 300 Log under WAC 296-27-02111.

(b) ((~~You~~)) The employer must keep a separate, confidential list of the case numbers and employee names for ((~~your~~)) their privacy concern cases so ((~~you~~)) they can update the cases and provide the information to the government if asked to do so.

(c) The following injuries or illnesses are the **only** types of privacy concern cases recognized by this section:

(i) An injury or illness to an intimate body part or the reproductive system;

(ii) An injury or illness resulting from a sexual assault;

(iii) Mental illnesses;

(iv) HIV infection, hepatitis, or tuberculosis;

(v) Needlestick injuries and cuts from sharp objects that are contaminated with another person's blood or other potentially infectious material (see definition in WAC 296-27-051 of this chapter); **and**

(vi) Other illnesses if the employee independently and voluntarily requests that their name not be entered on the log.

(4) If ((~~you have~~)) the employer has a reasonable basis to believe that information describing the privacy concern case may be personally identifiable even though the employee's name has been omitted, ((~~you~~)) they may use discretion in describing the injury or illness on both the OSHA 300 and 301 forms. ((~~You~~)) The employer must enter enough information to identify the cause of the incident and the general severity of the injury or illness, but ((~~you~~)) they do not need to include details of an intimate or private nature. For example, a sexual assault case could be described as "injury from assault," or an injury to a reproductive organ could be described as "lower abdominal injury."

(5) If ((~~you~~)) the employer decides to voluntarily disclose the forms to persons other than government representatives, employees, former employees or authorized representatives (as required by WAC 296-27-02111 and 296-27-03103), ((~~you~~)) the employer must remove or hide the employees' names and other personally identifying information, except for the following cases. ((~~You~~)) The employer may disclose the forms with personally identifying information only:

(a) To an auditor or consultant hired by the employer to evaluate the safety and health program;

(b) To the extent necessary for processing a claim for workers' compensation or other insurance benefits; or

(c) To a public health authority or law enforcement agency for uses and disclosures for which consent, an authorization, or opportunity to agree or object is not required under Department of Health and Human Services Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. 164.512.

(6) Falsification, failure to keep records or reports.

(a) RCW 49.17.190(2) of the act provides that "whoever knowingly makes any false statement, representation, or certification in any application, record, report, plan, or other document filed or required to be maintained pursuant to this chapter shall, upon conviction be guilty of a gross misdemeanor and be punished by a fine of not more than ten thousand dollars, or by imprisonment for not more than six months or by both."

(b) Failure to maintain records or file reports required by this chapter, or in the detail required by the forms and instructions issued under this chapter, may result in the issuance of citations and assessment of penalties as provided for in chapter 296-900 WAC, Administrative rules.

AMENDATORY SECTION (Amending WSR 15-11-066, filed 5/19/15, effective 7/1/15)

WAC 296-27-02101 Multiple business establishments. (1) ((~~You~~)) The employer must keep a separate OSHA 300 Log for each establishment that is expected to be in operation for one year or longer.

(2) ((~~You~~)) The employer must keep injury and illness records for short-term establishments (i.e., establishments that will exist for less than a year). ((~~You do~~)) The employer does not have to keep a separate OSHA 300 Log for each such establishment. ((~~You~~)) The employer may keep one OSHA 300 Log that covers all of your short-term establishments. ((~~You~~)) The employer may also include the short-term establishments' recordable injuries and illnesses on an OSHA 300 Log that covers short-term establishments for individual company divisions or geographic regions.

(3) If ((~~you~~)) the employer keeps records for an establishment at ((~~your~~)) their headquarters or other central location, ((~~you~~)) the employer must be able to:

(a) Transmit information about the injuries and illnesses from the establishment to the central location within seven calendar days of receiving information that a recordable injury or illness has occurred; **and**

(b) Produce and send the records from the central location to the establishment within the time frames required by WAC 296-27-02111, 296-27-03101(1), and 296-27-03103 when ((~~you are~~)) the employer is required to provide records to a government representative, employees, former employees, or employee representatives.

(4) If ((~~you have~~)) the employer has employees that work at different locations or do not work at any of ((~~your~~)) their establishments, ((~~you~~)) they must link each of ((~~your~~)) their employees with one of ((~~your~~)) their establishments for recordkeeping purposes. ((~~You~~)) The employer must record the injury and illness on the OSHA 300 Log of the injured or ill employee's establishment, or on an OSHA 300 Log that covers that employee's short-term establishment.

(5) If an employee of one of your establishments is injured or becomes ill while visiting or working at another of your establishments, or while working away from any of your establishments, ((~~you~~)) the employer must record the injury

or illness on the OSHA 300 Log of the establishment at which the injury or illness occurred. If the employee is injured or becomes ill and is not at one of your establishments, ((~~you~~)) the employer must record the case on the OSHA 300 Log at the establishment at which the employee normally works.

AMENDATORY SECTION (Amending WSR 15-11-066, filed 5/19/15, effective 7/1/15)

WAC 296-27-02103 Covered employees. (1) ((~~You~~)) The employer must record on the OSHA 300 Log the recordable injuries and illnesses of all employees on ((~~your~~)) their payroll, whether they are labor, executive, hourly, salary, part-time, seasonal, or migrant workers. ((~~You~~)) The employer also must record the recordable injuries and illnesses that occur to employees who are not on ((~~your~~)) their payroll if you supervise these employees on a day-to-day basis. If ((~~your~~)) the employer's business is organized as a sole proprietorship or partnership, the owner or partners are not considered employees for recordkeeping purposes.

Note: If a self-employed person is injured or becomes ill while working for you, ((~~you are~~)) the employer is not required to report the injury or illness because they are not covered under WISHA or the recordkeeping requirements.

(2) ((~~You~~)) The employer must record injuries and illnesses of employees from a temporary help service, employee-leasing service, or personnel supply service if ((~~you~~)) they supervise these employees on a day-to-day basis.

(3) ((~~You~~)) The employer must record an injury or illness of a contractor's employee who is working in your establishment if ((~~you~~)) they supervise them on a day-to-day basis. However, if the contractor's employee is under the day-to-day supervision of the contractor, the contractor is responsible for recording the injury or illness.

(4) ((~~You~~)) The employer must make sure that each injury and illness is recorded only once:

(a) Either on ((~~your~~)) their OSHA 300 Log (if ((~~you~~)) they provide day-to-day supervision); or

(b) On the other employer's OSHA 300 Log (if that company provides day-to-day supervision).

AMENDATORY SECTION (Amending WSR 15-11-066, filed 5/19/15, effective 7/1/15)

WAC 296-27-02105 Annual summary. (1) At the end of each calendar year, ((~~you~~)) the employer must:

(a) Review the OSHA 300 Log to verify that the entries are complete and accurate, and correct any deficiencies identified;

(b) Use the OSHA 300-A Log or equivalent form of your recorded injuries and illnesses to create your annual summary;

(c) Certify the annual summary; and

(d) Post the annual summary.

(2) ((~~You~~)) The employer must complete the annual summary by doing the following:

(a) Total the columns on the OSHA 300 Log (if you had no recordable cases, enter zeros for each column total); and

(b) Enter the calendar year covered, the company's name, establishment name, establishment address, annual average number of employees covered by the OSHA 300 Log, and the total hours worked by all employees covered by the OSHA 300 Log.

(c) Include the employee access and employer penalty statements found on the OSHA 300-A summary form when using an equivalent form as permitted by this chapter. For the definition of "equivalent form" see WAC 296-27-051.

(3) A company executive must certify that they have examined the OSHA 300 Log and that they reasonably believe, based on their knowledge of the process by which the information was recorded, that the annual summary is correct and complete.

(4) The company executive who certifies the log must be one of the following persons:

(a) An owner of the company (only if the company is a sole proprietorship or partnership);

(b) An officer of the corporation;

(c) The highest ranking company official working at the establishment; or

(d) The immediate supervisor of the highest ranking company official working at the establishment.

(5) ((~~You~~)) The employer must post a copy of the annual summary in each establishment in a conspicuous place or places where notices to employees are customarily posted. ((~~You~~)) The employer must ensure that the posted annual summary is not altered, defaced or covered by other material.

(6) ((~~You~~)) The employer must post the summary no later than February 1 of the year following the year covered by the records and keep the posting in place until April 30.

AMENDATORY SECTION (Amending WSR 15-11-066, filed 5/19/15, effective 7/1/15)

WAC 296-27-02107 Retention and updating. (1) ((~~You~~)) The employer must save the OSHA 300 Log, the privacy case list (if one exists), the OSHA 300-A Annual Summary, and the OSHA 301 Incident Report forms for five years following the end of the calendar year that each of these records cover.

(2) ((~~You~~)) The employer must update your stored OSHA 300 Logs during the five-year retention period to include newly discovered recordable injuries or illnesses and to show any changes that have occurred in the classification of previously recorded injuries and illnesses. If the description or outcome of a case changes, ((~~you~~)) the employer must remove or line-out the original entry and enter the new information.

Note: During the five-year retention period, ((~~you are~~)) the employer is not required to update the OSHA 300-A Annual Summary of Work-Related Injuries or Illnesses, or the OSHA 301 Incident Reports, but you may do so if you wish.

AMENDATORY SECTION (Amending WSR 15-11-066, filed 5/19/15, effective 7/1/15)

WAC 296-27-02111 Employee involvement. (1) Your employees and their representatives must be involved in the recordkeeping system in several ways. ((~~You~~)) The employer must do the following:

(a) ((~~Establish a process for how employees report work-related injuries and illnesses to you.~~

~~(b)~~)) Inform each employee of how they are to report an injury or illness to you.

(b) Provide employees with the information described in subsection (2) of this section.

(c) Provide ((~~limited~~)) access to your injury and illness records for your employees and their representatives as described in subsection (3) of this section.

(2) The employer must do the following to ensure employees report work-related injuries and illnesses to them:

(a) Establish a reasonable procedure for employees to report work-related injuries and illnesses promptly and accurately. A procedure is not reasonable if it would deter or discourage a reasonable employee from accurately reporting a workplace injury or illness;

(b) Inform each employee of your procedure for reporting work-related injuries and illnesses;

(c) Inform each employee that:

(i) Employees have the right to report work-related injuries and illnesses; and

(ii) The employer is prohibited from discharging or, in any manner, discriminating against employees for reporting work-related injuries or illnesses.

(d) The employer must not discharge or, in any manner, discriminate against any employee for reporting a work-related injury or illness.

(3) Your employees, former employees, their personal representatives, and their authorized employee representatives have the right to access the OSHA injury and illness records, with some limitations, as discussed in subsections ((~~(3)~~)) (4) through ((~~(7)~~)) (8) of this section.

((~~(3)~~)) (4) When an employee, former employee, personal representative, or authorized employee representative asks for copies of your current or stored OSHA 300 Log(s) for an establishment the employee or former employee has worked in, ((~~you~~)) the employer must give the ((~~requester~~)) requestor a copy of the relevant OSHA 300 Log(s) by the end of the next business day.

((~~(4) You~~)) (5) The employer must leave employee names and any other information on the OSHA 300 Log before giving copies to an employee, former employee, or an employee representative. However, to protect the privacy of injured and ill employees, ((~~you~~)) the employer may not record the employee's name on the OSHA 300 Log for certain "privacy concern cases," as specified in WAC 296-27-01119 (3).

((~~(5)~~)) (6) When an employee, former employee, or personal representative asks for a copy of the OSHA 301 Incident Report describing an injury or illness to that employee or former employee, ((~~you~~)) the employer must give the ((~~requester~~)) requestor a copy of the OSHA 301 Incident Report containing that information by the end of the next business day.

((~~(6)~~)) (7) When an authorized employee representative asks for copies of the OSHA 301 Incident Reports for an establishment where the agent represents employees under a collective bargaining agreement, ((~~you~~)) the employer must give copies of those forms to the authorized employee representative within seven calendar days. ((~~You are~~)) The employer is only required to give the authorized employee representative information from the OSHA 301 Incident Report section titled "Tell us about the case." ((~~You~~)) The employer must remove all other information from the copy of the OSHA 301 Incident Report or the equivalent substitute form that ((~~you~~)) they give to the authorized employee representative.

((~~(7) You~~)) (8) The employer may not charge for these copies the first time they are provided. However, if one of the designated persons asks for additional copies, ((~~you~~)) the employer may assess a reasonable charge for retrieving and copying the records. An example of what a "reasonable charge" would be is what a print company would charge for copying the same documents.

AMENDATORY SECTION (Amending WSR 15-11-066, filed 5/19/15, effective 7/1/15)

WAC 296-27-02113 Prohibition against discrimination. (1) ((~~Employers are prohibited~~)) The WISH Act prohibits employers from discriminating against an employee for reporting a work-related fatality, injury or illness. ((~~Employees are also protected when they~~)) It also protects the employee who files a safety and health complaint, or asks for access to chapter 296-27 WAC records ((~~which are required to be maintained by this section or exercise rights extended~~)), or otherwise exercises any rights afforded under ((~~WISHA~~)) this act.

(2) DOSH may not issue an injury and illness recordkeeping variance to a private sector employer. However, DOSH must recognize all recordkeeping variances issued by federal OSHA.

(3) DOSH may only grant an injury and illness recording and reporting variance to a state or local government employer within the state after obtaining approval to grant the variance from federal OSHA.

AMENDATORY SECTION (Amending WSR 15-11-066, filed 5/19/15, effective 7/1/15)

WAC 296-27-02117 Variances from the recordkeeping rule. (1) If ((~~you wish~~)) the employer wishes to keep records in a different manner from that prescribed in this section, ((~~you~~)) the employer may submit a variance petition to the Assistant Secretary of Labor for Occupational Safety and Health, U.S. Department of Labor, Washington, DC 20210. ((~~You~~)) The employer can obtain a variance only if ((~~you~~)) they can show that ((~~your~~)) their alternative recordkeeping system:

(a) Collects the same information as this section requires;

(b) Meets the purposes of the federal Occupational Safety and Health Act; and

(c) Does not interfere with the administration of the federal Occupational Safety and Health Act.

(2) ((~~You~~)) The employer must include the following items in ((~~your~~)) their variance petition:

(a) ((~~Your~~)) The employer's name and address;

(b) A list of the state(s) where the variance would be used;

(c) The address(es) of the business establishment(s) involved;

(d) A description of why ((~~you are~~)) the employer is seeking a variance;

(e) A description of the different recordkeeping procedures you propose to use;

(f) A description of how ((~~your~~)) the employer's proposed procedures will collect the same information as would be collected by this section and achieve the purpose of the act; and

(g) A statement that ((~~you have~~)) the employer has informed ((~~your~~)) their employees of the petition by giving them or their authorized representative a copy of the petition and by posting a statement summarizing the petition in the same way as notices are posted under 29 C.F.R. 1903.2(a).

(3) The assistant secretary will take the following steps to process your variance petition.

(a) The assistant secretary will offer your employees and their authorized representatives an opportunity to submit written data, views, and arguments about your variance petition.

(b) The assistant secretary may allow the public to comment on your variance petition by publishing the petition in the *Federal Register*. If the petition is published, the notice will establish a public comment period and may include a schedule for a public meeting on the petition.

(c) After reviewing your variance petition and any comments from your employees and the public, the assistant secretary will decide whether or not your proposed recordkeeping procedures will meet the purposes of the act, will not otherwise interfere with the act, and will provide the same information as required by this section. If your procedures meet these criteria, the assistant secretary may grant the variance subject to such conditions as he or she finds appropriate.

(d) If the assistant secretary grants your variance petition, OSHA will publish a notice in the *Federal Register* to announce the variance. The notice will include the practices the variance allows you to use, any conditions that apply, and the reasons for allowing the variance.

(4) ((~~You~~)) The employer must comply with this section's requirements while the assistant secretary is reviewing ((~~your~~)) their variance petition.

(5) The assistant secretary may elect not to review your variance petition if it includes an element for which you have been cited and the citation is still under review by a court, an administrative law judge (ALJ), or the OSH Review Commission.

(6) A variance may be revoked for good cause. The variance revocation procedures are the same as those followed to request the exception. In cases of willfulness or where necessary for public safety, the assistant secretary will:

(a) Notify you in writing of the facts or conduct that may warrant revocation of your variance; and

(b) Provide you, your employees, and authorized employee representatives with an opportunity to participate in the revocation procedures.

(7) DOSH must recognize any recordkeeping or reporting variance issued by federal OSHA.

AMENDATORY SECTION (Amending WSR 16-23-138, filed 11/22/16, effective 12/23/16)

WAC 296-27-031 Reporting fatalities, inpatient hospitalizations, amputations, and losses of an eye as the result of work-related incidents. (1) ((~~You~~)) The employer must report to DOSH within eight hours of a work-related incident that results in:

(a) A fatality; or

(b) An inpatient hospitalization of any employee.

Notes: 1. Secure the scene of work-related events that result in the death or inpatient hospitalization of any worker, refer to WAC 296-800-320.

2. Do not move equipment involved (i.e., personal protective equipment (PPE), tools, machinery or other equipment), unless it is necessary to remove the victim or prevent further injuries, refer to WAC 296-800-32010.

(2) ((~~You~~)) The employer must report to DOSH within twenty-four hours of a work-related incident that results in either an amputation or the loss of an eye that does not require inpatient hospitalization.

Notes: 1. If the amputation or loss of an eye requires inpatient hospitalization, follow the eight-hour reporting requirement in WAC 296-27-031(1).

2. Inpatient hospitalization that involves only observation or diagnostic testing is not a reportable inpatient hospitalization.

(3) If ((~~you do~~)) the employer does not learn about a reportable fatality, inpatient hospitalization, amputation, or loss of an eye at the time it takes place, ((~~you~~)) the employer must make the report to DOSH within the following time periods after the fatality, inpatient hospitalization, amputation, or loss of an eye is reported to you or any of your agents:

(a) Eight hours for a fatality or an inpatient hospitalization of one or more employees.

(b) Twenty-four hours for an amputation or a loss of an eye that does not require inpatient hospitalization.

(4) If ((~~you do~~)) the employer does not learn right away that the reportable fatality, inpatient hospitalization, amputation, or loss of an eye was the result of a work-related incident, ((~~you~~)) the employer must make the report to DOSH within the following time periods after you or any of your agents learn that the reportable fatality, inpatient hospitalization, amputation, or loss of an eye was the result of a work-related incident:

(a) Eight hours for a fatality or an inpatient hospitalization of one or more employees.

(b) Twenty-four hours for an amputation or a loss of an eye that does not require inpatient hospitalization.

(5) ((~~You~~)) The employer must report the fatality, inpatient hospitalization, amputation, or loss of an eye in the required time frame using one of the following methods:

(a) By telephone to the department's toll-free telephone number, 1-800-4BE-SAFE (1-800-423-7233) or in person to the Labor and Industries' Division of Occupational Safety and Health (DOSH) office located nearest to the site of the incident;

(b) By telephone to the OSHA toll-free telephone number, 1-800-321-OSHA (1-800-321-6742); or

(c) To DOSH by any other means.

(6) If the local office is closed, ((~~you~~)) the employer must report a fatality, inpatient hospitalization, amputation, or the loss of an eye incident by:

(a) Calling the department at 1-800-4BE-SAFE (1-800-423-7233); or

(b) Calling OSHA's toll-free telephone number at 1-800-321-6742.

(7) ((~~You~~)) The employer must provide DOSH with the following information for each fatality, inpatient hospitalization, amputation, or loss of an eye:

(a) The establishment name;

(b) The location of the work-related incident;

(c) The time and date of the work-related incident;

(d) The type of reportable event (i.e., fatality, inpatient hospitalization, amputation, or loss of an eye);

(e) The number of employees who suffered a fatality, inpatient hospitalization, amputation, or loss of an eye;

(f) The names of the employees who suffered a fatality, inpatient hospitalization, amputation, or loss of an eye;

(g) Your contact person and their phone number; and

(h) A brief description of the work-related incident.

(8) If a fatality does not occur during or right after the work-related incident, ((~~you~~)) the employer must only report it to DOSH if the fatality occurs within thirty days of the work-related incident.

(9) ((~~You do~~)) The employer does not have to report an incident that resulted in a fatality, inpatient hospitalization, amputation, or loss of an eye to DOSH if it occurred on a commercial or public transportation system (e.g., airplane, train, subway, or bus). However, the fatality, inpatient hospitalization, amputation, or loss of an eye must be recorded on your OSHA injury and illness records, if ((~~you are~~)) the employer is required to keep such records.

(10) ((~~You~~)) The employer must report to DOSH when a heart attack occurs in the work environment that results in a fatality or inpatient hospitalization. DOSH will decide whether to investigate the event, depending on the circumstances of the heart attack.

(11) ((~~You~~)) The employer must only report to DOSH each inpatient hospitalization that involves medical care or treatment. Inpatient hospitalization involving only observation or diagnostic testing need not be reported.

AMENDATORY SECTION (Amending WSR 15-11-066, filed 5/19/15, effective 7/1/15)

WAC 296-27-03101 Providing records to government representatives. (1) The employer must provide copies of the records within four business hours when an authorized government representative asks for the records you keep under this section((~~, you must provide copies of the records within four business hours~~)).

(2) If ((~~you~~)) the employer maintains the records at a location in a different time zone, ((~~you~~)) they may use the business hours of the establishment at which the records are located when calculating the deadline.

AMENDATORY SECTION (Amending WSR 15-11-066, filed 5/19/15, effective 7/1/15)

WAC 296-27-03103 ((~~Annual OSHA injury and illness survey.~~)) Electronic submission of injury and illness records to OSHA. (((~~(1) If you receive OSHA's annual survey form, you must fill it out and send it to OSHA or OSHA's designee, as stated on the survey form. You must report the following information for the year described on the form:~~

~~(a) The number of workers you employed;~~

~~(b) The number of hours worked by your employees; and~~

~~(c) The requested information from the records that you keep under this section.~~

~~(2) Each year, OSHA sends injury and illness survey forms to employers in certain industries. You do not have to send injury and illness data to OSHA unless you receive a survey form.~~

~~(3) You must send the survey reports to OSHA, or OSHA's designee, by mail or other means described in the survey form, within thirty calendar days, or by the date stated in the survey form, whichever is later.~~

~~(4) If you are exempt from keeping injury and illness records under WAC 296-27-00103 through 296-27-00107, OSHA may inform you in writing that it will be collecting injury and illness information from you in the following year. If you receive such a letter, you must keep the injury and illness records required by WAC 296-27-01103 through 296-27-01115 and make a survey report for the year covered by the survey.~~

~~(5) Washington state employers must respond to the OSHA survey form if they receive one.~~

~~(6) Nothing in this section affects DOSH's or federal OSHA's statutory authority to investigate conditions related to occupational safety and health.~~))

Note: The information required by this section is reported and tracked by OSHA for their own injury and illness data analysis. DOSH is not notified when employers submit this information to OSHA.

(1) **Summary of basic requirements.**

(a) Annual electronic submission of OSHA Form 300A Summary of Work-Related Injuries and Illnesses by establishments that employed two hundred fifty or more different employees. If your establishment employed two hundred fifty or more different employees during the course of the previous calendar year, and this chapter requires your establishment to keep records, then you must electronically submit information from OSHA Form 300A Summary of Work-Related Injuries and Illnesses to OSHA or OSHA's designee.

(b) Annual electronic submission of OSHA Form 300A Summary of Work-Related Injuries and Illnesses by establishments that both; employed twenty to two hundred forty-nine different employees, and are in designated industries. If your establishment employed twenty to two hundred forty-nine different employees during the course of the previous calendar year, and your establishment is in a designated industry listed in WAC 296-27-071 Appendix B, then you must electronically submit information from OSHA Form 300A Summary of Work-Related Injuries and Illnesses to OSHA or OSHA's designee.

(c) Electronic submission of OSHA 300A records upon notification. All establishments not meeting the criteria of (a) or (b) of this subsection, must, upon notification; electronically submit the information from your OSHA 300A to OSHA or OSHA's designee.

(d) Electronic submission of the employer identification number (EIN). When electronically reporting injury and illness records, the employer must also provide the EIN or federal tax identification number used by the establishment.

(2) **Basic requirements.**

(a) Categories of employers that must submit OSHA Form 300A information to OSHA.

(i) First, if your establishment had two hundred fifty or more total employees over the course of the previous calendar year, and this chapter requires your establishment to keep injury and illness records; then you must submit the required information to OSHA once a year. This information is due before the date listed in subsection (3) of this section.

(ii) Second, if your establishment had twenty or more, but fewer than two hundred fifty total employees over the course of the previous calendar year, and your establishment is in a designated industry listed in WAC 296-27-071 Appendix B; then you must submit the required information to OSHA once a year. This information is due before the date listed in subsection (3) of this section.

(iii) Third, if your establishment is not in either of the two categories above, then you must submit information to OSHA only when OSHA notifies you to do so for an individual calendar year. OSHA's notification will provide instructions for when this information is due.

(b) Categories of employees included under (a) of this subsection requirement.

Employers must count all full-time, part-time, seasonal, and temporary workers towards their running count of individual employees for the year. Each individual employed in the establishment during any part of the previous calendar year counts as one employee.

(c) Notification from OSHA for a subsection (1)(c) of this section employer to submit records electronically.

OSHA will only notify subsection (1)(c) of this section employers by mail when they must submit information as part of an individual data collection. OSHA will also announce individual data collections through publication in the Federal Register the OSHA newsletter, and announcements on the OSHA web site. If you are an employer who must routinely submit information per subsection (1)(a) and (b) of this section, then OSHA will not notify you about your routine submittal.

(d) Due date for the above mentioned information.

Employers required to submit information under subsection (1)(a) or (b) of this section, must submit the information once a year, by the date listed in subsection (3) of this section - Effective reporting date of this section of the year after the calendar year covered by the form or forms. Employers submitting information because OSHA notified them to submit information as part of an individual data collection under subsection (1)(c) of this section, must submit the information as specified in OSHA's notification.

(e) Process for employers to submit the above mentioned information.

Employers must submit the information electronically. OSHA will provide a secure web site for the electronic submission of information. For individual data collections under subsection (1)(c) of this section, OSHA will include the web site's location in the notification for the data collection.

(f) Partially exempt establishments from the recordkeeping rule itself, under WAC 296-27-00103 and/or 296-27-00105.

Employers that are partially exempt from keeping injury and illness records under WAC 296-27-00103 and/or 296-27-00105 do not have to routinely submit OSHA Form 300A information under subsection (1)(a) and (b) of this section. However, these employers must submit information under subsection (1)(c) of this section if OSHA informs you in writing that OSHA is collecting injury and illness information from you for any specific year. If you receive such a notification, then you must keep the injury and illness records required by this part and submit that information as directed by OSHA.

(g) Enterprise or corporate entities electronically submitting OSHA Form 300A records on behalf of its establishment(s).

Enterprise or corporate offices which, have ownership of, or control over, one or more establishments required to submit information under subsection (1) of this section; may collect and electronically submit the information on behalf of the establishment(s).

(3) **Effective reporting date.**

Employers must begin submitting the above mentioned information to OSHA by the following date and schedule.

Beginning in calendar year 2020, establishments which are required to submit under subsection (1)(a) and (b) of this section must routinely submit the required information by March 2nd, for the previous calendar year. For example employers will electronically report calendar year 2019 information to OSHA after; OSHA begins accepting calendar year 2019 information, and before March 2, 2020.

NEW SECTION

WAC 296-27-071 Appendix B—Annual electronic submission of OSHA Form 300A.

Table 3
Designated Industries

NAICS	INDUSTRY
11	Agriculture, forestry, fishing and hunting
22	Utilities
23	Construction
31-33	Manufacturing
42	Wholesale trade
4413	Automotive parts accessories, and tire stores
4421	Furniture stores
4422	Home furnishings stores
4441	Building material and supplies dealers
4442	Lawn and garden equipment and supplies stores

NAICS	INDUSTRY
4451	Grocery stores
4452	Specialty food stores
4521	Department stores
4529	Other general merchandise stores
4533	Used merchandise stores
4542	Vending machine operators
4543	Direct selling establishments
4811	Scheduled air transportation
4841	General freight trucking
4842	Specialized freight trucking
4851	Urban transit systems
4852	Interurban and rural bus transportation
4853	Taxi and limousine service
4854	School and employee bus transportation
4855	Charter bus industry
4859	Other transit and ground passenger transportation
4871	Scenic and sightseeing transportation, land
4881	Support activities for air transportation
4882	Support activities for rail transportation
4883	Support activities for water transportation
4884	Support activities for road transportation
4889	Other support activities for transportation
4911	Postal service
4921	Couriers and express delivery services
4922	Local messengers and local delivery
4931	Warehousing and storage
5152	Cable and other subscription programming
5311	Lessors of real estate
5321	Automotive equipment rental and leasing
5322	Consumer goods rental
5323	General rental centers
5617	Services to buildings and dwellings
5621	Waste collection
5622	Waste treatment and disposal
5629	Remediation and other waste management services
6219	Other ambulatory health care services
6221	General medical and surgical hospitals
6222	Psychiatric and substance abuse hospitals
6223	Specialty (except psychiatric and substance abuse) hospitals
6231	Nursing care facilities
6232	Residential mental retardation, mental health and substance abuse facilities
6233	Community care facilities for the elderly
6239	Other residential care facilities
6242	Community food and housing, and emergency and other relief services
6243	Vocational rehabilitation services
7111	Performing arts companies
7112	Spectator sports
7121	Museums, historical sites, and similar institutions
7131	Amusement parks and arcades
7132	Gambling industries
7211	Traveler accommodation
7212	RV (recreational vehicle) parks and recreational camps
7213	Rooming and boarding houses
7223	Special food services
8113	Commercial and industrial machinery and equipment (except automotive and electronic) repair and maintenance
8123	Dry-cleaning and laundry services

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 296-27-051	Definitions.
WAC 296-27-05101	Definitions.

WSR 19-17-069
PERMANENT RULES
DEPARTMENT OF LABOR AND INDUSTRIES

[Filed August 20, 2019, 10:25 a.m., effective October 1, 2019]

Effective Date of Rule: October 1, 2019.

Purpose: The department reviewed these chapters and made revisions to:

- Correct typographical and other errors (such as invalid telephone numbers and out-of-date references);
- Revise wording and formatting to make the rules easier to understand and apply; and
- Incorporate and formalize existing agency practices (such as expressly including in a risk classification employment that the department currently includes by interpretation or analogy).

The purpose of this rule making is not to make substantive changes to how employers are classified. This rule mak-

ing amends subclassifications while not making substantial changes to how employers are classified. In general, the department proposes to combine subclassifications where the underlying hazards are similar and where the subclassification distinction is no longer relevant. This allows the department to maintain the overall fairness of the rating system in general.

Citation of Rules Affected by this Order: Amending WAC 296-17A-0202 Pile Construction; 296-17A-0103 Drilling; 296-17A-0502 Flooring (no employees); 296-17A-0507 Roofing (no employees); 296-17A-0550 Drywall (no employees); 296-17A-0510 Framing (no employees); 296-17A-1101 Delivery; 296-17A-3402 Metal goods; 296-17A-3404 Metal goods; 296-17A-3905 Restaurants; and 296-17A-3909 Catering.

Statutory Authority for Adoption: RCW 51.04.020 and 51.16.035.

Adopted under notice filed as WSR 19-13-084 on June 18, 2019.

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

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

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 11, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 11, Repealed 0.

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

Date Adopted: August 20, 2019.

Joel Sacks
Director

AMENDATORY SECTION (Amending WSR 07-01-014, filed 12/8/06, effective 12/8/06)

WAC 296-17A-0103 Classification 0103.

0103-09 Drilling or blasting: N.O.C.

Applies to:

((~~contractors~~)) Businesses engaged in drilling operations for others not covered by another classification (N.O.C.). Work contemplated by this classification includes, but is not limited to, well drilling for oil, gas or water; exploratory well drilling; and drilling of holes in rock for shot holes. Such drilling generally contemplates the digging of a hole using a rotating or pounding type tool. Equipment used by drilling contractors includes earth auger drills, jackhammers, drilling rigs, and bits which will vary in size depending upon the terrain or material to be drilled and the depth and size of holes to be drilled. This classification also includes blasting operations not covered by another classification (such as the blasting of rock in connection with highway, street or road construction).

((~~This classification excludes~~)) **Exclusions:**

• Drilling operations performed in connection with concrete or building construction which is to be reported separately in the construction classification applicable for the work being performed;

• Drilling done in connection with all types of underground or surface mining and quarry operations which is to be reported separately in the applicable mining classification; ((~~and~~))

• Blasting performed as part of building demolition which is to be reported separately in classification 0518((~~.~~));

• All types of pile construction work, which is reported separately in:

- **0202-02,** Pile construction: Driven method;
- **0202-06,** Pile construction: Drilled method.

0103-10 Geophysical exploration: Seismic detection of the mechanical properties of the earth

Applies to establishments engaged in geophysical exploration, by seismic detection, of the earth's subsurface. Work contemplated by this classification involves a seismograph work crew consisting of a party chief, a permit person, a surveyor, drillers, shooters, observers and a computer analyst. The seismic method utilizes a dynamite blast that simulates a miniature earthquake. The recorder of the vibrations is the sensitive earthquake detector which records the intense vibrations on a rapidly moving tape. The data collected from the tapes and photographic records are interpreted and a contour map of the rocks and their foundation to depths of several thousand feet is developed.

This classification excludes geophysical exploration without seismic detection which is to be reported separately in classification 1007.

AMENDATORY SECTION (Amending WSR 08-15-132, filed 7/22/08, effective 1/1/09)

WAC 296-17A-0202 Classification 0202.

0202-02 Pile ((~~driving - Wood or concrete piling construction~~

~~Applies to contractors engaged in pile driving and piling construction. Pile driving involves long sturdy posts or columns of timber, steel, or concrete being driven into the earth as a foundation or support for a structure such as a building, pier or wharf. This type of activity usually occurs when a portion of the structure is going to be under water, in mud, at a site where the ground is soft or unstable, or when the structure is expected to be of extraordinary weight. Work contemplated by this classification includes driving wood or steel beams, driving concrete columns, shaft sinking or caisson work, stacking of concrete piles, erection of a cofferdam, and includes all cross beaming, decking, and similar carpentry incidental to, and connected with, pile driving operations as part of the foundation construction project. Shaft sinking is removal of earth from a hole with a relatively small diameter and usually at a considerable depth. The cofferdam is a temporary structure from which water can be pumped or sucked to provide a dry work area during construction of the foundation or substructure. Once the foundation support is complete, the cofferdam is taken apart and removed.~~

~~This classification excludes diving operations or activities which are to be reported separately in classification 0202-04.~~

~~***Special note*:** Pile driving projects could occur on or adjacent to navigable waters (harbors, rivers, canals) which is defined as those which form a continuous highway for interstate or international commerce. Workers who perform the work activities from on board a vessel could be subject to the Admiralty Law which recognizes such work crews and workers as a master or member of a vessel, and subject to federal law known as the Jones Act. Every person on board a vessel is deemed a seaman if connected with the operation while on navigable water. The term vessel has been interpreted by the courts to include any type of man-made floating object such as a floating derrick, pile driver or dredge, a barge, or a pontoon (which is a flat bottom boat) or portable float. Workers who perform the work activities from the shoreline or from adjacent areas such as an existing dock, pier, or bridge may or may not be subject to federal law covered under the U.S. Longshore and Harbor Workers Act. Usually, pile driving projects involve a variety of types of work crews such as those working from a floating derrick or pile driver, a barge, a pontoon, a shoreline pile crew, workers inside the cofferdam, as well as the maintenance and repair of the construction material or equipment. Care should be exercised prior to assignment of this classification as the workers could be subject to either or both of these acts. The criteria used in determining federal law and coverage is based on the most current federal court decisions and case law.~~)) **construction: Driven method**

Applies to:

Businesses engaged in pile construction utilizing a driven or pounding method. Pile driving involves long sturdy posts or columns of timber, steel, or concrete being driven into the earth as a foundation or support for a structure such as a building, pier or wharf. This type of activity usually occurs when a portion of the structure is going to be under water, in mud, at a site where the ground is soft or unstable, or when the structure is expected to be of extraordinary weight.

Work activities include, but are not limited to:

• Driving wood or steel beams;

• Driving concrete columns;

• All cross beaming, decking, and similar carpentry incidental to, and connected with, pile driving operations as part of the foundation construction project.

Exclusions:

• Diving operations or activities which are to be reported separately in classification 0202-04;

• Pile construction work utilizing a drilling method, which is reported in 0202-06;

• Other types of pile construction work that do not involve a drilled or driven method, but is a form of ground stabilization/improvement, which is reported in 0202-06.

Note: Contractors engaged in both pile construction using the driven method and drilled method will have both subclassifications 0202-02 and 0202-06 assigned, and must report in each subclassification as it applies to the work performed.

***Special note*:** Pile driving projects could occur on or adjacent to navigable waters (harbors, rivers, canals) which are defined as those which form a continuous highway for interstate or international commerce. Workers who perform the work activities from on board a vessel could be subject to the Admiralty Law which recognizes such work crews and workers as a master or member of a vessel, and subject to federal law known as the Jones Act. Every person on board a vessel is deemed a seaman if connected with the operation while on navigable waters. The term vessel has been interpreted by the courts to include any type of man-made floating object such as a floating derrick, pile driver or dredge, a barge, or a pontoon (which is a flat bottom boat) or portable float. Workers who perform the work activities from the shoreline or from adjacent areas such as an existing dock, pier, or bridge may or may not be subject to federal law covered under the U.S. Longshore and Harbor Workers Act. Usually, pile driving projects involve a variety of types of work crews such as those working from a floating derrick or pile driver, a barge, a pontoon, a shoreline pile crew, workers inside the cofferdam, as well as the maintenance and repair of the construction material or equipment. Care should be exercised prior to assignment of this classification as the workers could be subject to either or both of these acts. The criteria used in determining federal law and coverage is based on the most current federal court decisions and case law.

0202-03 Wharf, pier, dock and marine railway: Construction, maintenance and repair

Applies to contractors engaged in the construction, maintenance or repair of piers, wharves, docks and marine railways. A pier or wharf is a platform extending from a shore over water and supported by piles or pillars. A dock is the area between two piers or alongside a pier or wharf. These types of platforms are for vessels to tie up and provide an area for loading, unloading, or repairing vessels. Most often, the construction of such platforms will include the foundation or substructure being under water or mud, and the remainder of the platform being exposed above the water or mud. Work contemplated by this classification includes, but is not limited to, construction of the foundation or substructure which consists of shaft sinking, pile driving, stacking of piles and/or erection of a cofferdam, and includes all concrete, steel or carpentry work after the foundation or substructure is built to completion of the project. Shaft sinking involves the removal of earth from a hole with a relatively small diameter and usually at a considerable depth. Pile driving involves long sturdy posts or columns of timber, steel, or concrete being driven into the earth as a foundation or support for the structure. The cofferdam is a temporary structure from which water can be pumped or sucked to provide a dry work area during construction of the foundation or substructure. Once the foundation support is complete, the cofferdam is taken apart and removed. This classification also includes caisson work as part of the construction for the foundation or substructure support.

This classification excludes diving operations or activities which are to be reported separately in classification 0202-04.

***Special note*:** The construction of piers, wharves, docks and marine railways could occur on or adjacent to navigable

waters (harbors, rivers, canals) which is defined as those which form a continuous highway for interstate or international commerce. Workers who perform the work activities from on board a vessel could be subject to the Admiralty Law which recognizes such work crews and workers as a master or member of a vessel, and subject to federal law known as the Jones Act. Every person on board a vessel is deemed a seaman if connected with the operation while on navigable water. The term vessel has been interpreted by the courts to include any type of man-made floating object such as a floating derrick, floating barge, a pontoon (which is a flat bottom boat) or portable float. Workers who perform the work activities from the shoreline or from adjacent areas such as an existing dock, pier, or bridge may or may not be subject to federal law covered under the U.S. Longshore and Harbor Workers Act. Usually, these types of projects involve a variety of work crews such as those working from a floating derrick or barge, a pontoon, a shoreline pile crew, workers inside the cofferdam, as well as the maintenance and repair of the construction material or equipment. Care should be exercised prior to assignment of this classification as the workers could be subject to either or both of these acts. The criteria used in determining federal law and coverage is based on the most current federal court decisions and case law.

0202-04 Diving operations and subaqueous work, N.O.C.
Applies to establishments engaged in diving operations not covered by another classification (N.O.C.). Diving operations such as underwater diving, skin diving or scuba diving are performed in numerous types of uncontrolled environments such as the ocean, harbors, bays, dams, lakes, as well as controlled environments such as swimming pools or aquarium tanks. Work contemplated by this classification includes, but is not limited to, marine salvage and wreckage, underwater mining and sweeping, underwater construction or demolition, installation, repair and/or inspection of wharves, piers, and docks, inspection of ships, barges, and other vessels, underwater exploration, as well as diving instruction. Classification 0202 includes all diving activities with the following exception: Diving instructors who provide instructional lessons in a controlled environment such as a swimming pool may be reported separately in classification 6209 provided accurate time records are maintained for the instructional lesson hours. Failure to maintain accurate time records will result in the hours in question being assigned to classification 0202 without a division of hours between the two classifications.

***Special note*:** Many diving operations and activities occur on or adjacent to navigable waters (a harbor, river, canal, dam, lake) which is defined as those which form a continuous highway for interstate or international commerce. Workers who perform diving activities (to include divers, deck hands, or "diving tenders" who are support personnel such as line handlers and pump persons) from on board a vessel could be subject to the Admiralty Law which recognizes such work crews and workers as a master or member of a vessel, and subject to federal law known as the Jones Act. Every person on board a vessel is deemed a seaman if connected with the operation while on navigable water. The term vessel has been interpreted by the courts to include any type of man-made floating object such as a floating derrick or dredge, a boat or ship, a barge, or type of pontoon (which is a flat bottom boat) or portable float. Workers who perform diving activities (to include divers, deck hands, or "diving tenders" who are support personnel such as line handlers and pump persons) from the shoreline or from adjacent areas such as an existing dock, pier or bridge may or may not be subject to federal law covered under the U.S. Longshore and Harbor Workers Act. Care should be exercised prior to assignment of this classification as the workers could be subject to either or both of these acts. The criteria used in determining federal law and coverage is based on the most current federal court decisions and case law.

0202-05 Geoduck harvesting by divers (to be assigned only by the maritime specialist)
Applies to establishments engaged in diving operations to harvest wild geoduck clams from natural areas. Work contemplated by this classification includes subaqueous harvesting of geoduck clams, sea cucumbers or similar marine life.

***Special note*:** Many diving operations and activities occur on or adjacent to navigable waters (a harbor, river, canal, dam, lake) which is defined as those which form a continuous highway for interstate or international commerce. Workers who perform diving activities (to include divers, deck hands, or "diving tenders" who are support personnel such as line handlers and pump persons) from on board a vessel could be subject to the Jones Act or Admiralty Law which recognize such work crews and workers as masters or members of a vessel, and subject to federal law known as the Jones Act. Every person on board a vessel is deemed a seaman if connected with the operation while on navigable water. The term vessel has been interpreted by the courts to include any type of man-made floating object such as a floating derrick or dredge, a boat or ship, a barge, or type of pontoon (which is a flat bottom boat) or portable float. Workers who perform diving activities (to include divers, deck hands, or "diving tenders" or other support personnel such as line handlers and pump persons) from the shoreline or from adjacent areas such as an existing dock, pier or bridge may or may not be subject to federal law covered under the U.S. Longshore and Harbor Workers Compensation Act (LHWCA). Care should be exercised prior to assignment of this classification as the workers could be subject to either or both state fund or federal jurisdiction. The criteria used in determining federal law and coverage is based on the most current federal court decisions and case law.

0202-06-Pile construction: Drilled method

Applies to:
Businesses engaged in pile construction utilizing a drilling method. This classification also applies to other types of pile construction work that do not involve a drilled method but is a form of ground stabilization/improvement including, but not limited to:

- Cement grouting;
- Vibro concrete column;
- Vibro replacement.

Structural support (deep foundations), earth retention, ground improvement and grouting are necessary when:

- Surface layer is not adequate or is not economically feasible to use;

- Soils are soft or loose;
- Soil bearing capacity must be increased;
- Support is needed to stabilize slopes;
- Cutting off groundwater is needed;
- Remediating settlement.

Exclusions:

• Diving operations or activities which are to be reported separately in classification 0202-04.

• Pile construction work utilizing a driven or pounding method, which is to be reported in 0202-02, Pile construction: Driven method.

Note: Contractors engaged in both pile construction using the driven method and drilled method will have both subclassifications 0202-02 and 0202-06 assigned, and must report in each subclassification as it applies to the work performed.

Industry terminology:

Augercast piles *- Are formed by drilling into the ground with a hollow stemmed continuous flight auger to the required depth or degree of resistance.*

Drilled shafts *- Are typically high-capacity cast-in-place deep foundation elements constructed using an auger, drilling bucket or grab.*

Helical piles *- Are formed by rotating galvanized heads and steel pipe extensions, with attached helical cutting blades, into the ground at any angle using a high torque hydraulic motor.*

Macropiles/micropiles/tiedowns *- Are shallow or deep foundation elements constructed using threaded steel pipe or typically in the case of tiedown anchors just a reinforcing steel bar.*

Pit underpinning *- This technique creates support for an existing building when there is foundation damage or when there is going to be excavation or foundation work performed adjacent to it.*

Soldier beams and lagging *- Support technique where vertical piles are drilled at regular intervals along the planned excavation perimeter. The lagging effectively resists the load of the retained soil and transfers it to the beams.*

Soil nailing *- Is an earth retention technique using grouted tension-resisting steel elements (nails) that can be designed for permanent or temporary support.*

Secant piles *- Are piles constructed by overlapping drilled shafts with either structural or lean concrete fill.*

Tangent pile walls *- Are constructed using methods similar to secant piles but tangent piles are equally shaped and abut each other instead of intersecting.*

Soil mixing *- Process used to improve the characteristics of soft or loose soil profiles by mechanically mixing them with cementitious grout to create soil cement columns or panels.*

Vibro concrete columns *- Transfers loads through weak strata to a firm underlying stratum, using high modulus concrete columns.*

Vibro replacement *- Constructs dense aggregate columns (stone columns) by means of a crane-suspended downhole vibrator, to reinforce all soils and densify granular soils.*

Compaction grouting *- The densification of loose granular soils with the controlled injection of a low slump mortar-like grout.*

Permeation grouting *- A grouting technique that transforms granular soils into sandstone-like masses, by permeation with a low viscosity sodium silicate chemical grout or the use of microfine or ultrafine cement grouts.*

Grout injection pile *- Are steel and concrete pipe composite piles that are screwed into the ground under very high torque and down-pressure.*

Jet grouting *- A drill rod equipped with jet nozzles injects high-pressure water, air, and cement into the ground as the drill rod is rotated and raised.*

Special note**:** Pile driving projects could occur on or adjacent to navigable waters (harbors, rivers, canals) which are defined as those which form a continuous highway for interstate or international commerce. Workers who perform the work activities from on board a vessel could be subject to the Admiralty Law which recognizes such work crews and workers as a master or member of a vessel, and subject to federal law known as the Jones Act. Every person on board a vessel is deemed a seaman if connected with the operation while on navigable waters. The term vessel has been interpreted by the courts to include any type of man-made floating object such as a floating derrick, pile driver or dredge, a barge, or a pontoon (which is a flat bottom boat) or portable float. Workers who perform the work activities from the shoreline or from adjacent areas such as an existing dock, pier, or bridge may or may not be subject to federal law covered under the U.S. Longshore and Harbor Workers Act. Usually, pile construction projects involve a variety of types of work crews such as those working from a floating derrick or pile driver, a barge, a pontoon, a shoreline pile crew, workers inside the cofferdam, as well as the maintenance and repair of the construction material or equipment. Care should be exercised prior to assignment of this classification as the workers could be subject to either or both of these acts. The criteria used in determining federal law and coverage is based on the most current federal court decisions and case law.

AMENDATORY SECTION (Amending WSR 13-11-128, filed 5/21/13, effective 7/1/13)

WAC 296-17A-3402 Classification 3402.

3402-00 Pump, safe, scale, auto jack, water meter, air compressor and elevator: Manufacturing or assembly

Applies to:

((~~establishments engaged in the manufacture or assembly of air compressors. This includes air or gas compressors used for paint sprayers, air tools, tire inflation, and general industrial purposes. Operations contemplated include, but are not limited to, welding, machining, general mechanical and electrical work. Machinery and equipment includes, but is not limited to, hand and air tools, welders, punches, shears, and compression equipment. This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification when the repair is done as a part of and in connection with the manufacturing or assembly operation.~~

This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant.

3402-01 Printing or bookbinding machinery: Manufacturing or assembly

Applies to establishments engaged in the manufacture or assembly of printing or bookbinding machinery. The outside casings of the machines may be made of plate metal that varies between 1" to 2 1/2" in thickness. The machines used to make the presses and binding machinery may include both computer numeric controlled (CNC) and manual mills and lathes. Other machinery used in the manufacturing process includes, but is not limited to, welders or cutters, grinders, and drill presses. This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification when the repair is done as a part of and in connection with the manufacturing or assembly operation. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant; and the set up, installation and repair of printing or bookbinding machinery which is to be reported separately in classification 0603.

3402-02 Pump, safe, scale, auto jack, and water meter: Manufacturing or assembly

Applies to establishments engaged in the manufacture or assembly of pumps, safes, scales, auto jacks, and water meters. Materials range from brass screws and rubber washers used to rebuild water meters to plate metal and steel castings used for safe and pump manufacturing. Machinery includes, but is not limited to, hand tools used for repairs, lathes, welders, and pressure testers. This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification when the repair is done as a part of and in connection with the manufacturing or assembly operation. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant; the installation and repair of safes which is to be reported separately in classification 0607; and the installation of pumps which is to be reported separately in the applicable classification.

3402-03 Shoe or textile machinery: Manufacturing or assembly

Applies to establishments engaged in the manufacture or assembly of shoe machinery or textile machinery. Metal materials used vary in size, shape and dimension. Machinery includes, but is not limited to, drills, mills, lathes, saws, and welders. This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification when the repair is done as a part of and in connection with the manufacturing or assembly operation. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant and the installation and repair of shoe or textile machinery which is to be reported separately in classification 0603.

3402-04 Confectioners or food processing machinery: Manufacturing or assembly

Applies to establishments engaged in the manufacture or assembly of food processing or confectioners machinery. Metal materials used vary in size, shape and weight. These establishments often have an assembly line operation and a separate electronic assembly area. This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification when the repair is done as a part of and in connection with the manufacturing or assembly operation. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant and the installation and repair of confectioners and food processing machinery which is to be reported separately in classification 0603.

3402-05 Machine shops, N.O.C.

Applies to establishments engaged in general machine shop operations not covered by another classification (N.O.C.), tool sharpening, and mobile welding shops. Many of the establishments in this classification are "job shops." Size and shape of materials vary with steel and aluminum being the most common. Plastics, light weight aluminum, and alloyed metals are becoming increasingly popular in the manufacture of equipment for some industries. These establishments often have welding shops along with machine shops. Machinery and equipment includes, but is not limited to, mills, lathes, grinders, saws, welding equipment, inspection equipment, and material handling equipment. Machinery is both manual and computer numeric controlled (CNC). This classification also includes "mobile shops" which are used *exclusively* to repair machinery or equipment. A "mobile shop" in this classification usually means a van or pick up pulling a utility trailer equipped with hand tools, specialty tools, air tools, a compressor, and a portable welding unit. The machinery or equipment is usually repaired at the customer's location, however, sometimes the broken part is removed and taken back to the shop for repair.

This classification excludes repairs to buildings and structures which are to be reported separately in the appropriate construction classification, and mechanical repairs which are to be reported separately in the classification applicable to the work being performed.

***Special note*:** The term "job shop" is an industry term that means the shop will produce products to customer specifications.

3402-06 Power saw, lawn and garden equipment, small motor, N.O.C.: Repair

Applies to establishments engaged in repairing small power tools, small motors powered by gas or diesel, outboard marine engines, and lawn and garden equipment not covered by another classification (N.O.C.). The largest piece of equipment repaired in this classification is generally a riding lawn mower. Classification 3402-06 is assigned in conjunction with a store classification for establishments that have a store operation and also repair the type of items they sell. Classification 3402-06 may also be assigned to a manufacturers representative who performs warranty repairs. Tools used in this type of repair are mainly hand and air tools. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant and the repair of electrical motors which is to be reported separately in classification 5201.

3402-07 Gear: Manufacturing or grinding

Applies to establishments engaged in the manufacture or grinding of gears. Establishments in this classification may also cut key slots and broaches. Establishments that cut stock to manufacture the gear are often not the same ones that perform the final grinding process. Gears may go through two, three, or four different grinding, slotting, and/or keying establishments and then go to another establishment for electroplating or galvanizing before they are ready for sale or use. Precision machine shops may grind gears to the ten thousandths of an inch. Materials used are usually stainless steel, aluminum, or plastic. Machinery includes, but is not limited to, gear shapers, drill presses, mill, hobbers, grinders, some of which might be computer numeric controlled (CNC). This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification when the repair is done as a part of and in connection with the manufacturing or assembly operation. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant.

3402-08 Elevator: Manufacturing

Applies to establishments engaged in the manufacture of elevators and associated electronic components. Machinery includes, but is not limited to, mills, drills, lathes, saws, and grinders. This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification when the repair is done as a part of and in connection with the manufacturing or assembly operation. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant and the installation, service, and repair of elevators which is to be reported separately in classification 0602.

3402-12 Multimedia blasting

Applies to establishments engaged in multimedia (such as, but not limited to, glass, plastic and sand) blasting operations which strip paint or other coatings from metal or fiberglass. Most of the blasting operations in this classification are done on automobiles, but it also applies to establishments that perform blasting on items such as, but not limited to, barbecue grills, and cast iron pieces. Multimedia blasting processes in this classification are performed in a shop, use less air pressure and media with softer finishes than other blasting operations. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant and sandblasting of buildings or structures which is to be reported separately in classification 0504.

3402-14 Furnace, heater, radiator, wood, propane, or pellet stoves: Manufacturing

Applies to establishments engaged in the manufacture of furnaces, radiators, wood, propane, or pellet burning stoves or similar heating fixtures. Materials include, but are not limited to, metal cast parts, sheet metal, plate metal, aluminum, or stainless steel. Machinery includes, but is not limited to, hand tools, solder guns, punches, lathes, and saws. Establishments in this classification may have separate areas for electronic assembly and/or painting. This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification when the repair is done as a part of and in connection with the manufacturing or assembly operation. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant; establishments engaged in the manufacture of radiators for automobiles or trucks which are to be reported separately in classification 3402-48; and establishments engaged in the manufacture of baseboard heaters which are to be reported separately in classification 3404.

3402-16 Die casting

Applies to establishments engaged in the manufacture of products by die casting. Die casting is a manufacturing process for producing accurately dimensioned, sharply defined metal products which are referred to as "die castings." "Dies" are the steel molds used to mass produce the product. The process begins when ingots of various metal alloys are melted in die casting machines. The machine forces the metal into the die under hydraulic or pneumatic pressure. The casting quickly solidifies in the die, and is automatically ejected by the machine, and the cycle starts again. The castings are cleaned by grinding or sanding, which also removes any excess metal "flash." Many die casting manufacturers maintain their own machine shop for making the dies. Die making, when done as a part of die casting operations, is included within the scope of this classification. This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification when the repair is done as a part of and in connection with the manufacturing or assembly

operation. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant; and establishments engaged in making dies for others which are to be reported separately in classification 3402-74.

3402-26 Saw blade: Manufacturing, assembly, or sharpening

Applies to establishments engaged in the manufacture, assembly, or sharpening of saw blades such as, but not limited to, those used in circular saws, band saws, ripsaws, keyhole saws, and handsaws such as hacksaws or meat saws. This classification also includes sharpening services for items such as, but not limited to, tools, scissors, and knives. Materials include, but are not limited to, high tensile steel and carbide tipped blades. Machinery includes, but is not limited to, saws, mills, drills, and hand tools. This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification when the repair is done as a part of and in connection with the manufacturing or assembly operation. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant; establishments engaged in the repair or sharpening of chain saws which are to be reported separately in classification 3402-06; and establishments engaged in the manufacture or repair of electrical saws which are to be reported separately in classification 5201.

3402-28 Heat treating metal

Applies to establishments engaged in heat treating metal. The heat treating process may use computer numeric controlled (CNC) ovens or furnaces. The oven may heat up to 1200 degrees Fahrenheit and a furnace may heat up to 2000 degrees Fahrenheit. The metal(s) is placed on a platform; the platform is hydraulically moved into the first chamber and the door is automatically closed. At this time, the oxygen is burned from the chamber. Then the second chamber door is opened and the metal enters the oven/furnace. Depending upon the specifications, the heat treating process usually takes six to sixteen hours. When the metal is finished in the heating chamber it returns automatically to the first chamber. Then the platform lowers and the metals are dipped into a cooling agent. Once the metals are cooled to room temperature the platform rises, the door opens, and the materials are removed. The process is essentially the same without using computer numeric controlled (CNC) heat treating equipment except that, rather than being hydraulically operated, the machine operators move the metals through the system. Many establishments do not produce a product, but heat treat a variety of products to customer specifications. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant.

3402-29 Nut, bolt, screw, nail, tack, rivet, eyelet spike, needle, N.O.C.: Manufacturing

Sprinkler head, speedometer, carburetor: Manufacturing or assembly

Applies to establishments engaged in the manufacture of nuts, bolts, screws, nails, tacks, rivets, eyelets, spikes, and needles not covered by another classification (N.O.C.). This classification also applies to establishments engaged in the manufacture or assembly of sprinkler heads, speedometers, or carburetors. Materials include, but are not limited to, steel or iron rods which may be pressed or formed, and small component parts. Machinery includes, but is not limited to, saws, shears, presses, chuckers, threading and tapping machines, some of which may be computer numeric controlled (CNC). Establishments may have separate areas for deburring, inspecting, packing and shipping. The carburetor rebuilding may be performed on vehicles that are driven or towed into the shop, or on carburetors that have been already removed from the vehicles. In either case the repairs are made exclusively with hand and air tools and sometimes a diagnostic scope and a drill press. A speedometer is usually embodied with a mileage recording mechanism. The central feature of the device is a permanent magnet. There are gears, spindles, and a drive shaft present in most speedometers. There is also a unit counting disc and a spiral spring calibrator. Hand tools are used almost exclusively in the repair of this kind of speedometer. Today many speedometers are computer controlled. Basically, if this kind of speedometer is in need of repair, a computer chip(s) is replaced, using hand tools. This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification when the repair is done as a part of and in connection with the manufacturing or assembly operation. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant and establishments engaged in the manufacture of hardware that is not covered under another classification, such as handles, latches, and hinges which are to be reported separately in classification 3404, and the repair of speedometers or carburetors in a vehicle which is to be reported separately in the appropriate vehicle repair classification.

3402-32 Abrasive wheel: Manufacturing

Applies to establishments engaged in the manufacture of abrasive wheels. Manufacturing operations often include a laboratory where carbon and other materials are mixed together to form the abrasive edge of the mainly high tensile steel wheels. This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification when the repair is done as a part of and in connection with the manufacturing or assembly operation. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant.

3402-40 Welding or cutting, N.O.C. (*mobile operations limited to repair of equipment and machinery*)

Applies to establishments engaged in welding or cutting operations not covered by another classification (N.O.C.) either in the shop or at the customer's site. Steel is the predominant material along with some aluminum alloys. Machinery is predominantly welding equipment, but may include tools such as, but not limited to, grinders, saws, drills, and material handling equipment. This classification also includes "mobile shops" which are used *exclusively* to repair machinery or equipment. A "mobile shop" in this classification usually means a van or pick up pulling a utility trailer equipped with hand tools, specialty tools, air tools, a compressor, and a portable welding unit. The machinery or equipment is usually repaired at the customer's location, sometimes with the use of the customer's equipment; however, broken parts may be removed and taken back to the shop for repair.

This classification excludes welding construction and repairs to buildings or structures which are to be reported separately in the appropriate construction classification and mechanical repairs which are to be reported separately in the classification applicable to the work being performed.

3402-48 Automobile or truck, radiator and heater core: Manufacturing and repair shops

Applies to establishments engaged in the manufacture and/or repair of automobile or truck radiator and heater cores. Manufacturers in this classification may have a die casting area and a separate electronic assembly area. Tools and equipment include, but are not limited to, hand tools, solder guns, and punches. Shops that repair radiators may work on the radiators in the vehicles, but usually the radiators have been removed from the vehicle. The radiator is examined and the core may be removed. Next the radiator is cleaned, air pressurized, and dipped in a water tank to check it for leaks. Once the leaks are found they can generally be repaired by welding the holes shut. The radiator is dipped again to ensure the repair has been made properly. Cleaning the radiator may be done by sandblasting, ultra sound baths or by "rodding" the radiator to remove corrosion. Repair equipment includes, but is not limited to, welders, air and hand tools, dipping tanks, hoists, and forklifts. This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification when the repair is done as a part of and in connection with the manufacturing or assembly operation. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant.

3402-60 Office machinery, N.O.C.: Manufacturing or assembly; Cash register or sewing machines: Manufacturing or assembly

Applies to establishments engaged in the manufacture or assembly of cash registers, sewing machines and office machinery not covered by another classification (N.O.C.) such as, but not limited to, copiers, collators, mail/postage machines, calculators and automatic letter openers. Component parts may be metal, plastic, or wood. Operations include, but are not limited to, cutting, shaping, forming, drilling, riveting, clamping, and bolting; there may be a separate electronic assembly area. Machinery and tools vary within this classification; some establishments use hand and air tools only, others use additional equipment such as, but not limited to, saws, lathes, mills, drills, or water jets, some of which may be computer numeric controlled (CNC). This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification when the repair is done as a part of and in connection with the manufacturing or assembly operation. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant.

3402-61 Small arms and ammunition: Manufacturing, assembly, or rebuild

Applies to establishments engaged in the manufacture, assembly, or rebuild of small arms, the manufacture of ammunition and reloading. For the purpose of this classification, small arms means .50 caliber or less, such as pistols, rifles, shotguns, and light machine guns. Operations include, but are not limited to, metal stamping of casings, machining, assembling, and a high proportion of inspecting. This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification when the repair is done as a part of and in connection with the manufacturing or assembly operation. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant; the manufacture or repair of heavy arms which is to be reported separately in classification 5109; and gun stores which are to be reported separately in classification 6309.

3402-74 Tool: Manufacturing, not hot forming or stamping; Die: Manufacturing - Ferrous

Applies to establishments engaged in tool manufacturing or die manufacturing, for others, from ferrous materials. Tools manufactured in this classification are usually cutting tools used in lathes, mills, rotors, and saws. Machinery includes, but is not limited to, sharpeners, grinders, lathes and mills, which are both manual or computer numeric controlled (CNC). The die manufacturing included in this classification includes those made exclusively of ferrous materials including, but not limited to, jigs, fixtures, and dies for metal work in general. This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification when the repair is done as a part of and in connection with the manufacturing or assembly operation. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant and establishments engaged in the manufacture of machine-finished tools which are to be reported separately in classification 3402-83.

3402-77 Auto, truck, semi-trailer and bus body: Manufacturing;

Travel trailer body: Manufacturing or repair

Applies to establishments engaged in the manufacture of auto, truck, and bus bodies, and in the manufacture or repair of travel trailer bodies or cargo containers. Repairs are usually made with the use of welders or cutting torches and air or hand tools. These establishments will also repair or replace hydraulic units. Material used in the manufacture of goods in this classification is usually steel and aluminum, varying in thickness from 16 gauge to plate metal up to one inch thick. Shapes include, but are not limited to, sheet metal, tubes, solid rod or I-beams. Equipment includes, but is not limited to, shears, breaks, hydraulic presses, iron workers, drill presses, grinders, welders, hoist, cranes, and forklifts. Shops may have a finish sanding area as well as a paint area where the vehicle bodies are sprayed with primer, a body bonding material, or a finish coat of paint. This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification when the repair is done as a part of and in connection with the manufacturing or assembly operation. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant.

3402-83 Tool: Manufacturing and machine finishing

Applies to establishments engaged in manufacturing and machine finishing tools. Tools manufactured in this classification are usually hand held instruments such as, but not limited to, wrenches, screw drivers, hammers, torque wrenches, pliers, and sockets. Machinery includes, but is not limited to, air and hand tools, polishers, grinders, inspection equipment, mills, lathes, shapers, and drill presses, some of which may be computer numeric controlled (CNC). Establishments may have a galvanizing and/or electroplating area for the finish work which is included when performed by employees of employers subject to this classification. Other establishments in this classification send the finish work out. This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification when the repair is done as a part of and in connection with the manufacturing or assembly operation. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant; establishments engaged in the manufacture of tools from ferrous materials which are to be reported separately in classification 3402-74; and establishments engaged in tool forging which are to be reported separately in classification 5106.

3402-85 Auto or truck parts: Machining or rebuild not in vehicle

Applies to establishments engaged in machining or rebuilding auto or truck parts such as, but not limited to, water pumps, fuel pumps, transmissions, heads, brake drums, ball joints, and rear ends, which are not in the vehicle. Work contemplated in this classification may also include manufacturing sockets, pulleys, shafts, fittings, flywheels, and/or bearings. Machinery includes, but is not limited to, mills, lathes, grinders, sanders, presses, welders, and balancing equipment. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant and establishments engaged in manufacturing or rebuilding auto, truck, or aircraft engines which are to be reported separately in classification 3402-86.

3402-86 Auto, truck or aircraft engine, N.O.C.: Manufacturing or rebuilding

Applies to establishments engaged in manufacturing or rebuilding auto, truck, or aircraft engines not covered by another classification (N.O.C.), including manufacturing the component parts. Establishments in this classification often specialize in the type of engines they make or rebuild. The basic difference between automobile, truck, and aircraft engines is the size and weight of the parts being worked on. Engine rebuild shops use many specialized machines and air tools to tear the core down to an engine block; then rebuild the engine. After the engine is stripped down to the engine block, it is placed in a machine called a baker which heats to approximately 600 degrees and bakes away the grease. After baking, the engine block is placed in a sand blaster where the surface is cleaned with very fine steel shot. The engine block is then placed in a large pressure washer which removes the steel shot. Next, the crank and cam shafts are ground and turned on machinery similar to lathes. There is usually a separate room or area which is called the "head shop" where the heads and valves are machined on valve grinders, valve facers, and head grinders. Engine rebuild shops that do not have the equipment to grind the crank and cam shafts will contract work out to other shops, or buy new crank shafts and cam shafts. Other machinery includes, but is not limited to, boring bars and hones to polish cylinder walls, small pressure washers for oil pans and other smaller parts, solvent tanks, and hoists or forklifts for lifting the engines or engine parts. This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification when the repair is done as a part of and in connection with the manufacturing or assembly operation. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant and establishments engaged in machining or rebuilding auto or truck parts, other than engines, which are to be reported separately in classification 3402-85.

3402-91 Bed spring or wire mattress: Manufacturing

Applies to establishments engaged in the manufacture of bed springs or wire mattresses. The wire stock is coiled and cut to length on a coiling machine, then tempered in an oven to produce the spring. The coils are fastened to the frame either by hand or by machine. This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification when the repair is done as a part of and in connection with the manufacturing or assembly operation. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant and establishments engaged in the manufacture of stuffed mattresses which are to be reported separately in classification 3708.

3402-93 Valve: Manufacturing

Applies to establishments engaged in the manufacture of valves. Valves regulate the flow of air, gases, liquids, or loose material through structures by opening, closing, or obstructing passageways. They are operated manually, electrically, with compressed air, or hydraulic pressure. Valves are usually cut from aluminum, steel, or stainless steel either by a computer numeric controlled (CNC) machine or water jet machine. Depending upon the complexity of the valve, they are assembled in one or several stages. This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification when the repair is done as a part of and in connection with the manufacturing or assembly operation. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant and establishments engaged in the manufacture of valves made in a die mold which are to be reported separately in classification 3402-74.

3402-94 Precision machined parts, N.O.C.: Manufacturing

Applies to establishments engaged in manufacturing precision machined parts not covered by another classification (N.O.C.). Most of these establishments are "job shops." Job shops make component parts for other businesses according to customer specifications, rather than manufacturing a specific product. Many establishments in this classification manufacture precision parts for the aerospace industry. Machining usually begins with solid blocks of material such as, but not limited to, steel, aluminum, titanium, inconel, or plastic, although some hollow tube, flat bar, and angle stock may also be used. The "rough cuts" are often made on manual machines, and the finish cuts on computer numeric controlled (CNC) machines. Depending on the establishment and the job specifications, a specific part may be sent to one or more additional shops to be tempered, milled, or inspected before the original establishment is through with the manufacturing process. Some parts are so sensitive that climate controlled conditions are necessary. Both manual and CNC mills and lathes are the most common types of machines used. Others include, but are not limited to, saws, drills, and grinding machines. This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification when the repair is done as a part of and in connection with the manufacturing or assembly operation. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant.

3402-95 Storage battery: Manufacturing, assembly or repair

Applies to establishments engaged in the manufacture, assembly, or repair of storage batteries. Lead ingots, weighing 20-25 pounds, are melted and poured into a mold or casting machine. After the grids are cooled lead oxide is then pumped onto each side of a grid and cured by baking in an oven of about 300 - 400 degrees F. The plates are then assembled by placing a negative separator (zinc) between a positive separator (copper), and so forth until there are enough of these cells to form the battery. Next, they are sent to a burning machine that cures the paste and plates. After the burning process, the plates are placed into a plastic or hard rubber box-like container and cured for two or three days. The plates are welded together and the top is attached to the body of the battery case with an epoxy glue. Diluted sulfuric acid is added to the battery and then it is put on a charger. The battery is then cleaned and packed for shipping. This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification when the repair is done as a part of and in connection with the manufacturing or assembly operation. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant; establishments engaged in the manufacture of dry cell (flashlight type) batteries which are to be reported separately in classification 3602; and establishments engaged in battery sales and installation which are to be reported separately in the applicable automotive services classification.

3402-96 Automobile or motorcycle: Manufacturing or assembly

Applies to establishments engaged in the manufacture or assembly of automobiles or motorcycles. Most of the manufacturing operations, such as cutting, milling, and turning, are performed with computer numeric controlled (CNC) machinery. Most of the assembly operations are performed with air and hand tools. Other machinery includes but is not limited to saws, grinders, and drill presses. This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification when the repair is done as a part of and in connection with the manufacturing or assembly operation. This is a shop or plant only classification; it includes work

~~being performed in an adjacent yard when operated by an employer having operations subject to this classification.~~

~~This classification excludes all activities away from the shop or plant and establishments engaged only in the manufacture of auto bodies which are to be reported separately in classification 3402-77.~~

~~3402-98 Machinery, N.O.C.: Manufacturing or assembly~~

~~Applies to establishments engaged in the manufacture or assembly of machinery not covered by another classification (N.O.C.). For purposes of this classification, machinery means any combination of mechanical parts constructed primarily with metal. Finished products vary widely and range from hand held machines to those weighing thousands of pounds; products include, but are not limited to, grinding machines, boring machines, conveyer systems, and wood chippers. Machinery used to manufacture these items includes, but is not limited to, lathes, mills, press, breaks, shears, and welders, some of which may be computer numeric controlled (CNC). This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification when the repair is done as a part of and in connection with the manufacturing or assembly operation. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.~~

~~This classification excludes all activities away from the shop or plant.~~

~~3402-99 Photo processing machinery: Manufacturing or assembly~~

~~Applies to establishments engaged in the manufacture or assembly of photo processing machinery such as, but not limited to, photo processors or film enlargers. This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification when the repair is done as a part of and in connection with the manufacturing or assembly operation. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.~~

~~This classification excludes all activities away from the shop or plant.~~)) Businesses that manufacture or assemble pumps, safes, scales, auto jacks, water meters, air compressors, and elevators and associated electronic components.

Work activities include, but are not limited to:

- Welding;
- Machining;
- General mechanical and electrical work;
- Assembly work.

Machinery and equipment used include, but are not limited to:

- Hand tools;
- Lathes;
- Mills;
- Drills;
- Grinders;
- Saws;
- Welders;
- Punches;
- Shears;
- Compression equipment;
- Pressure testers.

Note: Machinery/equipment could be manual or computer numeric controlled (CNC).

Materials used include, but are not limited to:

- Brass screws and rubber washers;
- Metals of all types, gauges, sizes, shapes and dimensions.

This classification includes the repair of items being manufactured or assembled when done by employees having operations subject to this classification. This is a shop or plant only classification and includes work performed in an adjacent yard when operated by an employer having operations subject to this classification.

Exclusions:

- Worker hours or businesses installing or repairing safes must be reported separately in classification 0607;
- Worker hours or businesses engaged in installing, servicing or repairing elevators must be reported separately in classification 0602;
- Worker hours or businesses installing pumps must be reported in the applicable classification;
- Activities away from the shop or plant must be reported separately in the applicable classification.

Note: For rules on assigning and reporting in more than one basic classification, see WAC 296-17-31017 Multiple classifications.

3402-05 Machine shops, N.O.C., job shops, tool sharpening, mobile welding shops, storage battery manufacturing, assembly or repair, multimedia blasting, die casting, and heat treating metal

Applies to:

Businesses with general machine shop operations not covered by another class. This classification also applies to the manufacture, assembly or repair of storage batteries, tool sharpening, multimedia blasting, die-casting and heat-treating.

Work activities include, but are not limited to:

- Tool sharpening;
- Welding;
- Mobile welding shops;
- Machining;
- Multimedia blasting:

- Multimedia (such as, but not limited to, glass, plastic and sand) blasting operations which strip paint or other coatings from metal or fiberglass. Most of the blasting operations in this classification are done on automobiles, but it also applies to establishments that perform blasting on items such as, but not limited to, barbecue grills, and cast iron pieces. Multimedia blasting processes in this classification are performed in a shop, use less air pressure and media with softer finishes than other blasting operations.

• Die casting:

- Die-casting is a manufacturing process for producing accurately dimensioned, sharply defined metal products, which are referred to as "die castings." "Dies" are the steel molds used to mass-produce the product. The process begins when ingots of various metal alloys are melted in die casting machines. The machine forces the metal into the die under hydraulic or pneumatic pressure. The casting quickly solidifies in the die, and is automatically ejected by the machine, and the cycle starts again. The castings are cleaned by grinding or sanding, which also removes any excess metal "flash." Many die casting manufacturers maintain their own machine shop for making the dies. Die making, when done as a part of die casting operations, is included within the scope of this classification.

• Heat treating:

- Process may use computer numeric controlled (CNC) ovens or furnaces. The oven may heat up to 1200 degrees Fahrenheit and a furnace may heat up to 2000 degrees Fahrenheit. The metal(s) is placed on a platform; the platform is hydraulically moved into the first chamber and the door is automatically closed. At this time, the oxygen is burned from the chamber. Then the second chamber door is opened and the metal enters the oven/furnace. Depending upon the specifications, the heat treating process usually takes six to sixteen hours. When the metal is finished in the heating chamber, it returns automatically to the first chamber. Then the platform lowers and the metals are dipped into a cooling agent. Once the metals are cooled to room temperature the platform rises, the door opens, and the materials are removed. The process is essentially the same without using computer numeric controlled (CNC) heat-treating equipment except that, rather than being hydraulically operated, the machine operators move the metals through the system. Many establishments do not produce a product, but heat-treat a variety of products to customer specifications.

• Storage battery, manufacture, assembly or repair:

- Lead ingots, weighing 20-25 pounds, are melted and poured into a mold or casting machine. After the grids are cooled lead oxide is then pumped onto each side of a grid and cured by baking in an oven of about 300-400 degrees F. The plates are then assembled by placing a negative separator (zinc) between a positive separator (copper), and so forth until there are enough of these cells to form the battery. Next, they are sent to a burning machine that cures the paste and plates. After the burning process, the plates are placed into a plastic or hard rubber box-like container and cured for two or three days. The plates are welded together and the top is attached to the body of the battery case with an epoxy glue. Diluted sulfuric acid is added to the battery and then it is put on a charger. The battery is then cleaned and packed for shipping.

***Special note*:** The term "job shop" is an industry term that means the shop will produce products to customer specifications.

Machinery and equipment used include, but are not limited to:

• Mills;
• Lathes;
• Grinders;
• Saws;
• Welding equipment;
• Inspection equipment;
• Material handling equipment;
• Casting machines;
• Burning machines;
• Ovens or furnaces;
• Steel molds;
• Hand tools;
• Air tools;
• Compressors;
• Portable welding equipment;
• Mobile welding equipment.

- Are used exclusively to repair machinery or equipment. A "mobile shop" in this classification usually means a van or pickup pulling a utility trailer equipped with hand tools, specialty tools, air tools, a compressor, and a portable welding unit. The machinery or equipment is usually repaired at the customer's location; however, sometimes the broken part is removed and taken back to the shop for repair.

Note: Machinery/equipment could be manual or computer numeric controlled (CNC).

Materials used include, but are not limited to:

• Metals of all types, gauges, sizes, shapes and dimensions;
• Plastics.

This classification includes the repair of items being manufactured or assembled when done by employees having operations subject to this classification. This is a shop or plant only classification and includes work performed in an adjacent yard when operated by an employer having operations subject to this classification.

Exclusions:

• Worker hours or businesses sandblasting buildings or structures must be reported separately in classification 0504;
• Worker hours or businesses repairing buildings and structures must be reported separately in the appropriate construction classification;
• Worker hours or businesses doing mechanical repair (such as, on engines or electrical systems) must be reported separately in the classification applicable to the work being performed;
• Manufacturing dies for others, is classified in 3402-74;
• Manufacturing dry cell (flashlight type) batteries, is classified in 3602;
• Battery sales and installation, are classified in the applicable automotive services classification;
• Activities away from the shop or plant must be reported separately in the applicable classification, with the exception of mobile welding operations.

Note: For rules on assigning and reporting in more than one basic classification, see WAC 296-17-31017 Multiple classifications.

3402-06 Power saw, lawn and garden equipment, small motor, N.O.C: Repair

Applies to:

Businesses that repair small power tools, small motors powered by gas or diesel, outboard marine engines, and lawn and

garden equipment not covered by another classification (N.O.C.).

Machinery and equipment used include, but are not limited to:

• Hand and air tools.

Classification 3402-06 is assigned in conjunction with a store classification for establishments that have a store operation and repair the type of items they sell. Classification 3402-06 may also be assigned to a manufacturer representative who performs warranty repairs.

This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

Exclusions:

• Worker hours or businesses repairing electrical motors are classified in 5201;

• Activities away from the shop or plant which must be reported separately in the applicable classification.

Note: For rules on assigning and reporting in more than one basic classification, see WAC 296-17-31017 Multiple classifications.

3402-14 Furnace, heater, radiator, wood, propane, or pellet stoves: Manufacturing

Applies to:

Businesses that manufacture furnaces, radiators, wood, propane, or pellet burning stoves or similar heating fixtures.

Machinery and equipment used include, but are not limited to:

• Hand tools;
• Solder guns;
• Punches;
• Lathes;
• Saws.

Note: Machinery/equipment could be manual or computer numeric controlled (CNC).

Materials used include, but are not limited to:

• Sheet metal;
• Plate metal;
• Aluminum;
• Stainless steel.

Note: Establishments in this classification may have separate areas for electronic assembly and/or painting.

This classification includes the repair of items being manufactured or assembled when done by employees having operations subject to this classification. This is a shop or plant only classification and includes work performed in an adjacent yard when operated by an employer having operations subject to this classification.

Exclusions:

• Manufacturing radiators for automobiles or trucks, is classified in 3402-48;

• Manufacturing baseboard heaters, is classified in 3404;

• Activities away from the shop or plant must be reported separately in the applicable classification.

Note: For rules on assigning and reporting in more than one basic classification, see WAC 296-17-31017 Multiple classifications.

3402-26 Saw blade and abrasive wheel: Manufacturing, assembly or sharpening

Applies to:

Businesses that manufacture abrasive wheels, and businesses that manufacture, assemble, or sharpen saw blades such as, but not limited to, those used in circular saws, band saws, ripsaws, keyhole saws, and handsaws such as hacksaws or meat saws.

Abrasive wheel manufacturing operations often include a laboratory where carbon and other materials are mixed together to form the abrasive edges of the wheels.

Note: Businesses in this classification may also perform incidental sharpening services for items such as, but not limited to, tools, scissors, and knives.

Machinery and equipment used include, but are not limited to:

• Saws;
• Mills;
• Drills;
• Hand tools.

Materials used include, but are not limited to:

• High tensile steel;
• Carbide tipped blades.

This classification includes the repair of items being manufactured or assembled when done by employees having operations subject to this classification. This is a shop or plant only classification and includes work performed in an adjacent yard when operated by an employer having operations subject to this classification.

Exclusions:

• Repair or sharpening of chain saws, is classified in 3402-06;

• Manufacture or repair of electrical saws, is classified in 5201;

• Activities away from the shop or plant must be reported separately in the applicable classification.

Note: For rules on assigning and reporting in more than one basic classification, see WAC 296-17-31017 Multiple classifications.

3402-29 Nut, bolt, screw, nail, tack, rivet, eyelet spike, needle, bedspring, wire mattress, N.O.C.: Manufacturing; sprinkler head, speedometer, carburetor: Manufacturing or assembly

Applies to:

Businesses that manufacture nuts, bolts, screws, nails, tacks, rivets, eyelets, spikes, needles, bedspring, and wire mattresses not covered by another classification. N.O.C. This classification also applies to businesses that manufacture or assemble sprinkler heads, speedometers, or carburetors. Rebuilding carburetors is also included in this classification.

The carburetor rebuilding may be performed on vehicles that are driven or towed into the shop, or on carburetors that have been already removed from the vehicles.

Businesses in this classification may have separate areas for deburring, inspecting, packing and shipping.

Machinery and equipment used include, but are not limited to:

- Saws;
- Shears;
- Presses;
- Chuckers;
- Threading and tapping machines;
- Hand tools;
- Air tools;
- Diagnostic scopes;
- Drill press;
- Coiling machines;
- Ovens.

Note: Machinery/equipment could be manual or computer numeric controlled (CNC).

Materials used include, but are not limited to:

- Steel rods;
- Iron rods;
- Small component parts;
- Wire.

This classification includes the repair of items being manufactured or assembled when done by employees having operations subject to this classification. This is a shop or plant only classification and includes work performed in an adjacent yard when operated by an employer having operations subject to this classification.

Exclusions:

- Manufacturing stuffed mattresses, is classified in 3708;
- Manufacturing handles, latches, and hinges, is classified in 3404;
- Repair of speedometers or carburetors in a vehicle, is classified in the appropriate vehicle repair classification;
- Activities away from the shop or plant must be reported separately in the applicable classification.

Note: For rules on assigning and reporting in more than one basic classification, see WAC 296-17-31017 Multiple classifications.

3402-40 Welding or cutting, N.O.C. (mobile operations limited to repair of equipment and machinery)

Applies to:

Businesses doing welding or metal cutting not covered by another classification (N.O.C.) either in the shop or at the customer's site.

Machinery and equipment used include, but are not limited to:

- Welding equipment;
- Grinders;
- Saws;
- Drills;
- Material handling equipment.

Materials used include, but are not limited to:

- Steel;
- Aluminum alloys.

This classification also includes "mobile shops" which are used *exclusively* to repair machinery or equipment. A "mobile shop" in this classification usually means a van or pickup pulling a utility trailer equipped with hand tools, specialty tools, air tools, a compressor, and a portable welding unit. The machinery or equipment is usually repaired at the customer's location, sometimes with the use of the customer's equipment; however, broken parts may be removed and taken back to the shop for repair.

Exclusions:

- Worker hours or businesses doing welding construction or repairs to buildings or structures must be reported separately in the classification applicable to the work being performed;
- Worker hours or businesses doing mechanical repairs (such as, on engines and electrical systems) must be reported separately in the applicable classification.

Note: For rules on assigning and reporting in more than one basic classification, see WAC 296-17-31017 Multiple classifications.

3402-48 Automobile or truck, radiator and heater core: Manufacturing and repair shops

Applies to:

Businesses that manufacture and/or repair automobile or truck radiator and heater cores.

Work activities in this classification include, but are not limited to:

- Repair of radiators in the vehicle, or removed from vehicle;
- Radiators cleaned, air pressured, and dipped in water tank to check for leaks;
- Leaks repaired by welding the holes shut;
- Radiators dipped again to ensure the repair has been made properly;
- Cleaning radiator by sandblasting, ultra sound baths or "rodding" the radiator to remove corrosion.

Note: Manufacturer in this classification may have a die casting area and a separate electronic assembly area.

Machinery and equipment used include, but are not limited to:

- Hand tools and air tools;
- Solder guns;
- Punches;
- Welders;
- Dipping tanks;
- Hoists;
- Forklifts.

This classification includes the repair of items being manufactured or assembled when done by employees having operations subject to this classification. This is a shop or plant only classification and includes work performed in an adjacent yard when operated by an employer having operations subject to this classification.

Exclusions:

• Activities away from the shop or plant must be reported separately in the applicable classification.

Note: For rules on assigning and reporting in more than one basic classification, see WAC 296-17-31017 Multiple classifications.

3402-74 Tool: Manufacturing, not hot forming or stamping; machine finishing tools, die: Manufacturing ferrous

Applies to:

Businesses doing tool manufacturing or die manufacturing, for others, from ferrous materials.

Products manufactured include, but are not limited to:

• Jigs;
• Fixtures and dies for metal work;
• Wrenches;
• Screw drivers;
• Hammers;
• Torque wrenches;
• Pliers;
• Sockets;
• Cutting tools used in lathes, mills, rotors and saws.

Machinery and equipment used include, but are not limited to:

• Air and hand tools;
• Polishers;
• Sharpeners;
• Grinders;
• Inspection equipment;
• Mills;
• Lathes;
• Shapers;
• Sharpeners;
• Drill presses.

Note: Machinery/equipment could be manual or computer numeric controlled (CNC).

Businesses may have a galvanizing and/or electroplating area for the finish work, which is included when performed by employees of employers subject to this classification.

This classification includes the repair of items being manufactured or assembled when done by employees having operations subject to this classification. This is a shop or plant only classification and includes work performed in an adjacent yard when operated by an employer having operations subject to this classification.

Exclusions:

• Tool forging by hot forming or stamping is classified in 5106;

• Activities away from the shop or plant must be reported separately in the applicable classification.

Note: For rules on assigning and reporting in more than one basic classification, see WAC 296-17-31017 Multiple classifications.

3402-77 Auto, truck, semi-trailer and bus body: Manufacturing; travel trailer body: Manufacturing or repair; automobile or motorcycle: Manufacturing or assembly

Applies to:

Businesses that manufacture auto, truck, and bus bodies, or that manufacture or repair travel trailer bodies or cargo containers, or that manufacture or assemble automobiles or motorcycles.

Work activities include, but are not limited to:

• Welding operations;
• Using cutting torches;
• Operating milling, cutting and turning machines;
• Assembly operations performed with air and hand tools;
• Repair or replace hydraulic units;
• Shops may have a finish sanding area as well as a paint area where the vehicle bodies are sprayed with primer, a body bonding material, or a finish coat of paint.

Machinery and equipment used include, but are not limited to:

• Welders;
• Cutting torches;
• Air or hand tools;
• CNC machinery (computer numeric controlled);
• Saws;
• Grinders;
• Drill presses;
• Shears;
• Breaks;
• Hydraulic presses;
• Iron workers;
• Grinders;
• Hoists;
• Cranes and forklifts.

Materials used include, but are not limited to:

• Steel or aluminum, varying in thickness, 16 gauge to plate metal up to one inch thick;

• Shapes include sheet metal, tubes, solid rod or I-beams. This classification includes the repair of items being manufactured or assembled when done by employees having operations subject to this classification. This is a shop or plant only classification and includes work performed in an adjacent yard when operated by an employer having operations subject to this classification.

Exclusions:

• Activities away from the shop or plant must be reported separately in the applicable classification.

Note: For rules on assigning and reporting in more than one basic classification, see WAC 296-17-31017 Multiple classifications.

3402-85 Auto or truck parts; machining or rebuild not in vehicle

Applies to:

Businesses that machine or rebuild auto or truck parts that are not in the vehicle.

Products manufactured include, but are not limited to:

• Water pumps;
• Fuel pumps;
• Transmissions;

• Heads;
• Brake drums;
• Ball joints;
• Rear ends;
• Sockets;
• Pulleys;
• Shafts;
• Fittings;
• Flywheels;
• Bearings.

Machinery and equipment used include, but are not limited to:
• Mills;
• Lathes;
• Grinders;
• Sanders;
• Presses;
• Welders;
• Balancing equipment.

Note: Machinery/equipment could be manual or computer numeric controlled (CNC).

This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

Exclusions:
• Manufacturing or rebuilding auto, truck, or aircraft engines are classified in 3402-86;
• Activities away from the shop or plant must be reported separately in the applicable classification.

Note: For rules on assigning and reporting in more than one basic classification, see WAC 296-17-31017 Multiple classifications.

3402-86 Auto, truck, or aircraft engine, N.O.C.: Manufacturing or rebuilding

Applies to:
Businesses that manufacture or rebuild auto, truck, or aircraft engines not covered by another classification (N.O.C.), including manufacturing the component parts.

Note: The basic difference between automobile, truck, and aircraft engines is the size and weight of the parts worked on.

Work activities include, but are not limited to:
• Use specialized machines and air tools to tear the core down to an engine block;
• Rebuild the engine;
• After engine is stripped down to the engine block, it is placed in a machine called a baker which heats to approximately 600 degrees and bakes away the grease;
• After baking, the engine block is placed in a sand blaster where the surface is cleaned with very fine steel shot;
• Engine block is then placed in a large pressure washer which removes the steel shot;
• Crank and shafts are ground and turned on machinery similar to lathes;
• Heads and valves are machined on valve grinders, valve facers, and head grinders. Shops that do not have equipment to grind the crank and camshafts will contract work out to other shops, or buy new crank and camshafts.

Machinery and equipment used include, but are not limited to:
• Baker machines;
• Sand blasters;
• Pressure washers;
• Lathes;
• Valve grinders;
• Valve facers;
• Head grinders;
• Boring bars;
• Hones;
• Solvent tanks;
• Hoists;
• Forklifts.

This classification includes the repair of items being manufactured or assembled when done by employees having operations subject to this classification. This is a shop or plant only classification and includes work performed in an adjacent yard when operated by an employer having operations subject to this classification.

Exclusions:
• Machining or rebuilding auto or truck parts is classified in 3402-85;
• Activities away from the shop or plant must be reported separately in the applicable classification.

Note: For rules on assigning and reporting in more than one basic classification, see WAC 296-17-31017 Multiple classifications.

3402-94 Precision machined parts, N.O.C.: Manufacturing, gear: Manufacturing or grinding, small arms and ammunition: Manufacturing, assembly or rebuild, valve: Manufacturing

Applies to:
Businesses that manufacture precision-machined parts not covered by another classification (N.O.C); that manufacture or grind gears, that manufacture, assemble or rebuild small arms (.50 caliber or less), that manufacture or reload ammunition, or that manufacture valves.

Note: Most precision machine establishments are "job shops." Job shops make component parts for other businesses according to customer specifications, rather than manufacturing a specific product.

Work activities in this classification include, but are not limited to:
• Machining;
• Grinding gears;
• Metal stamping of casings;
• Assembly;
• Inspecting;
• Cutting key slots and broaches.

Products manufactured include, but are not limited to:
• Precision parts for aerospace/medical industry;
• Gears;
• Pistols;
• Rifles;

• Shotguns;
• Light machine guns;
• Valves (regulate the flow of air, gas, liquids, or loose material through structures by opening, closing or obstructing passageways. They operate manually, electronically, with compressed air, or hydraulic pressure);
• Other types of precision parts.

Machinery and equipment used include, but are not limited to:
• Manual and CNC (computer numeric controlled) mills and lathes;
• Water jet machines;
• Saws;
• Drill press/drills;
• Grinding machines;
• Gear shapers;
• Hobbers;
• Other types of CNC machinery.

Materials used include, but are not limited to:
• Steel;
• Stainless steel;
• Aluminum;
• Titanium;
• Inconel;
• Plastics;
• Shapes include; solid blocks, flat bar, tube, angle stock.
This classification includes the repair of items being manufactured or assembled when done by employees having operations subject to this classification. This is a shop or plant only classification and includes work performed in an adjacent yard when operated by an employer having operations subject to this classification.

Exclusions:
• Manufacturing or repairing of heavy arms is classified in 5109;
• Gun stores are classified in 6309;
• Manufacturing valves made in a die mold is classified in 3402-74;
• Activities away from the shop or plant must be reported separately in the applicable classification.
Note: For rules on assigning and reporting in more than one basic classification, see WAC 296-17-31017 Multiple classifications.

3402-98 Machinery, N.O.C.: Manufacturing or assembly

Applies to:
Businesses that manufacture or assemble machinery not covered by another classification (N.O.C.).

Finished products vary widely and range from hand held machines to those weighing thousands of pounds. For the purpose of this classification, machinery means any combination of mechanical parts constructed primarily with metal and associated electronic components.

Work activities in this classification include, but are not limited to:
• Cutting;
• Welding;
• Forming;
• Drilling;
• Riveting;
• Clamping and bolting;
• Machining.
Note: Manufacturers in this classification may have a separate electronic assembly area.

Machinery manufactured or assembled include, but are not limited to:
• Grinding machines;
• Boring machines;
• Conveyor systems;
• Wood chippers;
• Printing or bookbinding machinery;
• Confectioners or food processing machinery;
• Photo processing machinery (photo processors or film enlargers);
• Shoe or textile machinery;
• Office machinery (copiers, collators, mail/postage machines, calculators and automated letter openers);
• Cash registers;
• Sewing machines.

Machinery and equipment used include, but are not limited to:
• Lathes;
• Mills;
• Breaks;
• Shears;
• Welders;
• Presses;
• Binding machinery;
• Drills;
• Saws;
• Water jets;
• Hand and air tools.
Note: Machinery/equipment could be manual or computer numeric controlled (CNC).

Materials used include, but are not limited to:
• Metal in varied sizes, shapes and dimensions;
• Plastic;
• Wood.
This classification includes the repair of items being manufactured or assembled when done by employees having operations subject to this classification. This is a shop or plant only classification and includes work performed in an adjacent yard when operated by an employer having operations subject to this classification.

Exclusions:
• Worker hours or businesses setting-up, installing or repairing printing, bookbinding, confectioners, or food processing machines must be reported separately in 0603;
• Worker hours or businesses installing or repairing shoe or textile machinery must be reported separately in 0603;
• Activities away from the shop or plant must be reported separately in the applicable classification.
Note: For rules on assigning and reporting in more than one basic classification, see WAC 296-17-31017 Multiple classifications.

AMENDATORY SECTION (Amending WSR 08-15-132, filed 7/22/08, effective 10/1/08)

WAC 296-17A-3404 Classification 3404.

((**3404-01 Can: Manufacturing - Aluminum or galvanized**

Applies to establishments engaged in the manufacture of cans from aluminum or galvanized metals lighter than 9 gauge. Products include, but are not limited to, soda cans, food cans, and garbage cans. The galvanizing process includes dipping the tin/metal into liquid zinc. The manufacturing process involves cutting, forming, stamping, and soldering/welding. This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification and when the repair work is done as a part of, and in connection with, the manufacturing or assembly operations. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant.

3404-02 Galvanized iron works: Manufacturing - Nonstructural

Applies to establishments engaged in the manufacture of nonstructural galvanized iron from sheet metal lighter than 9 gauge. Processes include cutting, forming, welding, riveting, punching, and drilling. The equipment used includes, but is not limited to, drills, presses, punches, shears, and press breaks. Establishments in this classification may paint, powder coat, or silk screen their products; which is included when performed by employees of employers subject to this classification. This classification includes the repair of items being manufactured or assembled when done by employees of employers subject to this classification and when the repair work is done as a part of, and in connection with, the manufacturing or assembly operations. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant.

3404-03 Hardware, N.O.C.: Manufacturing

Applies to establishments engaged in the manufacture of hardware that is not covered by another classification (N.O.C.), such as, but not limited to, handles, latches, hinges, and buckles. Operations include, but are not limited to, stamping and assembly, electroplating and/or other types of finishing. This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification and when the repair work is done as a part of, and in connection with, the manufacturing or assembly operations. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant and establishments engaged in the manufacture of nuts, bolts, screws, nails, tacks, rivets, eyelets, spikes, and needles which are to be reported separately in classification 3402.

3404-04 Metal stamping

Applies to establishments engaged in the mass production of products by metal stamping techniques which impress, cut out, or shape something to a desired size. Products produced by this technique include, but are not limited to, license plates, pie plates, pots, and waste baskets. This classification includes any finish work when performed by employees of employers subject to this classification. This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification and when the repair work is done as a part of, and in connection with, the manufacturing or assembly operations. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant.

3404-06 Metal sign: Manufacturing

Applies to establishments engaged in the manufacture of signs from metals lighter than 9 gauge. Materials may be cut, punched, drilled, riveted, and welded. Machinery includes, but is not limited to, punches, presses, drills, shears, brake presses, water jets and welders. All operations necessary to make a sign operative, such as, but not limited to, adding electrical wiring or circuitry, painting, powder coating, or silk screening are included within the scope of this classification. This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification and when the repair work is done as a part of, and in connection with, the manufacturing or assembly operations. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant; the installation or removal of signs outside of buildings which is to be reported separately in classification 0403; the installation or removal of signs inside of buildings which is to be reported separately in classification 0513; sign painting or lettering on the inside of buildings, or establishments that paint on or apply lettering to sign "backings" that are manufactured by others, which is to be reported separately in classification 4109; and establishments engaged in the manufacture of wood or plastic signs which are to be reported separately in the classification applicable to the manufacturing process and materials.

3404-07 Metal goods, N.O.C.: Manufacturing or assembly from materials lighter than 9 gauge

Applies to establishments engaged in the manufacture or assembly of metal goods from materials lighter than 9 gauge which are not covered by another classification (N.O.C.) including water heaters, electric baseboard heaters, electric furnaces, boat manufacturing, and bicycles. Materials may be cut, punched, drilled, riveted, and welded. Machinery includes, but is not limited to, punches, presses, drills, shears, brake presses, and welders. This classification includes the

repair of items being manufactured or assembled when done by employees of an employer subject to this classification and when the repair work is done as a part of, and in connection with, the manufacturing or assembly operations. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant.

3404-12 Aluminum ware: Manufacturing from sheet aluminum

Applies to establishments engaged in the manufacture of aluminum ware such as, but not limited to, mail boxes, buckets, gutters, and down spouts, from sheet aluminum. Materials may be cut, bent, punched, drilled, riveted, and welded. Machinery includes, but is not limited to, punches, presses, drills, shears, brake presses, and welders. This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification and when the repair work is done as a part of, and in connection with, the manufacturing or assembly operations. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant.

3404-18 Metal coffin/casket: Manufacturing or assembly

Applies to establishments engaged in the manufacture of coffins or caskets out of metal. Materials may be cut, bent, punched, drilled, riveted, and welded. Machinery includes, but is not limited to, punches, presses, drills, shears, break presses, and welders. This classification includes the repair of items being manufactured or assembled when done by employees of an employer subject to this classification and when the repair work is done as a part of, and in connection with, the manufacturing or assembly operations. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification. Physically separated upholstery departments of establishments engaged in furniture, coffin, casket manufacturing, assembly, or finishing may be reported separately in classification 3808 provided all the conditions in the general reporting rule covering the division of an employees hours have been met.

This classification excludes all activities away from the shop or plant, and establishments engaged in the manufacture of caskets from wood or plastic which are to be reported separately in the classification applicable to the manufacturing process and materials.

3404-19 Metal awnings: Manufacturing or assembly

Applies to establishments engaged in the manufacture or assembly of awnings from metals lighter than 9 gauge. Materials may be cut, punched, drilled, riveted, and bent. Machinery includes, but is not limited to, punches, presses, drills, shears, brake presses, and welders. This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification and when the repair work is done as a part of, and in connection with, the manufacturing or assembly operations. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant, and establishments engaged in the manufacture of awnings from canvas or other textiles which is to be reported separately in classification 3802.

3404-20 Metal furniture, shower door, showcases: Manufacturing or assembly

Applies to establishments engaged in the manufacture or assembly of furniture, shower doors, or showcases made with metals lighter than 9 gauge. Other items manufactured in this classification include, but are not limited to, file cabinets, desks, and stands. Material may be cut, punched, drilled, riveted, and bent. Machinery includes, but is not limited to, punches, presses, drills, shears, brake presses, and welders. This classification includes the repair of items being manufactured or assembled when done by employees of an employer subject to this classification and when the repair work is done as a part of, and in connection with, the manufacturing or assembly operations. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification. Physically separated upholstery departments of establishments engaged in furniture, coffin, casket manufacturing, assembly, or finishing may be reported separately in classification 3808, provided all the conditions of the general reporting rule covering the division of an employee's hours have been met.

This classification excludes all activities away from the shop or plant and establishments engaged in the manufacture of wood furniture which are to be reported separately in classification 2905.

3404-21 Stove: Manufacturing from metals lighter than 9 gauge

Applies to establishments engaged in the manufacture of stoves from metals *lighter than 9 gauge*. Types of stoves include, but are not limited to, electric or gas cook stoves. Accessory materials such as, but not limited to, electrical assembly units, glass, plastic, or wood may be used in the manufacture of stoves. Materials may be cut, punched, drilled, riveted, and bent. Establishments in this classification may paint or powder coat their products which is included when performed by employees of employers subject to this classification. Machinery includes, but is not limited to, punches, presses, drills, shears, brake presses, grinders and welders. This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification and when the repair work is done as a part of, and in connection with, the manufacturing or assembly operations. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.

This classification excludes all activities away from the shop or plant, and establishments engaged in the manufacture of wood stoves or other stoves made of metals 9 gauge or

~~heavier which are to be reported separately in classification 3402.~~

~~**3404-24 Metal electric or gas lighting fixtures, lampshades or lantern: Manufacturing or assembly**~~

~~Applies to establishments engaged in the manufacture or assembly of metal fixtures, lampshades, or lanterns from materials lighter than 9 gauge. The metal fixtures may be equipped with electrical or gas lighting and used as signs or other display mediums. Metal may be cut, punched, drilled, riveted, and bent. Depending on the item being made, electrical or gas filled tubes or bulbs may be attached. Machinery includes, but is not limited to, punches, presses, drills, shears, break presses, grinders, welders, and solders. Establishments in this classification may make a finished product or only component pieces. This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification and when the repair work is done as a part of, and in connection with, the manufacturing or assembly operations. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.~~

~~This classification excludes establishments engaged in the manufacture of neon tube signs or displays that are not attached to metal backings which are to be reported separately in classification 3602, and all activities away from the shop or plant.~~

~~**3404-25 Brass or copper goods: Manufacturing**~~

~~Applies to establishments engaged in the manufacture of brass or copper goods such as, but not limited to, belt buckles, lamp stands, cooking utensils, and flower pots. Materials may be cut, punched, drilled, riveted, and bent. Machinery includes, but is not limited to, punches, presses, drills, shears, break presses, water jets, grinders, welders/solders and brazing guns. Establishments in this classification may make a finished product or a component part. This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification and when the repair work is done as a part of, and in connection with, the manufacturing or assembly operations. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.~~

~~This classification excludes all activities away from the shop or plant.~~

~~**3404-26 Aluminum window, sash or door: Manufacturing or assembly**~~

~~Applies to establishments engaged in the manufacture or assembly of windows, sashes or doors from aluminum. Accessory materials such as, but not limited to, glass, wood or plastic may also be used in the assembly process. Materials may be cut, punched, drilled, riveted, and bent. Machinery includes, but is not limited to, punches, presses, drills, shears, break presses, grinders, and welders/solders. Establishments in this classification may make a finished product or only component parts. Manufacturers may paint, enamel, or bake a finish onto products, which is included when performed by employees of employers subject to this classification. This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification and when the repair work is done as a part of, and in connection with, the manufacturing or assembly operations. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.~~

~~This classification excludes all activities away from the shop or plant; establishments engaged in manufacturing vinyl window sashes which are to be reported separately in classification 3512; and establishments engaged in manufacturing wooden window sashes and doors which are to be reported separately in classification 2903.~~

~~**3404-27 Auto or truck parts, N.O.C.: Manufacturing or assembly; miscellaneous stamped parts**~~

~~Applies to establishments engaged in the manufacture or assembly of auto or truck parts not covered by another classification (N.O.C.), and of miscellaneous stamped parts, such as, but not limited to, hub caps, fenders, and trim. Galvanizing or electroplating is included in this classification when performed by employees of employers subject to this classification. This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification and when the repair work is done as a part of, and in connection with, the manufacturing or assembly operations. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.~~

~~This classification excludes all activities away from the shop or plant.~~

~~**3404-29 Metal ski and toboggan: Manufacturing**~~

~~Applies to establishments engaged in the manufacture of skies or toboggans primarily from metal although wood or plastic component parts may also be used. Materials may be cut, punched, drilled, riveted, and bent. Machinery includes, but is not limited to, punches, presses, drills, water jets, shears, break presses, grinders, and welders/solders. Establishments in this classification may make a finished product or only a component part. This classification includes the repair of items being manufactured or assembled when done by employees of an employer having operations subject to this classification and when the repair work is done as a part of, and in connection with, the manufacturing or assembly operations. This is a shop or plant only classification; it includes work being performed in an adjacent yard when operated by an employer having operations subject to this classification.~~

~~This classification excludes all activities away from the shop or plant.~~)) **3404-06 Metal sign: Manufacturing**

Applies to:

Businesses that manufacture signs from metals lighter than 9 gauge.

Work activities include, but are not limited to:

- Punching;
- Drilling;
- Riveting;

• Welding;
• Painting;
• Powder coating;
• Silk screening;
• All activities necessary to make a sign operative, such as, adding electrical or circuitry.

Machinery and equipment used include, but are not limited to:
• Punches;
• Presses;
• Drills;
• Shears;
• Brake presses;
• Water jets;
• Welders.

This classification includes the repair of items being manufactured or assembled when done by employees having operations subject to this classification. This is a shop or plant only classification and includes work performed in an adjacent yard when operated by an employer having operations subject to this classification.

Exclusions:
• Worker hours or businesses installing or removing signs outside buildings must be reported separately in 0403;
• Worker hours or businesses installing or removing signs inside buildings must be reported separately in 0513;
• Worker hours or businesses painting or lettering signs on the inside of buildings, or painting on or applying lettering to sign "backings" that are manufactured by others must be reported separately in 4109;
• Manufacturing wood or plastic signs is classified in the classification applicable to the manufacturing process and materials;
• Activities away from the shop or plant must be reported separately in the applicable classification.
Note: For rules on assigning and reporting in more than one basic classification, see WAC 296-17-31017 Multiple classifications.

3404-07 Metal goods, N.O.C.: Manufacturing or assembly from materials lighter than 9 gauge

Applies to:
Businesses that manufacture or assemble metal goods from materials lighter than 9 gauge, that are not covered by another classification (N.O.C.). Metal goods in this classification include, but not limited to:
• Aluminum ware;
• Brass or copper goods.
This classification also includes the mass production of products by metal stamping.

Accessory materials such as, but not limited to, electrical assembly units, glass, plastic, or wood may be used in the manufacture of stoves.

Work activities include, but are not limited to:
• Dipping tin/metal into liquid zinc (galvanizing process);
• Cutting, drilling, punching, forming, bending, stamping, riveting and soldering/welding;
• Painting, powder coating or silk screening their products;
• Stamping and assembly work;
• Electroplating and other types of finishes;
• Electrical wiring or circuitry.

Products manufactured include, but are not limited to:
• Soda/food cans;
• Garbage cans;
• Handles, latches and hinges;
• License plates;
• Pie plates;
• Pots;
• Waste baskets;
• Water heaters;
• Electric baseboard heaters;
• Electric furnaces;
• Boats (lighter than 9 gauge);
• Bicycles;
• Mail boxes;
• Buckets;
• Gutters and downspouts;
• Electric or gas cook stoves;
• Belt buckles;
• Lamp stands;
• Cooking utensils;
• Flower pots;
• Stoves;
• Skis or toboggans;
• Hardware that is not covered by another classification (N.O.C.).
Note: Products manufactured in this classification may be finished products or component parts.

Machinery and equipment used include, but are not limited to:
• Drills;
• Presses;
• Punches;
• Shears;
• Brake press;
• Welders;
• Grinders;
• Water jets;
• Brazing guns.
Note: Machinery/equipment could be manual or computer numeric controlled (CNC).

This classification includes the repair of items being manufactured or assembled when done by employees having operations subject to this classification. This is a shop or plant only classification and includes work performed in an adjacent yard when operated by an employer having operations subject to this classification.

Exclusions:
• Manufacturing nuts, bolts, screws, nails, tacks, rivets, eyelets, spikes and needles is classified in 3402;
• Manufacturing stoves of metals 9 gauge or heavier is classified in 3402;
• Activities away from the shop or plant which must be reported separately in the applicable classification.

Note: For rules on assigning and reporting in more than one basic classification, see WAC 296-17-31017 Multiple classifications.

3404-20 Metal furniture, shower door, showcases, coffin/casket: Manufacturing or assembly

Applies to:
Businesses that manufacture or assemble furniture, shower doors, coffins or caskets made with metals lighter than 9 gauge.

Work activities include, but are not limited to:
- Cutting;
- Drilling;
- Punching;
- Bending;
- Riveting;
- Soldering/welding.

Products manufactured include, but are not limited to:
- Coffins/caskets;
- Furniture;
- Shower doors;
- Showcases;
- File cabinets;
- Desks;
- Stands.

Machinery and equipment used include, but are not limited to:
- Punches;
- Presses;
- Drills;
- Shears;
- Brake presses;
- Welders.

This classification includes the repair of items being manufactured or assembled when done by employees having operations subject to this classification. This is a shop or plant only classification and includes work performed in an adjacent yard when operated by an employer having operations subject to this classification.

Exclusions:
- Manufacturing wood furniture is classified in 2905;
- Manufacturing caskets from wood or plastic, is classified in the classification applicable to the manufacturing process and material;
- Physically separated upholstery departments of establishments engaged in furniture, coffin, casket manufacturing, assembly, or finishing may be reported separately in classification 3808, provided all the conditions of the general reporting rule covering the division of an employee's hours have been met;
- Activities away from the shop or plant which must be reported separately in the applicable classification.

Note: For rules on assigning and reporting in more than one basic classification, see WAC 296-17-31017 Multiple classifications.

3404-24 Metal electric or gas lighting fixtures, lampshades or lantern: Manufacturing or assembly

Applies to:
Businesses that manufacture or assemble metal fixtures, lampshades, or lanterns from materials lighter than 9 gauge. Businesses in this classification may make a finished product or only component pieces.

Work activities include, but are not limited to:
- Punching;
- Cutting;
- Riveting;
- Drilling;
- Welding;
- Soldering;
- Assembly work;
- Attaching electrical or gas-filled tubes.

Machinery and equipment used include, but are not limited to:
- Punches;
- Presses;
- Drills;
- Shears;
- Brake presses;
- Grinders;
- Welders.

This classification includes the repair of items being manufactured or assembled when done by employees having operations subject to this classification. This is a shop or plant only classification and includes work performed in an adjacent yard when operated by an employer having operations subject to this classification.

Exclusions:
- Manufacturing neon tube signs or displays that are not attached to metal backings is classified in 3602;
- Activities away from the shop or plant which must be reported separately in the applicable classification.

Note: For rules on assigning and reporting in more than one basic classification, see WAC 296-17-31017 Multiple classifications.

3404-26 Aluminum window, sash, door and metal awnings: Manufacturing or assembly

Applies to:
Businesses that manufacture or assemble windows, sashes, doors, or awnings from metals lighter than 9 gauge. Accessory materials such as, but not limited to, glass, wood or plastic may be used in the assembly process.

Businesses in this classification may make a finished product or only component parts.

Work activities include, but are not limited to:
- Punching;
- Drilling;
- Riveting;
- Bending;
- Welding;
- Painting;
- Enameling;
- Assembly work.

Machinery and equipment used include, but are not limited to:

• Punches;
• Presses;
• Drills;
• Shears;
• Brake presses;
• Grinders;
• Welders.

This classification includes the repair of items being manufactured or assembled when done by employees having operations subject to this classification. This is a shop or plant only classification and includes work performed in an adjacent yard when operated by an employer having operations subject to this classification.

Exclusions:

• Manufacturing vinyl window sashes is classified in 3512;
• Manufacturing wooden window sashes and doors is classified in 2903;
• Manufacturing awnings from canvas or other textiles is classified in 3802;
• Activities away from the shop or plant which must be reported separately in the applicable classification.

Note: For rules on assigning and reporting in more than one basic classification, see WAC 296-17-31017 Multiple classifications.

3404-27 Auto or truck parts, N.O.C.: Manufacturing or assembly; miscellaneous stamped parts

Applies to:

Businesses that manufacture or assemble auto or truck parts not covered by another classification (N.O.C.).

Work activities include, but are not limited to:

• Punching;
• Drilling;
• Riveting;
• Bending;
• Welding;
• Assembly work;
• Galvanizing;
• Electroplating.

Products manufactured include, but are not limited to:

• Hub caps;
• Fenders;
• Trim;
• Auto or truck parts produced with metals lighter than 9 gauge (nonstamped).

Machinery and equipment used include, but are not limited to:

• Punches;
• Presses;
• Drills;
• Shears;
• Brake presses;
• Grinders;
• Welders.

This classification includes the repair of items being manufactured or assembled when done by employees having operations subject to this classification. This is a shop or plant only classification and includes work performed in an adjacent yard when operated by an employer having operations subject to this classification.

Exclusions:

• Activities away from the shop or plant which must be reported separately in the applicable classification.

AMENDATORY SECTION (Amending WSR 12-11-109, filed 5/22/12, effective 7/1/12)

WAC 296-17A-0502 Classification 0502.

0502-04 Floor coverings or countertops: Installation or removal

Applies to contractors engaged in the installation or removal of floor coverings or countertops.

• Floor coverings include, but are not limited to, carpet, vinyl, laminate, tile, terrazzo, or parquet;

• Countertops include, but are not limited to, laminate, tile, and solid surface (synthetic).

Tile is various sizes and shapes, usually from 1" x 1" up to 24" x 24" and packaged in a box. Tile installation in this classification includes, but is not limited to:

• Ceramic, glass, or clay tiles;

• Stone in tile-size dimensions, often used for interior installations in floors, showers, countertops, and backsplashes such as:

- Granite;
- Marble;
- Slate.

Work contemplated by this classification includes the installation and/or removal of:

• Countertops;
• Flooring;
• Padding;
• Tack or door strips;
• Subflooring;
• Base boards;
• Artificial turf when used for areas such as patios, and laid similarly to carpet.

This classification excludes contractors engaged in:

• The installation of stone countertops as described in classification 0302;

• The installation of hardwood countertops or flooring which is to be reported separately in classification 0513;

• The installation of countertops as described in this classification when the installation is part of an interior finish carpentry or cabinetry contract, which is to be reported in classification 0513;

• The installation of brick, block and slab stone as described in classification 0302;

• The installation of roofing tiles which is to be reported separately in classification 0507;

• The installation of artificial field turf in landscaping projects or athletic fields which is to be reported in classification 0301; and

• Floor covering stores which are to be reported separately in the applicable classification.

***Special note*:** Contractors often have a showroom to display examples of their work and products which they install. If all the conditions of the general reporting rules covering standard exception employees have been met, employees engaged exclusively in showing the display areas or showrooms to customers are to be assigned classification 6303.

((~~**0502-99 Floor coverings or countertops: Installation or removal**~~

~~Applies to floor covering contractors who consider themselves to be independent contractors, have no employees, and have not elected owner coverage for themselves.~~

~~The purpose of assigning this classification is to allow the independent contractor the opportunity to be checked for "account in good standing" status for prime contractor liability.~~

~~***Special note*:** Any contractor who hires employees or elects owner coverage is required to report in the applicable construction classification.~~))

AMENDATORY SECTION (Amending WSR 14-17-085, filed 8/19/14, effective 9/19/14)

WAC 296-17A-0507 Classification 0507.

0507-05 Roofwork construction and repair

Applies to contractors engaged in the installation or repair of roofing material on all types of new or existing buildings or structures. Roofing materials include, but are not limited to, felt roofing paper, rolled composition, wood, fiberglass or composition shingles or shakes, aluminum or sheet metal, masonry or ceramic tile, tar, and polyurethane foam. Installation of roofing materials varies with the product. Wood, fiberglass and composition shingles are nailed; masonry, slate or ceramic tiles require drilling, nailing or cementing; polyurethane foam is applied by spray then coated with a protective layer of paint-like material; hot tar requires melting in tanks, usually at ground level, then it is pumped or raised by bucket to the roof top and applied by spray or mop; cold apply uses an adhesive to bond roofing membranes to form a roofing system; cold tar is applied by brush, spray or mop; single ply involves large sheets of roofing material which are unrolled on the roof with edges overlapping and seamed; and metal roofing is seam welded or nailed. For purposes of this classification the term "roofwork" includes repairs to the subroof such as the replacement of trusses, rafters, supports, and sheathing, but excludes the placement of trusses, rafters, supports or sheathing on new building construction. Essentially, when removing the existing roof material from an existing building or structure it is not uncommon to find dry rot or deterioration to parts of the subroof. The repair of the subroof is part of the roof repair or replacement project and is included in this classification. By contrast, when a subroof is constructed on new buildings or structures, this activity is to be reported separately in the classification applicable to the work being performed such as 0510 for wood frame construction or 0518 for nonwood frame construction. This classification includes the installation or on-site maintenance of roofing materials composed of impermeable barriers, sod, soil, and plants, sometimes termed landscape roofing, living roofing, garden roofing, green/environmentally beneficial roofing, brown/biodiverse roofing, or vegetative roofing; and any installation or maintenance of a landscape roofing irrigation system.

This classification excludes roof cleaning, moss or snow removal on single story buildings not incidental to, or part of, a roofing contract which is to be reported separately in classification 6602; roof cleaning or moss removal of multiple story buildings not incidental to, or part of, a roofing contract which is to be reported separately in classification 0504; the installation of gutters and downspouts which is to be reported separately in classification 0519; waterproofing parts of buildings other than roofs which is to be reported separately in classification 0504 and/or 0101; placing roof trusses, rafters, supports and sheathing on new wood frame buildings which is to be reported separately in classification 0510; the application of polystyrene strips used as insulation on mobile homes which is to be reported separately in classification 0512; and placing roof trusses, rafters, supports and sheathing on new buildings, N.O.C. which is to be reported separately in classification 0518.

((~~**0507-99 Roofwork construction and repair (only to be assigned by the roofing specialist)**~~

~~Applies to roofing contractors who consider themselves to be independent contractors, have no employees, and have not elected owner coverage for themselves.~~

~~The purpose of assigning this classification is to allow the independent contractor the opportunity to be checked for "account in good standing" for prime contractor liability.~~

~~***Special note*:** Any contractor who hires employees or elects owner coverage is required to report in the applicable construction classification.~~))

AMENDATORY SECTION (Amending WSR 14-17-085, filed 8/19/14, effective 9/19/14)

WAC 296-17A-0510 Classification 0510.

0510-00 Wood frame building: Construction or alterations, N.O.C.

Applies to contractors engaged in wood frame building construction or alterations not covered by another classification (N.O.C.). For the purposes of this classification, wood frame building construction means buildings erected exclusively of wood or wood products. This classification includes all building framing activities done in connection with wood frame building construction including:

• Placement of roof trusses;

• Sheathing roofs;

• Installation of exterior building siding;

• Installation of exterior doors and door frames;

• Installation of windows, window frames, and skylights when performed by framing workers as part of the framing contract on a wood frame building;

• Erection of log home shells at customer's location.

The manufacturing of log homes in a permanent yard which includes peeling the logs, notching the logs with chainsaws, and assembly is to be reported in classification 1003-06.

This classification excludes all other phases of wood frame building construction not listed as part of the framing activities above such as, but not limited to:

• Site preparation and excavation (0101);

• Overhead or underground utilities, asphalt work, or concrete work which is to be reported separately in the applicable classification;

• New landscape work (0301);

• Brick work (0302);

• Stucco work (0303);

• Plumbing work (0306);

• HVAC work (0307);

• Carpet and tile work (0502);

• Exterior painting (0504);

• Roof work (0507);

• Insulation work (0512);

• Interior finish carpentry - Interior doors, cabinets, fixtures or molding (0513);

• Installation of garage doors (0514);

• Installation of sheet metal siding, gutters, and nonstructural sheet metal patio covers/carports (0519);

• Interior painting (0521);

• Electrical work (0601); and

• Wallboard installation, taping or texturing which are to be reported separately in the applicable classifications. For a more thorough description of the activities included and excluded from wood frame building construction, review the Construction Industry Guide.

***Special note*:** Classification 0510 also includes wood frame building alterations or remodel work when the activity involves building new additions. The term "new additions" is defined as adding on to an existing wood frame building (upwards or outwards) in which the use of structural supports and main bearing beams is required. This is distinguishable from classification 0516 - Building repair or carpentry work that typically does not require the placement of structural supports or main bearing beams. The purpose of classification 0516 is to build or rebuild with nonstructural or bearing beams, or to replace an existing portion (including existing structural and bearing beams) of a wood frame building for appearances or as a result of deterioration to make it appear new again. Care should be exercised as the terminology to build, rebuild, remodel, construct or reconstruct is irrelevant to assignment of classification which should recognize what the project actually involves.

***Guidelines*:**

• Altering all or part of an existing wood frame building by adding on new additions - 0510;

• Constructing a new wood frame building that never existed - 0510;

• Remodeling all or part of an existing wood frame building *without* adding on new additions - 0516;

• Altering all or part of an existing wood garage by adding on new additions - 0510;

• Altering the existing interior of a wood frame building by adding exterior additions - 0510;

• Constructing a new wood garage that never existed - 0510;

• Constructing, altering, or remodeling the interiors of nonwood frame buildings - 0516;

• Constructing a new wood carport or wood shed that never existed - 0510;

• Constructing or replacing a wood deck for any type of nonwood building - 0516;

• Constructing or replacing a wood deck on an existing wood house - 0516;

• Construction of a new wood deck by the framing contractor when a new wood house is being built - 0510;

• Installation of windows, window frames, and skylights when performed by framing workers as part of the framing contract of a wood frame building - 0510;

• Installation of nonmetal siding on a new wood frame building or a new addition - 0510;

• Installation of nonmetal siding on an existing structure by:

- A siding contractor - 0510;

- A remodeling contractor with subclassification 0516-02 - 0510;

- A remodeling contractor with subclassification 0516-00 - 0516-00;

• Rebuilding an existing wood carport or wood shed (all or part) with or without new additions - 0516;

• Remodeling all or part of an existing wood garage without adding on new additions - 0516;

• Remodeling the existing interior of a wood frame building without adding exterior additions - 0516.

0510-99 ((~~Wood frame building:~~)) Construction ((~~or alteration, N.O.C. (only to be assigned by the wood framing specialist)~~)) contractor: No employees

Applies to ((~~framing~~)) construction contractors who ((~~consider themselves to be independent contractors,~~)) have no ((~~employees~~)) reportable workers, and have not elected owner coverage for themselves.

The purpose of assigning this classification is to allow the ((~~independent~~)) contractor the opportunity to be checked for "account in good standing" status for prime contractor liability. All businesses with active workers' compensation accounts must submit quarterly premium reports by the due dates, including businesses with no worker hours or other exposure to report.

***Special note*:** Any contractor who ((~~hires employees~~)) has reportable workers or elects owner coverage is required to report in the applicable ((~~construction~~)) classification.

Excluded operations:

• Drywall contractors who have no reportable workers and have not elected owner coverage for themselves are classified in 0550-99.

AMENDATORY SECTION (Amending WSR 07-01-014, filed 12/8/06, effective 12/8/06)

WAC 296-17A-0550 Classification 0550.

0550-00 Wallboard installation, including scrapping ((-)): Nondiscounted rate (*to be assigned only by the drywall underwriter*)

Applies to contractors engaged in the installation or repair of wallboard. This classification includes the installation of wallboard, drywall, or sheetrock in all types of residential or commercial buildings or structures. The process

consists of cutting wallboard with a utility knife, hacksaw, or power saw to the desired size and then butting material into place and nailing or screw fastening to wood or metal wall studs. Electrical box, window, or door openings are cut out where needed. Installation may require the use of scaffolding, ladders, specialty lifts, or stilts when working at heights, including the use of T holders or hydraulic lifts to hold material being installed on ceilings. This classification also includes wallboard scrapping (picking up and discarding unused portions of wallboard remnants or scraps) at the construction site when performed by employees of the wallboard contractor.

This classification excludes delivery of materials to the construction site by material dealer employees which is to be reported separately in the applicable delivery classification; delivery and stocking of materials to the construction site when performed by employees of the wallboard contractor which is to be reported separately in classification 1101; wallboard taping (including priming and texturing when performed by employees of the wallboard contractor) which is to be reported separately in classification 0541 or 0551; wallboard scrapping by nonwallboard contractor employees which is to be reported separately in the applicable construction debris cleanup classification; plastering, stuccoing or lathing work which is to be reported separately in classification 0303; and the framing of nonbearing walls when performed by the drywall contractor which is to be reported separately in classification 0516.

0550-99 Wallboard installation (only to be assigned by the drywall specialist)

Applies to drywall contractors who ((~~consider themselves to be independent contractors,~~)) have no ((~~employees~~)) reportable workers, and have not elected owner coverage for themselves.

The purpose of assigning this classification is to allow the ((~~independent~~)) contractor the opportunity to be checked for "account in good standing" for prime contractor liability. All businesses with active workers' compensation accounts must submit quarterly premium reports by the due dates, including businesses with no worker hours or other exposure to report.

***Special note*:** Any contractor who ((~~hires employees~~)) has reportable workers or elects owner coverage is required to report in the applicable ((~~construction~~)) classification.

AMENDATORY SECTION (Amending WSR 13-11-128, filed 5/21/13, effective 7/1/13)

WAC 296-17A-1101 Classification 1101.

Note: Classification 1101 is only to be assigned as a nature of business or if a basic classification specifically excludes delivery.

1101-04 Automobile delivery or repossessing

Applies to ((~~establishments~~))**:**

• Businesses engaged in delivering or repossessing individual automobiles for others; and

• Drivers of sound trucks. ((~~Generally, a client will contact the service company and arrange for a car to be delivered to a specific destination or request that a car of which they (client) is the legal owner, be repossessed and delivered to a specific location. In either case, a driver, not a motorized transportation service, does the delivery. Duties of employees subject to this classification~~))

Duties are generally limited to:

• Unlocking vehicles; and

• Driving.

Generally, a client will contact the service company and arrange for a car to be delivered to a specific destination or request that a car of which they (client) are the legal owner, be repossessed and delivered to a specific location. In either case, a driver, not a motorized transportation service, does the delivery. It is common on long distance deliveries for the service company to use more than one driver. ((~~This classification also applies to drivers of sound trucks.~~

~~This classification excludes operation of~~))

Exclusions:

• Worker hours or businesses operating tractor/trailer combinations to transport vehicles ((~~which is to~~)) must be reported separately in classification 1102; and ((~~the use of~~))

• Worker hours using a tow truck ((~~which is to~~)), must be reported separately in classification 1109.

1101-06 Delivery by retail and wholesale stores and distributors, N.O.C.

Applies to:

• Employees of retail and wholesale stores engaged in inter-store delivery or customer merchandise delivery when excluded from the store classification((~~,~~));

• Employees of a company that contracts to perform those same services((~~,~~));

• Small package specialty delivery companies((~~,~~)); and

• Delivery not covered by another classification (N.O.C.). ((~~Employees subject to this classification are generally involved in~~))

Work activities include, but are not limited to:

• Loading and unloading delivery vans or trucks ((~~and~~));

• Driving from store to store((~~, or~~));

• Driving from a store to a customer's location((~~. Drivers may have~~)); and

• May drive designated routes or delivery areas.

((~~This classification excludes establishments~~)) **Exclusions:**

• Businesses engaged in general trucking services such as hauling bulk merchandise or commodities which are to be reported separately in classification 1102.

1101-09 Parcel delivery companies for delivery of small parcels

Applies to ((~~establishments~~))**:**

• Businesses engaged in the delivery of small parcels for others((~~. Establishments~~));

• Contract mail delivery route drivers and contract hauling of mail between post offices; and

• Businesses subject to this classification may offer overnight express services, but usually do not deliver packages that exceed 150 pounds.

Work ((~~contemplated by this classification includes, but is~~)) **activities include, but are not limited to**((~~,~~))**:**

• Driving((~~,~~)) delivery vehicles; and

• Loading and unloading delivery vehicles. ((~~This classification also applies to contract mail delivery route drivers and contract hauling of mail between post offices.~~

~~This classification excludes the delivery of~~))

Exclusions:

• Worker hours or businesses delivering bulk freight such as that delivered by trucking companies ((~~which are to~~)) must be reported separately in classification 1102.

((**~~1101-14 News agents or distributors of magazines, periodicals and telephone books - No retail dealers~~**

~~Applies to establishments engaged in the distribution of newspapers, periodicals, and telephone books. Work contemplated by this classification includes, but is not limited to, driving, loading and unloading the vehicles, stocking shelves, and removing old periodicals from shelves.~~))

1101-17 Driver delivery sales, N.O.C.

Applies to ((~~establishments~~))**:**

• Businesses engaged in route sales of a wide variety of merchandise not covered by another classification (N.O.C.) ((~~,~~)) including, but not limited to, hand tools, automotive supply, and household items((~~. Sales personnel deliver products, show samples and solicit~~)); and

• Businesses or employees known as merchandisers who deliver products such as, but not limited to, greeting cards, over-the-counter medications, and grooming products to their customer's place of business then perform related merchandising functions.

Work activities include, but are not limited to:

• Delivering products;

• Showing samples;

• Soliciting further orders((~~. They may also call~~));

• Calling on new customers along their route((~~. The classification also applies to establishments or employees known as merchandisers who deliver products to their customer's place of business then perform related merchandising functions such as~~));

• Taking inventory of goods on hand((~~,~~));

• Restocking((~~,~~));

• Reordering((~~,~~));

• Removing outdated or damaged merchandise from shelves or the premises((~~, and/or~~)); and

• Assembling temporary displays ((~~which are~~)) usually made of lightweight material such as cardboard or plastic and used for promotional or seasonal goods. ((~~These merchandisers often deal in products such as, but not limited to, greeting cards, over-the-counter medications, and grooming products.~~

~~This classification excludes~~))

Exclusions:

• Employees of ((~~establishments~~)) businesses who provide merchandising services, but who do not deliver products to the customer's place of business, ((~~who~~)) may be reported separately in classification 0607; and ((~~establishments~~))

• Businesses engaged in the set up or removal of advertising or merchandise displays that involve more than incidental assembly of seasonal or promotional exhibits ((~~which are to~~)) must be reported separately in classification 0607.

***Special note*:** The distinguishing factor between merchandising employees who are to be reported in classification 1101-17 and those who may be reported in classification 0607 is the delivery of products to the customer's place of business. Any employee who delivers merchandise to the customer's place of business is to be reported in classification 1101.

((**~~1101-19 Route food services~~**

~~Applies to establishments engaged in route food services where prepackaged, prepared food is sold, or where food may be prepared in the mobile unit for immediate sale by employees of the route food service. Duties include, but are not limited to, driving, food preparation, loading and unloading the vehicle, and cashiering. Typical route food services include, but are not limited to, traveling coaches that sell beverages and prepared pastries or snack items at various locations during a given work day, ice cream wagons, refrigerated trucks that sell specialty prepackaged foods to route customers, or mobile "short-order" food services that sell fast foods at special events or at locations where hot food may not be available.~~

~~This classification excludes food preparation at a fixed location for the route food vehicles which may be reported separately in classification 3905 or as applicable, food vendors operating from a push cart or mobile stand and food vendors who operate from a truck or van but who do not move from place to place throughout the day who are to be reported separately in classification 3905.~~

~~1101-20 Computer tape or accounting records delivery service~~

~~Applies to establishments engaged in picking up and delivering computer tape, accounting records, or similar financial records to or from storage centers to customer locations. Delivery drivers in this classification often work in metropolitan areas and drive small cars or bicycles.~~

~~1101-21 Errand service~~

~~Applies to establishments engaged in providing errand services for others. Types of errands include, but are not limited to, shopping services, delivery of food, beverages or other commodities, and delivery of body fluid samples to laboratories. Vehicles used by these services are typically small cars or bicycles. This classification also applies to the distribution of sample merchandise by vehicle.~~)) **1101-21 Delivery services**

Applies to:

• Businesses engaged in providing certain delivery services, usually using vans, cars, or bicycles.

Typical services include:

• Delivering accounting or financial records;

• Delivering bodily fluid samples to and from laboratories;

• Errands;

• Delivering food, beverages, and other commodities;

• Delivering newspapers, magazines, telephone books;

• Route food services of prepackaged foods; and

• Shopping.

Work activities include, but are not limited to:

• Cashiering;

• Driving;

• Loading and unloading;

• Preparing and packaging foods for route service;

• Removing old periodicals from shelves;

• Running errands for others;
• Selling prepackaged foods on a route;
• Shopping for others;
• Stocking shelves; and
• Honor snack services operated independently from, and not in connection with, coin-operated vending machine services.

Exclusions:

• Food truck businesses, are classified in classification 3905;
• Preparing and prepackaging food to sell as part of a route food delivery service that is not a food truck business as described in classification 3905, may be reported in classification 3905 if detailed time records are kept. Otherwise, all hours for the route food delivery service must be reported in classification 1101;
• Shopping and errand services performed as part of chore services for clients is classified in classification 6511; and
• Stocking and restocking vending machines as part of a vending machine business is classified in classification 0606.

AMENDATORY SECTION (Amending WSR 17-11-120, filed 5/23/17, effective 7/1/17)

WAC 296-17A-3905 Classification 3905.

3905-00 Restaurants, N.O.C.

Applies to establishments engaged in restaurant operations not covered by another classification (N.O.C.). These establishments are "traditional, family or full service" restaurants that provide sit-down services, or cafeteria or buffet style meals. This classification includes the preparation and service of food and beverages. Establishments in this classification may serve beer and wine including on premises consumption of beer from microbrewery operations in connection with the restaurant; however, they are prohibited from selling spirits or hard liquor. Typical occupations include, but are not limited to, hostesses, wait staff and assistants, cooks, dishwashers, cashiers, and managerial staff. This classification also includes the preparation of "take-out food" that customers pick up directly from the restaurant for consumption away from the premises and the operation of a card room in conjunction with the restaurant.

This classification excludes establishments engaged in operating restaurants or lounges that sell spirits or hard liquor which are to be reported separately in classification 3905-07, and catering services that are not part of the restaurant operation which are to be reported separately in classification 3909.

***Special note*:** Traditional, family or full service restaurants are establishments where wait persons bring customers a menu, take orders, and deliver prepared meals to the customer's table or where customers choose from a variety of food items from a buffet or cafeteria style service. Such establishments will generally use nondisposable eating utensils and plates to serve food as opposed to throw away paper plates and plastic eating utensils. Includes establishments where orders are placed at the counter, and the food or drink is delivered to your table. Care should be exercised when dealing with establishments that provide entertainment such as musicians, entertainers, disc jockeys or piano players who may be exempt from coverage as an independent contractor. Musicians or entertainers who are considered to be employees of a restaurant are to be reported separately in classification 6605.

3905-01 Food trucks, food, drink, and candy vendors or concessionaires

Applies to street vendors, food trucks, and ((~~businesses engaged in operating~~)) food, drink or candy concessions at places such as, but not limited to, ball parks, race tracks, theaters ((~~and~~)), exhibitions, and other public or private spaces. This classification is applicable only to food service or concession operations which are operated independently from the facility or event ((~~at which~~)) where the ((~~concession~~)) service is being provided. These independent vendors selling food items are not employees of the facility or site where the event or exhibition is taking place. Vendors subject to this classification sell a variety of foods, snacks, and beverages ((~~items~~)) from booths, food trucks, mobile push carts, mobile stands, carrying boxes, or trays.

This classification excludes food and beverage operations (concession stands) operated in connection with an event or facility by employees of the event sponsor or facility operator which are to be reported separately in the classification applicable to the event or exhibition; ((~~vendors and~~)) route food services((~~, operating in a truck or van moving from place to place throughout the day~~)) selling prepackaged items on a route, which are to be reported separately in classification 1101; vendors of nonfood items which are to be reported separately in the applicable classification; and vending machine service companies that replenish food, snack and beverage products in connection with the vending machine business which are to be reported separately in classification 0606.

3905-03 Commissaries and restaurants with construction, erection, logging or mine operations

Applies to commissary or restaurant operations conducted *exclusively* in connection with a construction, erection, logging or mining camp operation. This classification is limited to food preparation services provided at a camp site or at a mess hall used to feed employees of the construction, logging, erection, or mining company. The foods prepared and served are not intended for, or offered to, the general public.

***Special note*:** The purpose of this classification is to provide employees engaged in the food preparation activity with a classification representative of the work being performed, even though such activities may be occurring at or adjacent to the construction, logging, erection or mining site as provided for in the general reporting rule covering general inclusions.

3905-04 Eating establishments, N.O.C. such as public lunch counters in stores

Applies to establishments not covered by another classification (N.O.C.) engaged in operating lunch counters and restaurants within a retail store location. Use of this classification is limited to employees of an employer who also operates the retail store where the food service is located.

3905-06 Taverns

Applies to establishments engaged in the operation of a tavern. A tavern is primarily engaged in the sale of beer, wine, and alcoholic beverages for on-premises consumption, and may also provide a variety of foods ranging from peanuts and pretzels to hot food dishes. Typical occupations include, but are not limited to, bartenders, wait staff and assistants, cooks, dishwashers, and managerial staff. Beer may also be sold by the keg with the rental of necessary taps and pumps. This classification includes the operation of a "beer garden" at special events such as, but not limited to, fairs or race meets, and the operation of a card room in connection with the tavern.

***Special note*:** Care should be exercised when dealing with establishments that provide entertainment such as musicians, entertainers, disc jockeys or piano players who may be exempt from coverage as an independent contractor. Musicians or entertainers who are considered to be employees of a tavern must be reported separately in classification 6605.

3905-07 Restaurants serving spirits or hard liquor

Applies to establishments engaged in the operation of a restaurant having a license to sell spirits or hard liquor, beer and wine in connection with their food preparation and service. This classification includes the preparation and service of food and beverages at sit down restaurants and lounges including on premises consumption of beer from microbrewery operations in connection with the restaurant. Such establishments have extensive cooking facilities and equipment to prepare full meals. Typical occupations covered by this classification include, but are not limited to, bartenders, hostesses, wait staff and assistants, valet parking attendants, cooks, busboys, dishwashers, cashiers, and managerial staff. This classification also includes the preparation of "take-out food" that customers pick up directly from the restaurant for consumption away from the premises and the operation of a card room in connection with the restaurant.

This classification excludes establishments engaged as a restaurant without a license to sell spirits or hard liquor which are to be reported separately in classification 3905-00; taverns which are to be reported separately in classification 3905-06; catering services which are not part of a restaurant operation which are to be reported separately in classification 3909; musicians who are to be reported separately in classification 6605; and entertainers such as dancers who are to be reported separately in classification 6620.

***Special note*:** Care should be exercised when dealing with establishments that provide entertainment such as musicians, entertainers, disc jockeys or piano players who may be exempt from coverage as independent contractors. Musicians or entertainers who are considered to be employees of a restaurant must be reported separately in classification 6605.

3905-08 Pizza parlors

Applies to establishments engaged in operating a pizza parlor or restaurant. Establishments subject to this classification specialize in the preparation and sales of pizza (but may also provide other foods) and beverages such as wine, beer, alcoholic beverages, or soft drinks for on-premises consumption. Typical occupations include, but are not limited to, hostesses, wait staff and assistants, cooks, dishwasher, cashiers, and managerial staff. This classification also includes establishments that deliver pizza to customers, or where customers can pick up already prepared pizza at the shop, but where no customer seating is provided.

This classification excludes U-bake pizza operations which are to be reported separately in classification 6403.

***Special note*:** Care should be exercised when dealing with establishments that provide entertainment such as musicians, entertainers, disc jockeys or piano players who may be exempt from coverage as independent contractors. Musicians or entertainers who are considered to be employees of a pizza parlor must be reported separately in classification 6605.

3905-09 Fast food drive-ins, N.O.C.

Applies to establishments engaged in the operation of fast food drive-ins or restaurants. These establishments serve easily prepared foods quickly and nonalcoholic beverages which can be eaten on the premises or picked up by customers at a counter or a drive through window. Fast food establishments offer a variety of menu items such as, but not limited to, hamburgers, french fries, tacos, sandwiches, fried chicken, hot dogs, fish and chips, smoothies. Such establishments will generally use disposable eating utensils and throw away plates.

This classification excludes ((~~street vendors and/or route food services which are to be reported separately in classification 1101 and~~)) full service restaurants which are to be reported separately in classification 3905-00.

3905-11 Soft drink lounges

Applies to establishments engaged in operating soft drink lounges. These types of establishments may provide entertainment such as dancing for an adult audience or a place where youth under age 21 can dance or listen to music. These lounges do not sell alcoholic beverages. This classification includes the preparation and service of light snacks and hors d'oeuvres, such as chips, peanuts, pretzels or finger sandwiches.

This classification excludes entertainers such as exotic dancers who are to be reported separately in classification 6620; and musicians who are to be reported separately in classification 6605.

***Special note*:** Care should be exercised when dealing with establishments that provide entertainment such as musicians, entertainers, disc jockeys or piano players who may be exempt from coverage as independent contractors. Musicians or entertainers who are considered to be employees of a lounge must be reported separately in classification 6605 or 6620 as applicable.

3905-12 Ice cream parlors

Applies to establishments engaged in the operation of an ice cream parlor or frozen yogurt shop. These specialty shops offer a limited menu, usually confined to ice cream and frozen yogurt offered in individual servings, various size containers, and specialty items. Special occasion ice cream cakes may be ordered and picked up at a later date by the customer. These establishments usually provide customer seating.

This classification excludes ((~~vendors and/or~~)) route food services((~~, operating in a truck or van moving from place to place throughout the day~~)) <u>selling prepackaged ice cream on a route</u>, which are to be reported separately in clas-

sification 1101((~~, and vendors selling ice cream from a booth, push cart, mobile stand or tray which are to be reported separately in classification 3905-01~~)).

3905-13 Candy, nut, and popcorn retail stores with on-premises manufacturing

Applies to establishments engaged in operating candy, nut or popcorn stores where some or all the products sold are manufactured on the premises. Establishments in this classification may sell a variety of candies, nuts, or popcorn, or may specialize in one or two products. They may also sell their products in gift wrapped packages.

This classification excludes establishments engaged in selling candy, nuts, or popcorn, *that do not manufacture* any product on the premises, which are to be reported separately in classification 6406; and establishments primarily engaged in the wholesale manufacturing of candy which is to be reported separately in classification 3906.

3905-14 Espresso/coffee stands and carts

Applies to vendors operating espresso or coffee stands or carts. Products sold include, but are not limited to, coffee, espresso, lattes, Italian sodas, soft drinks, pastries and prepackaged items. These types of vendors *do not prepare food*. This classification is distinguishable from retail coffee, tea or spice stores in that coffee stands or carts in classification 3905 sell only ready-to-serve products; they do not sell packaged coffee, tea or spice items.

((~~This classification excludes street vendors and/or route food services which are to be reported separately in classification 1101.~~))

AMENDATORY SECTION (Amending WSR 07-01-014, filed 12/8/06, effective 12/8/06)

WAC 296-17A-3909 Classification 3909.

3909-00 Caterers

Applies to ((~~establishments~~))**:**

• Businesses engaged in catering operations((~~. This classification includes the preparation and serving of~~)) that prepare and serve food and beverages for customers ((~~who have arranged for their services~~)) for social and business events such as weddings, parties, bar mitzvahs, meetings or banquets. Foods prepared and served range from deli trays, sandwiches, box lunches, and buffets, to full meals. The food may be prepared at the caterer's own facility and delivered to the customer's location or may be prepared at the customer's location. ((~~Catering services~~))

Work activities include, but are not limited to((~~, event planning,~~))**:**

• Planning event;

• Arranging tables((~~, decorations,~~));

• Decorating;

• Supplying utensils and dishes((~~,~~));

• Bartending((~~,~~));

• Waiting and busing tables((~~,~~)); and

• Taking care of leftover food and related clean-up after the event. ((~~This classification also includes~~))

Also included are:

• Businesses catering to airlines which involves preparing various foods and direct delivery to the airline with special trucks that maintain hot or cold foods((~~. This classification also applies to~~)); and

• Businesses providing mobile food services, such as the nationwide federally supported Meals on Wheels program. Services are provided by communities or civic/social organizations to local residents who, because of physical disability or age, are unable to prepare their own food. The food is prepared and delivered to the client's home.

((~~This classification excludes street vendors or~~))

Note: Delivery by employees is included in classification 3909.

Exclusions:

• Food truck businesses classified in 3905-01; and

• Route food service((~~s~~)) businesses selling prepackaged food on a route, which ((~~are to be reported separately~~)) is classified in classification 1101-21.

WSR 19-17-073
PERMANENT RULES
HEALTH CARE AUTHORITY
(Public Employees Benefits Board)

[Admin #2019-01—Filed August 20, 2019, 11:07 a.m., effective January 1, 2020]

Effective Date of Rule: January 1, 2020.

Purpose: The purpose is to create new rules and to amend some of the existing rules to support the public employees benefits board (PEBB) program.

1. Implement PEBB policy resolutions:

- Amended WAC 182-08-187 to allow an error correction if an employing agency provides incorrect information regarding PEBB program benefits to the employee that they relied upon, and at a minimum the error will be corrected prospectively with enrollment in benefits effective the first day of the month following the date the error is identified;
- Amended WAC 182-12-205 to clarify a subscriber may defer PEBB retiree insurance coverage due to enrollment in CHAMPVA;
- Amended WAC 182-12-209 to include PEBB retiree term life insurance eligibility for an eligible school employee who participates in the school employees benefits board (SEBB) program life insurance; and
- Amended WAC 182-12-300 to include new deadlines for completing wellness activities.

2. Make technical amendments:

- Amended WAC 182-08-190, 182-12-131, and 182-12-138 to include requirements for the paid family and medical leave program;
- Amended WAC 182-08-198 to include a special open enrollment event must be an event other than an employee gaining initial eligibility, and to include an exception related to the availability of a dental plan, explain the consequences of a subscriber not making a new health plan selection when moving to a new location, and to clarify the disruption of care life events;

- Amended WAC 182-08-199 to include the requirement that the change in residence results in the dependent losing their health insurance when the dependent moves into or out of the United States, to include the requirement that the change in residence results in the dependent losing their health insurance, and to clarify the disruption of care life events;
- Amended WAC 182-12-111 to remove references related to school districts and charter schools, and amended to include educational service districts for their nonrepresented employees through December 31, 2023;
- Amended WAC 182-12-116 to remove charter school;
- Amended WAC 182-12-171, 182-12-200, 182-12-205, 182-12-211, and 182-12-265 to include retiring school employee and to remove school district and charter school;
- Amended WAC 182-12-262 to change notification requirements for removing a dependent who loses eligibility, to adjust the amount of time for subscribers to provide notice from twelve months to no more than sixty days for adding a newborn or a child based on adoption, to clarify when a dependent's PEBB insurance coverage will begin and end, and to add corresponding WAC references for different types of enrollees;
- Amended WAC 182-16-055 to replace existing WAC with WAC 182-08-191;
- Amended WAC 182-16-064 to include that an employing agency must follow PEBB program rules and instructions from the health care authority (HCA);
- Amended WAC 182-16-066 to include that the appellant has the burden of proof in a brief adjudicative proceeding or a formal administrative hearing;
- Amended WAC 182-16-120 to clarify that the time prescribed is ten days or less;
- Amended WAC 182-16-2000 and 182-16-3000 with the correct RCW citation;
- Amended WAC 182-16-2010 to correct PEBB benefits' and PEBB appeals unit's descriptions;
- Amended WAC 182-16-2020 to require the state agency to perform a complete review of the denial, removed the language that the state agency may hold a formal meeting or formal administrative hearing, included when the request for administrative review may be considered denied, and removed language related to the state agency may reverse eligibility, premium surcharges, or enrollment decisions based on circumstances with a WAC reference;
- Amended WAC 182-16-2085 and 182-16-2090 to increase readability;
- Amended WAC 182-16-2100 to include the written or oral request for review of the initial order must be made by using the contact information included in the initial order and to clarify the authority may review an order resulting from a brief adjudicative proceeding on its own motion if the appellant has not requested review;
- Amended WAC 182-16-2160 with the correct RCW citation and to clarify the director designates a hearing officer to conduct the formal administrative hearing;
- Amended WAC 182-16-3080 and 182-16-3100 to correct notice requirements and rescheduling requirement references;
- Amended WAC 182-16-3130 to detail who may request the hearing officer quash or change a subpoena request at any time before the deadline given in the subpoena;
- Amended WAC 182-16-3190 to correct a WAC reference and to clarify if the request for reconsideration is granted issuing a new written final order; and
- Amended WAC 182-16-3200 with the correct RCW citations.

3. Amend rules to improve administration of the PEBB program:

- Within the definitions sections of chapters 182-08, 182-12, and 182-16 WAC:
  - Amended the definition of "Life insurance" to remove the reference to accidental death and dismemberment (AD&D) insurance and created a new definition for "AD&D";
  - Amended the definition of "Calendar days or days" to include all legal state holidays as described in RCW 1.16.050;
  - Amended the definition of "Dependent care assistance program or DCAP" to reflect the correct statute and to incorporate who may participate;
  - Amended the definition of "Employee" to include nonrepresented educational service districts' employees and to remove employees of employee organizations currently pooled with employees of school districts;
  - Amended the definition of "Employer group" to clarify school districts and charter schools could enter in [into] contractual agreement through December 31, 2019; and educational service districts could enter in [into] contractual agreement through December 31, 2023, with HCA;
  - Amended the definition of "Employing agency" to remove school district and educational service district;
  - Amended the definition of "Long-term disability insurance or LTD insurance" to clarify supplemental long-term disability insurance offered to and paid for by the employee;
  - Amended the definition of "Medical flexible spending arrangement or medical FSA" to correct statute reference and to match with statute;
  - Amended the definition of "PEBB insurance coverage" to include accidental death and dismemberment insurance;
  - Amended the definition of "Premium payment plan" to include state statute's and federal regulations' references;
  - Amended the definition of "Premium surcharge" to clarify that it is the PEBB Uniform Medical Plan;
  - Created new definitions of "Forms or form," "Public employee," and "state registered domestic partner";
  - Amended the definition of "Salary reduction plan" to match with statute;

- Amended the definition of "State agency" for an error correction; and
- Amended the definition of "Subscriber" to clarify a subscriber is enrolled in PEBB benefits.

- Within the definitions sections of chapters 182-08 and 182-12 WAC:
  - Amended the definitions of "Annual open enrollment" and "Continuation coverage" for clarity;
  - Amended the definition of "Employer contribution" to remove charter school;
  - Amended the definition of "Employer-paid coverage" to remove charter school and include SEBB insurance coverage for which an employer contribution is made by a SEBB organization;
  - Created a new definition of "Supplemental coverage"; and
  - Amended the definition of "Waive" to clarify an eligible employee affirmatively declining enrollment in a PEBB health plan.
- Amended the following definitions in WAC 182-12-109:
  - Amended the definition of "Seasonal employee" to match with statute; and
  - Created new definitions of "School employee," "SEBB," "SEBB insurance coverage," and "SEBB organization."
- Amended the following definitions in WAC 182-16-020:
  - Amended the definition of "Appellant" to clarify it is a person who requests a brief adjudicative proceeding with the PEBB appeals unit;
  - Amended the definition of "Brief adjudicative proceeding" to include WAC references;
  - Amended the definition of "Denial" or "Denial notice" to include contracted vendor;
  - Created a new definition of "Dispositive motion";
  - Amended the definition of "Final order" to clarify an order that is the final HCA decision; and
  - Amended the definition of "Formal administrative hearing" to include statute and WAC references.
- Amended WAC 182-08-180 to clarify that PEBB insurance coverage premiums and applicable premium surcharges are due for all subscribers, to include HCA may develop a reasonable payment plan of up to twelve months in duration upon subscriber or subscriber's legal representative's request, to clarify under what circumstances the PEBB director, the PEBB director's designee, or the PEBB appeals unit may approve a premium refund, to add the PEBB director, the PEBB director's designee, or the PEBB appeals unit may approve an enrollment change that was originally requested and which forms the basis for a refund, and to clarify employing agency errors will be corrected with corresponding WAC references;
- Amended WAC 182-08-185 to clarify premium surcharge is in addition to the medical premium, to clarify medicare risk pool by adding a corresponding statute, and to clarify when an employee or a subscriber may attest for the spousal premium surcharge;
- Amended WAC 182-08-187 to clarify an enrollment error for failure to enroll an employee and their dependents in PEBB insurance coverage;
- Amended WAC 182-08-190 to remove charter school and to clarify the employer contributions must be paid to HCA;
- Created WAC 182-08-191 to include employees and subscribers' address requirements;
- Amended WAC 182-08-196 to clarify when a subscriber must elect a new health plan when their previously selected health plan becomes unavailable and when they submit the required forms and consequences of not making a new election;
- Amended WAC 182-08-197 to clarify when an employee may enroll in supplemental coverage and what coverage an employee may be defaulted to when the employing agency or contracted vendor did not receive the required forms within thirty-one days;
- Amended WAC 182-08-200 to clarify which employing agency is responsible for employer contribution when an employee changes employment;
- Amended WAC 182-08-235 and 182-08-245 to remove charter school and school districts, and to include educational service districts as employer groups applying for their nonrepresented employees;
- Amended WAC 182-12-113 to include state agencies must determine employee's dependents' eligibility for PEBB benefits and to clarify state agencies must inform the employee their right to appeal when they are ineligible for benefits and the employer contribution due to a change in work patterns;
- Amended WAC 182-12-114 to clarify when employees, seasonal employees, and faculty are eligible for PEBB benefits through stacking;
- Amended WAC 182-12-123 to include PEBB in the title for clarity, to include a WAC reference when the PEBB program will terminate the employee's enrollment as a dependent, and to remove health plans sponsored by school district and charter school and replace them with SEBB;
- Amended WAC 182-12-128 to clarify a special enrollment event must be an event other than an employee gaining initial eligibility for PEBB benefits, to clarify if an employee waives PEBB medical the employee may not enroll dependents into PEBB medical, to include WAC 182-12-262 reference when referring to the dependents' effective date of PEBB medical, and to include the requirement that the change in residence results in the dependent losing their health insurance when the dependent moves into or out of the United States;
- Amended WAC 182-12-133 to change references from PEBB insurance coverage to PEBB benefits;
- Amended WAC 182-12-146 to restructure this section for clarity, to include additional WAC references when clarifying COBRA eligibility for a retiree or a retiree's dependent, to make a technical correction from an employee's to a subscriber's state registered domestic partner in the note section of subsection (6), to clarify when COBRA coverage will end, and to clarify a COBRA-eligible employee can continue medical FSA if they have a greater amount in remaining benefits than remaining contribution payments for the current year;

- Amended WAC 182-12-148 to clarify HCA will refund premiums and applicable premium surcharges the employee paid when the employer contribution is reinstated;
- Amended WAC 182-12-171 to include PEBB retiree insurance coverage enrollment when referencing first premium payment;
- Amended WAC 182-12-211 to include defer enrollment in the title, to clarify the date of enrollment or deferment in PEBB retiree insurance coverage must be indicated on the form, to add a new subsection to indicate premiums and applicable premium surcharges are due from the effective date of enrollment;
- Amended WAC 182-12-260 to include notice requirements for an employee when a dependent is no longer eligible, to include WAC references for retirees, survivors, and PEBB continuation coverage enrollees, to clarify when PEBB insurance coverage will end, to include when enrollment of an extended dependent or a dependent with a disability will begin, and to make a technical correction and replace health plan references with PEBB benefits;
- Amended WAC 182-12-263 to clarify subscribers on continuation coverage or PEBB retiree insurance coverage submit the required forms to the PEBB program;
- Amended WAC 182-12-265 to include survivors of school employee and a note regarding a spouse, state registered domestic partner, or child of an eligible school employee enrolled in SEBB insurance coverage may continue health plan enrollment as described in WAC 182-31-090;
- Amended WAC 182-12-270 to make error corrections and moved existing language to a new subsection (3) for clarity;
- Amended WAC 182-12-300 to include a statute when describing medicare risk pool and to make an error correction;
- Amended WAC 182-16-2030, 182-16-2040, 182-16-2050, 182-16-2060 regarding PEBB appeals unit's notification;
- Amended WAC 182-16-2050 regarding state agency's requirements when handling a salary reduction plan's appeal;
- Amended WAC 182-16-2080 and 182-16-3010 to clarify when HCA employees may represent an appellant;
- Amended WAC 182-16-2100 to clarify that when requesting for reconsideration, the request can be made written or orally and is subject to be granted in a written final order;
- Amended WAC 182-16-2105 to clarify procedures after a withdrawal request is received;
- Amended WAC 182-16-2120 to clarify the exception when no evidence may be offered in support of a motion for reconsideration;
- Amended WAC 182-16-2130 to clarify the RCW references when filing a written petition for judicial review and to include the PEBB program and the employing agency may not request judicial review;
- Amended WAC 182-16-3010 to clarify employees of the HCA or HCA's authorized agents may not represent an appellant unless approved by the hearing officer;
- Amended WAC 182-16-3030 to remove de novo (anew);
- Amended WAC 182-16-3120 about entering an order dismissing the dispositive motion;
- Amended WAC 182-16-3140 to clarify if no request is received [by] the deadline, the dismissal order becomes HCA's final decision without further action;
- Amended WAC 182-16-3160 to clarify which hearing representative an appellant may contact to withdraw a formal administrative hearing;
- Amended WAC 182-16-3180 to clarify the party filing the request for reconsideration must serve copies of the request on all other parties on the same day the request is served on the hearing officer, and to clarify the exception when no evidence may be offered in support of a motion for reconsideration; and
- Amended WAC 182-16-3190 to clarify a new written final order is issued if the request is granted and to correct a WAC citation reference.

Citation of Rules Affected by this Order: New WAC 182-08-191; and amending WAC 182-08-015, 182-08-120, 182-08-180, 182-08-185, 182-08-187, 182-08-190, 182-08-196, 182-08-197, 182-08-198, 182-08-199, 182-08-200, 182-08-235, 182-08-245, 182-12-109, 182-12-111, 182-12-113, 182-12-114, 182-12-116, 182-12-123, 182-12-128, 182-12-131, 182-12-133, 182-12-138, 182-12-141, 182-12-142, 182-12-146, 182-12-148, 182-12-171, 182-12-180, 182-12-200, 182-12-205, 182-12-207, 182-12-209, 182-12-211, 182-12-260, 182-12-262, 182-12-263, 182-12-265, 182-12-270, 182-12-300, 182-16-010, 182-16-020, 182-16-055, 182-16-064, 182-16-066, 182-16-120, 182-16-130, 182-16-2000, 182-16-2010, 182-16-2020, 182-16-2030, 182-16-2040, 182-16-2050, 182-16-2060, 182-16-2080, 182-16-2085, 182-16-2090, 182-16-2100, 182-16-2105, 182-16-2120, 182-16-2130, 182-16-2140, 182-16-2150, 182-16-2160, 182-16-3000, 182-16-3010, 182-16-3030, 182-16-3080, 182-16-3100, 182-16-3120, 182-16-3130, 182-16-3140, 182-16-3160, 182-16-3170, 182-16-3180, 182-16-3190, and 182-16-3200.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Other Authority: PEBB policy resolution.

Adopted under notice filed as WSR 19-14-095 on July 1, 2019.

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

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

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

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 1, Amended 77, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 1, Amended 77, Repealed 0.

Date Adopted: August 20, 2019.

Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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

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

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

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

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

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

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

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

"Continuation coverage" means the temporary continuation of health plan coverage available to enrollees ((~~after a qualifying event occurs as administered~~)) under the Consolidated Omnibus Budget Reconciliation Act (COBRA), 42 U.S.C. Secs. 300bb-1 through 300bb-8, the Uniformed Services Employment and Reemployment Rights Act (USERRA), 38 U.S.C. Secs. 4301 through 4335, or ((~~PEBB insurance coverage extended by~~)) the public employees benefits ((~~board under WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, and 182-12-270~~)) board's policies.

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

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

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

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

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

"Director" means the director of the authority.

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

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

exchange established in RCW 43.71.020 seeks and receives approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(g) and (n); ((~~and~~)) (f) through December 31, 2019, employees of a charter school established under chapter 28A.710 RCW; and (g) through December 31, 2023, nonrepresented employees of an educational service district. "Employee" does not include: Adult family home providers; unpaid volunteers; patients of state hospitals; inmates; employees of the Washington state convention and trade center as provided in RCW 41.05.110; students of institutions of higher education as determined by their institution; and any others not expressly defined as employees under RCW 41.05.011 or by the authority under this chapter.

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

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

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

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

"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, and through December 31, 2019, school districts and charter schools, and through December 31, 2023, educational service districts obtaining employee benefits through a contractual agreement with the authority to participate in benefit plans developed by the public employees benefits board as described in WAC 182-08-245.

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

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

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

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

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

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

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

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

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

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

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

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

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

"Life insurance" ((~~for eligible employees includes~~)) means basic life insurance ((~~and accidental death and dismemberment (AD&D) insurance~~)) paid for by the employing agency, as well as ((~~optional~~)) supplemental 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.

"Long-term disability insurance" or "LTD insurance" ((~~includes~~)) means basic long-term disability insurance paid for by the employing agency and supplemental long-term disability insurance offered to ((~~employees on an optional basis~~)) and paid for by the employee.

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby eligible 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 established under ((~~this~~)) chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

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

"PEBB" means the public employees benefits board.

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

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

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

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

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

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

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

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

"Public employee" has the same meaning as employee.

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

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

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

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

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

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

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

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

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

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

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

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

WAC 182-08-120 Employer contribution for the public employees benefits board (PEBB) benefits. The employer contribution must be used to provide public employees benefits board (PEBB) insurance coverage for the basic life insurance benefit, basic accidental death and dismemberment insurance benefit (AD&D), the basic long-term disability (LTD) insurance benefit, medical ((~~and~~)) insur-

ance, dental insurance, and to establish a reserve for any remaining balance. There is no employer contribution available for any other insurance coverage for employees employed by state agencies.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-08-180 Premium payments and premium refunds. Public employees benefits board (PEBB) insurance coverage premiums and applicable premium surcharges for all subscribers are due as described in this section, except when an employing agency is correcting its enrollment error as described in WAC 182-08-187 ((~~(3)~~)) (4) or ((~~(4)~~)) (5).

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

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

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

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

(c) Unpaid or underpaid premiums or applicable premium surcharges for all subscribers must be paid, and are due from the employing agency, subscriber, or a subscriber's legal representative to the HCA. For subscribers not eligible for the employer contribution or employees eligible for the employer contribution as described in WAC 182-12-138, monthly premiums or applicable premium surcharges that remain unpaid for thirty days will be considered delinquent. A subscriber is allowed a grace period of thirty days from the date the monthly premiums or applicable premium surcharges become delinquent to pay the unpaid premium balance or applicable premium surcharges. If a subscriber's monthly premiums or applicable premium surcharges remain unpaid for sixty days from the original due date, the subscriber's PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premiums and any applicable premium surcharges were paid. If it is determined by the HCA that payment of the unpaid balance in a lump sum would be considered a hardship, the HCA may develop a reasonable payment plan of up to twelve months in duration with the subscriber or the subscriber's legal representative upon request.

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

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

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

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

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

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

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

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

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

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

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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

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

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

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

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

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

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

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

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

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

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

Exceptions:

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

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

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

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

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

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

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

(2) A subscriber will incur a premium surcharge in addition to the subscriber's monthly medical premium, if an enrolled spouse or state registered domestic partner ((~~elected~~)) has chosen not to enroll in another employer-based group medical where the spouse's or state registered domestic partner's share of the medical premium is less than ninety-five percent of the additional cost an employee would be required to pay to enroll a spouse or state registered

domestic partner in the PEBB Uniform Medical Plan (UMP) Classic and the benefits have an actuarial value of at least ninety-five percent of the actuarial value of the PEBB UMP Classic's benefits.

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

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

(ii) ((~~When a special open enrollment event occurs as described in WAC 182-12-262 (1)(c). A subscriber must submit the required form to enroll a spouse or state registered domestic partner in PEBB medical. The subscriber must include their attestation on that form. An employee must submit the form to their employing agency. Any other subscriber must submit the form to the PEBB program. If the subscriber's attestation results in a premium surcharge it will take effect the same date as PEBB medical begins;~~

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

• Incurring the surcharge;

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

• Not incurring the surcharge because the actuarial value of benefits provided through the spouse's or state registered domestic partner's employer-based group medical was less than ninety-five percent of the actuarial value of the PEBB UMP Classic's benefits.

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

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

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

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

Exceptions:

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

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

(3) An employee who covers their spouse or state registered domestic partner who has waived their own PEBB medical must attest as described in this subsection, but will not incur a premium surcharge ((~~will not be applied~~)) if the employee provides an attestation that their spouse or state registered domestic partner is eligible for PEBB coverage.

(4) A subscriber who covers their spouse or state registered domestic partner who elected not to enroll in a TRICARE plan must attest as described in this subsection, but will not incur a premium surcharge ((~~will not be applied~~)) if the subscriber provides an attestation that their spouse or state registered domestic partner is eligible for a TRICARE plan.

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-08-187 How do employing agencies and contracted vendors correct enrollment errors and is there a limit on retroactive enrollment? (1) An employing agency or contracted vendor that makes one or more of the following enrollment errors must correct the error as described in subsections (2) through (4) of this section.

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

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

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

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

(e) Enrolling an employee or their dependent((~~s~~)) in PEBB insurance coverage when they are not eligible as described in WAC 182-12-114 or 182-12-260 and it is clear

there was no fraud or intentional misrepresentation by the employee involved((.)); or

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

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

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

(((~~(2)~~))) (3) **Enrollment or termination.**

(a) PEBB medical and dental enrollment is effective at a minimum the first day of the month following the date the enrollment error is identified, unless the authority determines additional recourse is warranted, as described in subsection (((~~(4)~~))) (5) of this section. If the enrollment error is identified on the first day of the month, the enrollment correction is effective that day;

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

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

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

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

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

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

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

(((~~(3)~~))) (4) **Premium payments.**

(a) The employing agency must remit to the authority the employer contribution and the employee contribution for health plan premiums, applicable premium surcharges, basic life, basic AD&D, and basic LTD ((~~from~~)) starting the date PEBB insurance coverage begins as described in subsections (((~~(2)~~))) (3) and (((~~(4)~~))) (5)(a)(i) of this section. If a state agency failed to notify a newly eligible employee of their eligibility for PEBB benefits, the state agency may only collect the employee contribution for health plan premiums and applicable premium surcharges for coverage for months following notification of a new enrollment period.

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

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

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

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

(((~~(4)~~))) (5) **Recourse.**

(a) Employee eligibility for PEBB benefits begins on the first day of the month following the date eligibility is established as described in WAC 182-12-114. Dependent eligibility is described in WAC 182-12-260, and dependent enrollment is described in WAC 182-12-262. When retroactive correction of an enrollment error is limited as described in subsection (((~~(2)~~))) (3) of this section, the employing agency must work with the employee, and receive approval from the

authority, to implement retroactive PEBB insurance coverage within the following parameters:

(i) Retroactive enrollment in a PEBB health plan;

(ii) Reimbursement of claims paid;

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

(iv) Other legal remedy received or offered; or

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

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

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

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

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

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

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

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

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

(((~~5~~))) (6) Washington state patrol officers disabled while performing their duties as determined by the chief of the Washington state patrol are eligible for the employer contribution for PEBB medical as authorized in RCW 43.43.040. No other retiree or disabled employee is eligible for the employer contribution for PEBB benefits unless they are an eligible employee as described in WAC 182-12-114 or 182-12-131.

(((~~6~~))) (7) The terms of payment to HCA for employer groups ((~~and charter schools~~)) shall be stipulated under contract with the HCA.

NEW SECTION

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

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-08-196 What happens if my health plan becomes unavailable due to a change in contracted service area or eligibility for medicare? (1) A subscriber((~~s~~)) must ((~~select~~)) elect a new health plan ((~~within sixty days of~~)) when their ((~~chosen~~)) previously selected health plan ((~~becoming~~)) becomes 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 their enrollment in medicare.~~

~~(a) Employees~~)) as described below:

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

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

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

(((~~(c)~~))) (iii) The effective date of the change in health plan will be the first day of the month following the later of the date the health plan becomes unavailable or the date the form is received. (((~~(2) The PEBB program will change health plan enrollment as follows if the~~))) If that day is the first of the month, the change in health plan begins on that day.

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

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

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

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

(c) A subscriber who fails to ((~~select~~)) elect 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 as required in (a) or (b) of this subsection will be enrolled in a ((~~successor plan if one is available or an existing~~)) health plan designated by the director or designee.

(((~~(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~~)) (2) A subscriber ((~~enrolled in a~~)) must elect a new health plan ((~~as described in subsection (2) of this section may not change~~)) when their previously selected health ((~~plans except as allowed in WAC 182-08-198~~)) plan becomes unavailable due to the subscriber or subscriber's dependent ceasing to be eligible for their current health plan because of enrollment in medicare as described below:

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

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

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

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

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

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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

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

(a) An employee must complete the required forms indicating their enrollment elections, including an election to waive PEBB medical ((~~if~~)) provided the employee 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~~)) Their employing agency must ((~~be received by their employing agency~~)) receive the forms no later than thirty-one days after the employee becomes eligible for PEBB benefits under WAC 182-12-114.

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

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

(iii) If an employee is eligible to participate in the ((~~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~~)) supplemental PEBB benefits, the employee must return the required form to their state agency. The form must be received by the state agency no later than thirty-one days after the employee becomes eligible for PEBB benefits.

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

(i) Uniform Medical Plan Classic;

(ii) Uniform Dental Plan;

(iii) Basic life insurance;

(iv) Basic AD&D insurance;

(v) Basic long-term disability insurance;

(((~~(v)~~))) (vi) Dependents will not be enrolled; and

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

(2) The employer contribution toward PEBB insurance coverage ends according to WAC 182-12-131. When an employee's employment ends, participation in the ((~~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 begin((~~s~~)) on the first day of the month the employee is in pay status eight or more hours((~~.~~)).

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

regains eligibility, except as described in subsection (3)(b) of this section:

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

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

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

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

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

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

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

(d) If an employee is eligible to participate in the ((~~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~~)) supplemental PEBB benefits, the employee must return the required form to the contracted vendor or their state agency. The contracted vendor or employee's state agency must receive the form no later than thirty-one days after the employee becomes eligible for PEBB benefits.

(4) If an employee who is eligible to participate in the ((~~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 thirty days or less and within the current plan year. The employee must notify their new state agency of the transfer by providing the new state agency's personnel, payroll, or benefits office the required form no later than thirty-one days after the employee's first day of work with the new state agency.

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-08-198 When may a subscriber change health plans? A subscriber((~~s~~)) may change health plans at the following times:

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

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

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

If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial sup-

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

(a) Subscriber acquires a new dependent due to:

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

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

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

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

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

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

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

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

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

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

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

(h) Subscriber or a subscriber's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from medicaid or ((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))) (2). A subscriber has six months from the date of their or their dependent's enrollment in medicare Part B to enroll in a PEBB medicare supplement plan for which they or their dependent is eligible. The forms must be received by the PEBB program no later than six months after the enrollment in medicare Part B for either the subscriber or the subscriber's dependent;

(j) Subscriber or a subscriber's dependent's current health plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA). The ((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 for active and ongoing treatment, 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)). A subscriber may not change their health plan election if the subscriber's or dependent's physician stops participation with the subscriber's health plan unless the PEBB program determines that a continuity of care issue exists. The PEBB program will consider but not limit its consideration to the following:

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

(ii) Treatment following a recent organ transplant;

(iii) A scheduled surgery;

(iv) Recent major surgery still within the postoperative period ((of up to eight weeks)); or

(v) ((Third trimester of)) Treatment for a high-risk pregnancy.

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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

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

(2) **During annual open enrollment:** An eligible employee may elect to enroll in or opt out of participation under the ((state's)) premium payment plan during the annual open enrollment by submitting the required form to their employing agency. An eligible employee may elect to enroll

or reenroll in the medical FSA, DCAP, or both during the annual open enrollment by submitting the required forms to their employing agency or applicable contracted vendor as instructed. All required forms must be received no later than the last day of the annual open enrollment. The enrollment or new election becomes effective January 1st of the following year.

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

(3) **During a special open enrollment:** An employee who is eligible to participate in the salary reduction plan may enroll or revoke their election and make a new election under the ((~~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 form to their employing agency. The employing agency must receive the required form and evidence of the event that created the special open enrollment no later than sixty days after the event occurs.

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

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

(i) Employee acquires a new dependent due to:

• Marriage;

• Registering a state registered domestic partnership when the dependent is a tax dependent of the ((~~subscriber~~)) employee;

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

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

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

• Employee has a change in marital status;

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

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

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

• An eligible dependent dies.

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

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

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

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

Note:

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

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

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

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

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

(xi) Employee or an employee's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from medicaid or ((~~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) requires evidence that the employee or employee's dependent is no longer eligible for an HSA;

(xiv) Employee or an employee's dependent experiences a disruption of care for active and ongoing treatment, that

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

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

• Treatment following a recent organ transplant;

• A scheduled surgery;

• Recent major surgery still within the postoperative period ((~~of up to eight weeks~~)); or

• ((~~Third trimester of~~)) Treatment for a high-risk pregnancy.

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

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

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

(i) Employee acquires a new dependent due to:

• Marriage;

• Registering a state registered domestic partnership if the domestic partner qualifies as a tax dependent of the ((~~subscriber~~)) employee;

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

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

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

• Employee has a change in marital status;

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

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

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

• An eligible dependent dies.

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

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

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

(i) Employee acquires a new dependent due to:

• Marriage;

• Registering a state registered domestic partnership if the domestic partner qualifies as a tax dependent of the ((~~subscriber~~)) employee;

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

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

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

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

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

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

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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

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

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

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

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

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

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

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

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

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

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

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

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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 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~~)) applying for its nonrepresented employees 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 applying for its nonrepresented employees must purchase medical, dental, life, and long-term disability insurance.

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

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

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

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

(ii) Age;

(iii) Gender;

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

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

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

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

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

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

(iii) Summary of historical plan costs; and

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

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

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

• Current premiums for the health plan.

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

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

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

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

(iii) Executive summary of benefits;

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

(v) Summary of historical plan costs.

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

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

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

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~~)) purchasing PEBB insurance coverage for nonrepresented employees will be a composite rate equal to the rate charged to state agencies plus an amount equal to the employee premium based on health plan election and family enrollment. ((~~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 nonrepresented employees and include the funds in their payment to the authority.

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

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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

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

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

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

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

"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 state holidays as set forth in RCW 1.16.050.

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

"Continuation coverage" means the temporary continuation of health plan coverage available to enrollees ((~~after a qualifying event occurs as administered~~)) under the Consolidated Omnibus Budget Reconciliation Act (COBRA), 42 U.S.C. Secs. 300bb-1 through 300bb-8, the Uniformed Services Employment and Reemployment Rights Act (USERRA), 38 U.S.C. Secs. 4301 through 4335, or ((~~PEBB insurance coverage extended by~~)) the public employees benefits ((~~board under WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, and 182-12-270~~)) board's policies.

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

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

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

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

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

"Director" means the director of the authority.

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

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

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

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

"Employer-based group 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~~)) HCA by a state agency((~~,~~)) or employer group((~~, or charter school~~)) for its eligible employees as described under WAC 182-12-114 and 182-12-131.

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

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

"Employing agency" for the public employees benefits board 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; and a tribal government covered by chapter 41.05 RCW.

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

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

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

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

"Federal retiree medical plan" means the Federal Employees Health Benefits program (FEHB) or TRICARE plans which are not employer-based group medical.

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

"Health plan" means a plan offering medical or dental, or both, developed by the ((~~public employees benefits board~~)) PEBB 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~~)) means basic life insurance ((~~and accidental death and dismemberment (AD&D) insurance~~)) paid for by the employing agency, as well as ((~~optional~~)) supplemental 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.

"Long-term disability insurance" or "LTD insurance" ((~~includes~~)) means basic long-term disability insurance paid for by the employing agency and supplemental long-term disability insurance offered to and paid for by the employee((~~s on an optional basis~~)).

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby eligible 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 established under ((~~this~~)) chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"Pay status" means all hours for which an employee receives pay.

"PEBB" means the public employees benefits board.

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

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

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

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

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

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

• The spouse's or state registered domestic partner's share of the medical premium is less than ninety-five percent of the additional cost an employee would be required to pay to enroll a spouse or state registered domestic partner in the

public employees benefits board (PEBB) Uniform Medical Plan (UMP) Classic; and

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

"Public employee" has the same meaning as employee.

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

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

"School employee" includes:

(a) Through December 31, 2023, all employees of school districts and charter schools established under chapter 28A.710 RCW, and represented employees of educational service districts. For the exclusive purpose of eligibility for PEBB retiree insurance coverage, the term "school employee" also includes nonrepresented employees of an educational service district; and

(b) Effective January 1, 2024, all employees of school districts, educational service districts, and charter schools established under chapter 28A.710 RCW.

"SEBB" means school employees benefits board established in RCW 41.05.740.

"SEBB insurance coverage" means any health plan, life insurance, accidental death and dismemberment insurance, or long-term disability insurance administered as a SEBB benefit.

"SEBB organization" means a public school district or educational service district or charter school established under chapter 28A.710 RCW that is required to participate in benefit plans provided by the school employees benefits board.

"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~~)) a state 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. Employees eligible to participate in the salary reductions plan may enroll in or revoke their election under the DCAP, medical FSA, or the premium payment plan and make a new election. For special open enrollment events related to specific PEBB benefits, see WAC 182-08-198, 182-08-199, 182-12-128, and 182-12-262.

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

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

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

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

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

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

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

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

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

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

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

(2) **Employer groups.** Employer groups may apply to participate in PEBB insurance coverage for groups of employees described in (a)(i) of this subsection and for members of the group's governing authority as described in (a)(i),

(ii), and (iii) of this subsection at the option of each employer group:

(a) All eligible employees of the entity must transfer as a unit with the following exceptions:

(i) Bargaining units may elect to participate separately from the whole group;

(ii) Nonrepresented employees may elect to participate separately from the whole group provided all nonrepresented employees join as a group; and

(iii) Members of the employer group's governing authority may participate as described in the employer group's governing statutes and RCW 41.04.205.

(b) Employer groups must apply through the process described in WAC 182-08-235. Applications from employees of employee organizations representing state civil service employees, the Washington health benefit exchange, and employer groups with five thousand or more employees, except for ((~~school districts and~~)) educational service districts are subject to review and approval by the health care authority (HCA) based on the employer group evaluation criteria described in WAC 182-08-240.

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

(3) **((~~School districts,~~)) Washington state educational service districts((~~, and charter schools~~)).** In addition to subsection (2) of this section, the following applies to ((~~school districts,~~)) Washington state educational service districts((~~, and charter schools~~)) enrolling in PEBB insurance coverage for its nonrepresented employees until December 31, 2023:

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

(b) The HCA may collect these amounts in accordance with the district fiscal year, as described in RCW 28A.505.030.

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

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

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

(5) **Eligible nonemployees.**

(a) Blind vendors actively operating a business enterprise program facility in the state of Washington and deemed eligible by the department of services for the blind (DSB) may voluntarily participate in PEBB medical. Dependents of blind vendors are eligible as described in WAC 182-12-260. Eligible blind vendors and their dependents may enroll during the following times:

(i) When newly eligible: The DSB will notify eligible blind vendors of their eligibility in advance of the date they are eligible for enrollment in PEBB medical.

To enroll, blind vendors must submit the required forms to the DSB. The forms must be received by the DSB no later than thirty-one days after the blind vendor becomes eligible for PEBB medical.

(ii) During the annual open enrollment: Blind vendors may enroll during the annual open enrollment. The required form must be received by the DSB before the end of the annual open enrollment. Enrollment will begin January 1st of the following year.

(iii) Following loss of other medical insurance coverage: Blind vendors may enroll following loss of other medical insurance coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA). To enroll, blind vendors must submit the required forms to the DSB. The forms must be received by the DSB no later than sixty days after the loss of other medical insurance coverage. In addition to the required forms, the DSB will require blind vendors to provide evidence of loss of other medical insurance coverage.

(iv) Blind vendors who cease to actively operate a facility become ineligible to participate in PEBB medical as described in (a) of this subsection. Enrollees who lose eligibility for coverage may continue enrollment in PEBB medical on a self-pay basis under COBRA coverage as described in WAC 182-12-146(5).

(v) Blind vendors are not eligible for PEBB retiree insurance coverage.

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

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

(6) **Individuals and entities not eligible as employees include:**

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

(b) Unpaid volunteers;

(c) Patients of state hospitals;

(d) Inmates in work programs offered by the Washington state department of corrections as described in RCW 72.09.100 or an equivalent program administered by a local government;

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

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

(g) Any others not expressly defined as an employee.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-113 What are the obligations of a state agency in the application of employee eligibility? (1) All state agencies must carry out all actions, policies, and guidance issued by the public employees benefits board (PEBB) program necessary for the operation of benefit plans, education of employees, claims administration, and appeals pro-

cess including those described in chapters 182-08, 182-12, and 182-16 WAC. State agencies must:

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

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

(c) Carry out corrective action and pay any penalties imposed by the authority and established by the board when the state agency's eligibility determinations fail to comply with the criteria under these rules.

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

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

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

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

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

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

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

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

(3) State agencies must determine employee's dependents eligibility for PEBB benefits according to the criteria in WAC 182-12-260.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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 they are anticipated to work an average of at least eighty hours per month and are 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 become eligible through stacking when they meet the requirements described in (a) of this subsection. They 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, basic accidental death and dismemberment (AD&D) insurance, and basic long-term disability (LTD) 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 they are anticipated to work an average of at least eighty hours per month and are anticipated to work for at least eight hours in each month of at least three consecutive months of the season.

(b) **Determining eligibility.**

(i) **Upon employment:** A seasonal employee is eligible from the date of employment if the employing agency anticipates that they 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 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 become eligible through stacking when they meet the requirements described in (a) of this subsection. They 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, basic AD&D insurance, and basic LTD 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 they are anticipated to work, or has actually worked, half-time or more. Spring and fall are considered consecutive quarters/semesters when first establishing eligibility for faculty that work less than half-time during the summer quarter/semester.

(iii) **Upon revision of anticipated work pattern:** Faculty who receive additional workload after the beginning of the anticipated work period (quarter, semester, or instructional year), such that their workload meets the eligibility criteria 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). A faculty becomes eligible through stacking when they meet the requirements as described in (a) of this subsection. When a faculty works for more than one institution of higher education, the faculty must notify their employing agencies that they work at more than one institution and may be eligible through stacking.

(c) **When PEBB insurance coverage begins.**

(i) Medical, dental, basic life insurance, basic AD&D insurance, and basic LTD 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, basic AD&D insurance, and basic LTD 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 their 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, basic AD&D insurance, and basic LTD 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, basic AD&D insurance, and basic LTD 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 182-12-116 Who is eligible to participate in the ((~~state's~~)) salary reduction plan? (1) Employees of state agencies are eligible to participate in the state's salary reduction plan provided they are eligible for public employees benefits board (PEBB) benefits as described in WAC 182-12-114 and they elect to participate within the time frames described in WAC 182-08-197, 182-08-187, or 182-08-199.

(2) Employees of employer groups, as defined in WAC 182-12-109, ((~~and charter schools~~)) are not eligible to participate in the state's salary reduction plan.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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

(1) An individual who has more than one source of eligibility for enrollment in PEBB health plan coverage (called "dual eligibility") is limited to one enrollment.

(2) An eligible employee may waive PEBB medical and enroll as a dependent under the health plan of their spouse, state registered domestic partner, or parent as described in WAC 182-12-128.

(3) A dependent enrolled in a PEBB health plan who becomes eligible for PEBB benefits as an employee must elect to enroll in PEBB benefits as described in WAC 182-08-197 (1) or (3). This includes making an election to enroll in or waive enrollment in PEBB medical as described in WAC 182-12-128.

(a) If the employee does not waive enrollment in PEBB medical, the employee is not eligible to remain enrolled in their spouse's, state registered domestic partner's, or parent's PEBB health plan as a dependent. If the employee's spouse, state registered domestic partner, or parent does not remove the employee (who is enrolled as a dependent) from their subscriber account, the PEBB program will terminate the employee's enrollment as a dependent the last day of the month before the employee's ((~~employer paid coverage~~)) enrollment in PEBB benefits begins as described in WAC 182-12-114.

Exception: An enrolled dependent who becomes newly eligible for PEBB benefits as an employee may be dual-enrolled in PEBB coverage for one month. This exception is only allowed for the first month the dependent is enrolled as an employee, and only if the dependent becomes enrolled as an employee on the first working day of a month that is not the first day of the month.

(b) If the employee elects to waive their enrollment in PEBB medical, the employee will remain enrolled in PEBB medical under their spouse's, state registered domestic partner's, or parent's PEBB health plan as a dependent.

(4) A child who is eligible for medical and dental under two subscribers may be enrolled as a dependent under the health plan of only one subscriber.

(5) When an employee is eligible for the employer contribution towards PEBB insurance coverage due to employment in more than one PEBB-participating employing agency the following provisions apply:

(a) The employee must choose to enroll under only one employing agency.

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

(b) If the employee loses eligibility under the employing agency, they ((~~may choose to enroll as described in (a) of this subsection, the employee~~)) must notify their other employing agency no later than sixty days from the date PEBB coverage ends through the employing agency described in (a) of this subsection to transfer coverage.

(c) The employee's PEBB insurance coverage elections remain the same when an employee transfers their enrollment ((~~from enrollment~~)) under one employing agency to another employing agency without a break in PEBB insurance coverage for one month or more, as described in (b) of this subsection.

(6) A retiree who defers enrollment in a PEBB health plan as described in WAC 182-12-200 by enrolling as an eligible dependent in a health plan sponsored by PEBB, ((~~a Washington state school district,~~)) a Washington state educational service district, or ((~~a Washington state charter school~~)) SEBB and who loses the employer contribution for such coverage must enroll in PEBB retiree insurance coverage as described in WAC 182-12-200 or defer enrollment as described in WAC 182-12-205.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-128 When may an employee waive enrollment in public employees benefits board (PEBB) medical and when may they enroll in PEBB medical after having waived enrollment? An employee may waive enrollment in public employees benefits board (PEBB) medical if they are enrolled in other employer-based group medical, a TRICARE plan, or medicare as described in subsection (1)(a) through (c) of this section. A special open enrollment event must be an event other than an employee gaining initial eligibility for PEBB benefits. An employee who waives enroll-

ment in PEBB medical must enroll in dental, basic life insurance, basic accidental death and dismemberment insurance, and basic long-term disability (LTD) 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 their employing agency at one of the following times:

(a) **When the employee becomes eligible:** An employee ((~~enrolled in other employer-based group medical, a TRICARE plan, or medicare~~)) may waive PEBB medical when they become eligible for PEBB benefits. The employee must indicate their election to waive enrollment in PEBB medical on the required form and submit the form to their employing agency. The employing agency must receive the form no later than thirty-one days after the date the employee becomes eligible for benefits (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 their employing agency. The employing agency must receive the form 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 to the employing agency.

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~~)) employee may not enroll dependents ((~~may not be enrolled~~)) in PEBB 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 revoke their election and make a new election 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 their employing agency. The employing agency must receive the form 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 to the employing agency.

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~~)) for an employee on 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~~)) (see WAC 182-12-262 for the PEBB medical effective date of a newly born child, newly adopted child, spouse, or state registered domestic partner).

(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 registered domestic partnership;

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

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

(b) 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 their employer contribution toward their employer-based group medical;

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

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

(e) 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 and that change in residence resulted in the dependent losing their health insurance;

(g) A court order requires the employee or any other individual to provide a health plan for an eligible dependent of the ((~~subscriber~~)) employee (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 a TRICARE plan, or loses eligibility for a TRICARE plan;

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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 their potential eligibility to their 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) or the paid family and medical leave program 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 surcharges 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 18-20-117, filed 10/3/18, effective 1/1/19)

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~~)) benefits due to an event described in (b)(i) through (vi) of this subsection may continue PEBB ((~~insurance coverage~~)) benefits by self-paying the premium and applicable premium surcharges set by the health care authority (HCA) from the date eligibility for the employer contribution is lost:

(a) Employees may continue any combination of medical, dental, ((~~and~~)) life insurance, and accidental death and dismemberment (AD&D) 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~~)) supplemental long-term disability (LTD) insurance.

(b) Employees in the following circumstances who lose their eligibility for the employer contribution toward PEBB benefits 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 USERRA;

(v) Employees whose employment ends due to a layoff as defined in WAC 182-12-109; ((~~or~~)) and

(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 PEBB program, whichever is later((.));

(d) Employees may self-pay for a maximum of twenty-nine months. The employee's first premium payment and applicable premium surcharges ((is)) are due ((to the HCA)) no later than forty-five days after the election period ends as described in (c) of this subsection.

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 and AD&D 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 and applicable premium surcharges as premiums become due((.)); and

(e) If the employee's monthly premium or applicable premium surcharges remain((s)) 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 surcharges ((was)) were paid as described in WAC 182-08-180 (1)(c).

(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 and applicable premium surcharges as described in WAC 182-12-146.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-138 What options are available if an employee is approved for the federal Family and Medical Leave Act (FMLA) or the paid family and medical leave program? (1) An employee on approved leave under the federal Family and Medical Leave Act (FMLA) or the family and medical leave insurance program under chapter 50A.04 RCW (paid family and medical leave program) may continue to receive the employer contribution toward public employees benefits board (PEBB) insurance coverage in accordance with the federal FMLA or RCW 50A.04.245. The employee may also continue current ((optional)) supplemental life, supplemental accidental death and dismemberment (AD&D), and ((optional)) supplemental long-term disability (((LTD))) insurance. The employee's employing agency is responsible for determining if the employee is eligible for leave under FMLA and the duration of such leave. The employment security department is responsible for determining if the employee is eligible for leave under the paid family and medical leave program.

(2) If an employee's monthly premium or applicable premium surcharges remain((s)) 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 surcharges ((was)) were paid.

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-141 If an employee reverts from an eligible position, what happens to their 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, they 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 PEBB program, whichever is later;

(b) The employee's first premium payment and applicable premium surcharges ((is)) are due to the HCA no later than forty-five days after the election period ends as described in (a) of this subsection. 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 and accidental death and dismemberment 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 and applicable premium surcharges as premiums become due; and

(d) If the employee's monthly premium or applicable premium surcharges remain((s)) 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 surcharges ((was)) were paid as described in WAC 182-08-180 (1)(c).

(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 surcharges set by the HCA under WAC 182-12-133.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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, and accidental death and dismemberment (AD&D) insurance by self-paying the premium and applicable premium surcharges 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 PEBB program, whichever is later;

(b) The employee's first premium payment and applicable premium surcharges ((~~is~~)) are due to the HCA no later than forty-five days after the election period ends as described in (a) of this subsection. 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 and AD&D 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 and applicable premium surcharges as premiums become due; and

(d) If the employee's monthly premium or applicable premium surcharges remain((~~s~~)) 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 surcharges ((~~was~~)) were paid as described in WAC 182-08-180 (1)(c).

(2) **Benefits-eligible seasonal employees** may continue any combination of medical, dental, ((~~and~~)) life insurance, and AD&D insurance by self-paying the premium and applicable premium surcharges set by the 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 PEBB program, whichever is later;

(b) The employee's first premium payment and applicable premium surcharges ((~~is~~)) are due to the HCA no later than forty-five days after the election period ends as described in (a) of this subsection. 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 and AD&D 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 and applicable premium surcharges as premiums become due; and

(d) If the employee's monthly premium or applicable premium surcharges remain((~~s~~)) 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 surcharges ((~~was~~)) were paid as described in WAC 182-08-180 (1)(c).

(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, dental, or both for the remaining difference in months by self-paying the premium and applicable premium surcharges 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 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-146 When is an enrollee eligible to continue public ((~~employee's~~)) employees 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 and applicable premium surcharge set by the health care authority (HCA).~~

~~**Note:** Based on RCW 26.60.015 and public employee benefits board policy resolution that extended PEBB coverage for dependents not otherwise eligible for COBRA, an employee's state registered domestic partner and the state registered domestic partner's children may continue PEBB insurance coverage on the same terms and conditions as spouses and other eligible dependents under COBRA.~~

~~(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 PEBB program, 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 election period ends as described in (a) of this subsection. Following the enrollee's first premium payment, premiums and applicable premium surcharges must be paid as described in WAC 182-08-180 (1)(c);~~

~~(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 election period ends as described below. 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.~~

~~(3)~~)) An employee or an employee's dependent who loses eligibility for the employer contribution toward public employees benefits board (PEBB) benefits and who qualifies for continuation coverage under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) may continue coverage for medical, dental, or both.

(2) An employee or an employee's dependent who loses eligibility for continuation coverage described in WAC 182-12-133, 182-12-138, 182-12-141, 182-12-142, or 182-12-148 but who has not used the maximum number of months allowed under COBRA may continue medical, dental, or both for the remaining difference in months.

(((~~(4)~~))) (3) 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.

(((~~(5) A retired employee,~~)) (4) A retiree or a dependent of a ((~~retired employee~~)) retiree, who is no longer eligible ((~~to continue coverage~~)) as described in WAC 182-12-171, 182-12-180, or 182-12-260 may continue medical, dental, or both.

(((~~(6)~~))) (5) 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.

(6) An enrollee may continue PEBB health plan coverage under COBRA by self-paying the premium and applicable premium surcharges set by the health care authority (HCA):

Note: Based on RCW 26.60.015 and public employees benefits board policy resolution that extended PEBB coverage for dependents not otherwise eligible for COBRA, a subscriber's state registered domestic partner and the state registered domestic partner's children may continue PEBB benefits on the same terms and conditions as spouses and other eligible dependents under COBRA.

(a) The 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 PEBB program, whichever is later;

(b) The first premium payment under COBRA coverage and applicable premium surcharges are due to the HCA no later than forty-five days after the election period ends as described in (a) of this subsection. Following the enrollee's first premium payment, premiums and applicable premium surcharges must be paid as described in WAC 182-08-180 (1)(c);

(c) COBRA continuation coverage enrollees who voluntarily terminate their COBRA coverage will not be eligible to reenroll in COBRA coverage unless they regain eligibility as described in WAC 182-12-114. Those who request to terminate their COBRA coverage must do so in writing. COBRA coverage will end on the last day of the month in which the PEBB program receives the termination request or on the last day of the month specified in the COBRA enrollee's termination request, whichever is later. 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;

(d) An employee enrolled in a medical flexible spending arrangement (FSA) and the employee's dependents will have an opportunity to continue making contributions to their medical FSA by electing COBRA if on the date of the qualifying event, as described under 42 U.S.C. Sec. 300bb-3, the employee's medical FSA has a greater amount in remaining benefits than remaining contribution payments for the current year. The election must be received by the contracted vendor no later than sixty days from the date the PEBB health plan coverage ended or from the postmark date on the election notice sent by the contracted vendor, whichever is later. The first premium payment under COBRA coverage is due to the contracted vendor no later than forty-five days after the election period ends as described above.

(7) Medical and dental coverage under COBRA begin on the first day of the month following the day the COBRA enrollee loses eligibility for PEBB health plan coverage as described in WAC 182-12-131, 182-12-133, 182-12-141, 182-12-142, 182-12-148, 182-12-171, 182-12-180, 182-12-250, 182-12-260, or 182-12-265.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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 surcharges 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 applicable premium surcharges associated with PEBB insurance coverage as premiums and applicable premium surcharges become due. If the monthly premium or applicable premium

surcharges remain((~~s~~)) 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 applicable premium surcharges ((~~was~~)) were paid as described in WAC 182-08-180 (1)(c).

(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, dental, or both 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) When the employer contribution is reinstated, the HCA will refund to the employee any premiums and applicable 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 amount for PEBB insurance coverage from the refund of ((~~any~~)) premiums and applicable premium surcharges self-paid by the employee during the appeal period.

(b) All ((~~optional~~)) supplemental life, supplemental accidental death and dismemberment, and ((~~optional~~)) supplemental LTD 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~~)) supplemental 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~~)) supplemental coverage.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-171 When is a retiring employee or a retiring school employee eligible to enroll in public employees benefits board (PEBB) retiree insurance coverage? A retiring employee or a retiring school employee is eligible to continue enrollment or defer enrollment in public employees benefits board (PEBB) insurance coverage as a retiree if they meet procedural and substantive eligibility requirements as described in subsections (1), (2), and (3) of this section. An elected and full-time appointed official of the legislative and executive branch of state government is eligible as described in WAC 182-12-180.

(1) **Procedural requirements.** A retiring employee or a retiring school employee must enroll or defer enrollment in PEBB retiree insurance coverage as described in (a) through (d) 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 or the school 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 or the school employee's employer-paid coverage, COBRA coverage, or continuation coverage ends;

(b) The employee's or the school employee's first premium payment for PEBB retiree insurance coverage enrollment and applicable premium surcharges ((~~is~~)) are due to the health care authority (HCA) no later than forty-five days after the election period ends as described in (a) of this subsection. Following the employee's or the school employee's first premium payment, premiums and applicable premium surcharges must be paid as described in WAC 182-08-180 (1)(c); and

(c) If a retiring employee or a retiring school employee elects to enroll a dependent in PEBB health plan coverage, the dependent must be enrolled in the same PEBB medical and PEBB dental plan as the retiring employee or the retiring school employee;

Exception: If a retiring employee or a retiring school employee selects a medicare supplement plan, nonmedicare enrollees will be enrolled in the Uniform Medical Plan (UMP) Classic. If a retiring employee or a retiring school employee selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees.

(d) To defer enrollment in a PEBB health plan, the employee or the school 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.

(2) **Substantive eligibility requirements.**

(a) An employee ((~~as defined in WAC 182-12-109~~)) who is eligible for PEBB benefits through an employing agency, or ((~~an~~)) a school employee who is ((~~enrolled in~~)) eligible for SEBB benefits through a SEBB organization or basic benefits through ((~~a Washington state school district,~~)) an 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 they meet procedural and substantive eligibility requirements.

To be eligible to continue enrollment or defer enrollment in PEBB insurance coverage as a retiree, the employee or the school employee must be eligible to retire under a Washington state-sponsored retirement plan when the employee's or school employee's employer-paid coverage, COBRA coverage, or continuation coverage ends.

(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(25)), must meet their 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 their 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,~~)) an 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 they were a member of public employees retirement system Plan 1 or Plan 2 during their 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,~~)) 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 they 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 school 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 school employee who ends employment before October 1, 1993; or

(ii) A retiring school 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 school employee the choice between a lump sum actuarially equivalent payment and the ongoing monthly payment, as allowed by the plan, or the school employee enrolled before 1995; or

(iii) A retiring school employee who is a member of a Plan 3 retirement system, also called a separated employee (defined in RCW 41.05.011(25)), must meet their Plan 3 retirement eligibility criteria; or

(iv) ((~~An~~)) A school 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 they enrolled in a PEBB health plan no later than the HCA's annual open enrollment period for the year beginning January 1, 1995.

(3) A retiring employee or a retiring school employee and their enrolled dependents who are entitled to medicare must enroll and maintain enrollment in both medicare Parts A and B if the employee or the school employee retired after July 1, 1991. If a retiree or an enrolled dependent becomes entitled to medicare after enrollment in PEBB retiree insurance coverage, they must enroll and maintain enrollment in medicare Parts A and B to remain enrolled in a PEBB retiree 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 a PEBB retiree health plan. 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.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-180 When is an elected and full-time appointed official of the legislative and executive branch of state government, or their survivor eligible to continue enrollment in public employees benefits board (PEBB) retiree insurance coverage? (1) An elected and full-time appointed official of the legislative and executive branch of

state government is eligible to continue enrollment or defer enrollment in public employees benefits board (PEBB) retiree insurance coverage under the same terms as an outgoing legislator, when they voluntarily or involuntarily leave public office. The following officials are eligible 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 PEBB retiree insurance coverage as described in (a) and (b) of this subsection and must meet procedural requirements as described in subsection (3) 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 as described in (a) through (d) of this subsection:

(a) For an official 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. The effective date of PEBB retiree insurance coverage is the first day of the month after the official leaves public office;

For a survivor to enroll in PEBB retiree insurance coverage, the required forms must be received by the PEBB program no later than sixty days after the later of the date of the official's death or the date the survivor's PEBB insurance coverage ends. The effective date of PEBB retiree insurance coverage is the first day of the month after the date of the official's death or the first day of the month after the survivor's PEBB insurance coverage ends;

(b) The official's or survivor's first premium payment and applicable premium surcharges ((~~is~~)) are due to the health care authority (HCA) no later than forty-five days after the official's or survivor's election period ends as described in (a) of this subsection. 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)(c);

(c) If an official or a survivor elects to enroll a dependent in PEBB health plan coverage, the dependent must be enrolled in the same PEBB medical and PEBB dental plan as the official or survivor;

Exception: If an official or a survivor selects a medicare supplement plan, nonmedicare enrollees will be enrolled in the Uniform Medical Plan (UMP) Classic. If an official or a survivor selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees.

(d) 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 entitled to medicare or becomes entitled to medicare after enrollment in PEBB retiree insurance coverage, they must enroll and maintain enrollment in medicare Parts A and B to remain enrolled in a PEBB retiree 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 a PEBB retiree health plan. The enrollee may continue PEBB health plan enrollment as described in WAC 182-12-146.

(5) An official described in subsection (1) of this section shall be included in the term "retiree" or "retiring employee" as used in chapters 182-08, 182-12, and 182-16 WAC.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-200 May a retiring employee, a retiring school employee, or a retiree enrolled as a dependent in a health plan sponsored by public employees benefits board (PEBB), ((~~a Washington state school district,~~)) a Washington state educational service district, or ((~~a Washington state charter~~)) school employees benefits board (SEBB) defer PEBB health plan enrollment under PEBB retiree insurance coverage? (1) A retiring employee or a retiring school employee may defer enrollment in a public employees benefits board (PEBB) health plan at retirement or after enrolling in PEBB retiree insurance coverage. Enrollment in a PEBB health plan may be deferred when they are enrolled as a dependent in a health plan sponsored by PEBB, ((~~a Washington state school district,~~)) a Washington state educational service district, or ((~~a Washington state charter school~~)) SEBB, including such coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or continuation coverage. A retiring employee or a retiring school employee who defers enrollment at retirement must meet substantive eligibility requirements as described in WAC 182-12-171(2) or requirements as described in WAC 182-12-180(1).

(2) A retiree who defers enrollment in medical must defer enrollment in dental. Retirees must be enrolled in medical to enroll in dental. A retiree who defers enrollment in a PEBB health plan also defers enrollment for all eligible dependents.

(3) A retiree who defers enrollment may later enroll in a PEBB health plan if they provide evidence of continuous enrollment in a health plan sponsored by PEBB, ((~~a Washington state school district,~~)) a Washington state educational service district, or ((~~a Washington state charter school~~)) SEBB, and submits the required form as described in (a) and (b) of this subsection:

(a) During the PEBB annual open enrollment period. The required form must be received by the PEBB program no later than the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or

(b) When enrollment in a health plan sponsored by PEBB, ((~~a Washington state school district,~~)) a Washington state educational service district, or ((~~a Washington state charter school~~)) SEBB ends, or such coverage under COBRA or continuation coverage ends. The required forms to enroll must be received by the PEBB program no later than sixty days after coverage ends. PEBB health plan coverage begins the first day of the month following the date the other coverage ends. To continue in a deferred status, the retiree must defer enrollment as described in WAC 182-12-205.

(4) If a retiree elects to enroll a dependent in PEBB health plan coverage, the dependent must be enrolled in the same PEBB medical or PEBB dental plan as the retiree.

Exception: If a retiree selects a medicare supplement plan, nonmedicare enrollees will be enrolled in the Uniform Medical Plan (UMP) Classic. If a retiree selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-205 May a retiree or a survivor defer or voluntarily terminate public employees benefits board (PEBB) health plan enrollment under PEBB retiree insurance coverage? (1) The following individuals may defer enrollment in a public employees benefits board (PEBB) health plan:

(a) A retiring employee or a retiring school employee;

(b) A dependent becoming eligible as a survivor; or

(c) A retiree or a survivor enrolled in PEBB retiree insurance coverage.

(2) A subscriber described in subsection (1) of this section who defers enrollment in a PEBB health plan also defers enrollment for all eligible dependents, except as described in subsection (3)(c) of this section.

(3) A subscriber described in subsection (1) of this section who defers enrollment in a PEBB health plan must maintain continuous enrollment in other medical as described in this section or WAC 182-12-200. A subscriber who defers enrollment in medical must defer enrollment in dental. A subscriber must be enrolled in medical to enroll in dental.

(a) Beginning January 1, 2001, enrollment in a PEBB health plan may be deferred when the subscriber is enrolled in employer-based group medical as an employee or the dependent of an employee, or such medical insurance continued under Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage or continuation coverage.

(b) Beginning January 1, 2001, enrollment in a PEBB health plan may be deferred when the subscriber is enrolled as a retiree or the dependent of a retiree in a federal retiree medical plan.

(c) Beginning January 1, 2006, enrollment in a PEBB health plan may be deferred when the subscriber is enrolled in medicare Parts A and B and a medicaid program that provides creditable coverage as described in this chapter. Dependents may continue their PEBB health plan enrollment if they meet PEBB eligibility criteria and are not eligible for creditable coverage under a medicaid program.

(d) Beginning January 1, 2014, subscribers who are not eligible for Parts A and B of medicare may defer enrollment in a PEBB health plan when the subscriber is enrolled in exchange coverage.

(e) Beginning July 17, 2018, enrollment in a PEBB health plan may be deferred when the subscriber is enrolled ((~~as a retiree or the dependent of a retiree~~)) in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).

(4) To defer PEBB health plan enrollment, the required forms must be submitted to the PEBB program.

(a) For a retiring employee or a retiring school employee who meets the substantive eligibility requirements as described in WAC 182-12-171(2), enrollment will be deferred the first of the month following the date their employer-paid coverage, COBRA coverage, or continuation coverage ends. The forms must be received by the PEBB program no later than sixty days after the employer-paid coverage, COBRA coverage, or continuation coverage ends.

(b) For an official leaving public office who meets the requirements as described in WAC 182-12-180(1), enrollment will be deferred the first of the month following the date the official leaves public office. The forms must be received by the PEBB program no later than sixty days after the official leaves public office.

(c) For an employee or a school employee determined to be retroactively eligible for disability retirement who meets the requirements as described in WAC 182-12-211 (1)(a) through (c), enrollment will be deferred as described in WAC 182-12-211 (2) or (3). The forms and formal determination letter must be received by the PEBB program no later than sixty days after the date on the determination letter.

(d) For an eligible survivor, the dependent must meet the requirements described below and the forms must be received by the PEBB program within the time described:

(i) For a survivor of an employee or a school employee who meets the requirements as described in WAC 182-12-265 (1) or (3), enrollment will be deferred the first of the month following the later of the date of the employee's or the school employee's death or the date the survivor's PEBB insurance coverage, ((~~school district coverage,~~)) educational service district coverage, or ((~~charter~~)) school employees benefits board (SEBB) insurance coverage ends. The forms must be received by the PEBB program no later than sixty days after the later of the date of the employee's or the school employee's death or the date the survivor's PEBB insurance coverage, ((~~school district coverage,~~)) educational service district coverage, or ((~~charter school~~)) SEBB insurance coverage ends.

(ii) For a survivor of an official who meets the requirements as described in WAC 182-12-180(2), enrollment will be deferred the first of the month following the later of the date of the official's death or the date the survivor's PEBB insurance coverage ends. The forms must be received by the PEBB program no later than sixty days after the later of the

date of the official's death or the date the survivor's PEBB insurance coverage ends.

(iii) For a survivor of a retiree who meets the requirements as described in WAC 182-12-265(2), enrollment will be deferred the first of the month following the date of the retiree's death. The forms must be received by the PEBB program no later than sixty days after the retiree's death.

(iv) For a survivor of an emergency service personnel killed in the line of duty who meets the requirements as described in WAC 182-12-250, enrollment will be deferred the first of the month following the later of one of the events described in WAC 182-12-250 (5)(a) through (d). The forms must be received by the PEBB program no later than one hundred eighty days after the later of one of the events described in WAC 182-12-250 (5)(a) through (d).

(e) For an enrolled retiree or survivor who submits the required forms to defer enrollment in a PEBB health plan, enrollment will be deferred effective the first of the month following the date the required forms are received by the PEBB program. If the forms are received on the first day of the month, enrollment will be deferred effective that day.

Exception: When a subscriber or their dependent is enrolled in a medicare advantage plan, then enrollment in a PEBB health plan will be deferred effective the first of the month following the date the medicare advantage plan disenrollment form is received.

(5) A retiree who meets substantive eligibility requirements in WAC 182-12-171(2) and whose employer-paid coverage, COBRA coverage, or continuation coverage ended between January 1, 2001, and December 31, 2001, was not required to have submitted the deferral form at that time, but must meet all procedural requirements as stated in this section, WAC 182-12-171, and 182-12-200.

(6) A subscriber described in subsection (1) of this section who defers enrollment while enrolled in qualifying coverage as described in subsection (3)(a) through (e) of this section may later enroll themselves and their dependents in a PEBB health plan by submitting the required forms as described below and evidence of continuous enrollment in one or more qualifying coverages as described in subsection (3)(a) through (e) of this section:

(a) A subscriber who defers enrollment while enrolled in employer-based group medical or such medical insurance continued under COBRA coverage or continuation coverage may enroll in a PEBB health plan by submitting the required forms and evidence of continuous enrollment to the PEBB program:

(i) During the PEBB annual open enrollment period. The required forms must be received by the PEBB program no later than the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or

(ii) When their employer-based group medical or such coverage under COBRA coverage or continuation coverage ends. The required forms and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after coverage ends. PEBB health plan coverage begins the first day of the month after the employer-based group medical coverage, COBRA coverage, or continuation coverage ends.

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

(i) During the PEBB annual open enrollment period. The required forms must be received by the PEBB program no later than the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or

(ii) When the federal retiree medical plan coverage ends. The required forms and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after coverage ends. PEBB health plan coverage begins the first day of the month after coverage under the federal retiree medical plan ends.

(c) A subscriber who defers enrollment while enrolled in medicare Parts A and B and a medicaid program that provides creditable coverage as described in this chapter may enroll in a PEBB health plan by submitting the required forms and evidence of continuous enrollment to the PEBB program:

(i) During the PEBB annual open enrollment period. The required forms must be received by the PEBB program no later than the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or

(ii) When their medicaid coverage ends. The required forms and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after coverage ends. PEBB health plan coverage begins the first day of the month after the medicaid coverage ends; or

(iii) No later than the end of the calendar year when their medicaid coverage ends if the retiree or survivor was also determined eligible under 42 U.S.C. § 1395w-114 and subsequently enrolled in a medicare Part D plan. Enrollment in the PEBB health plan will begin January 1st following the end of the calendar year when the medicaid coverage ends. The required forms must be received by the PEBB program no later than the last day of the calendar year in which the medicaid coverage ends.

(d) A subscriber who defers enrollment while enrolled in exchange coverage will have a one-time opportunity to enroll or reenroll in a PEBB health plan by submitting the required forms and evidence of continuous enrollment to the PEBB program:

(i) During the PEBB annual open enrollment period. The required forms must be received by the PEBB program no later than the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or

(ii) When exchange coverage ends. The required forms and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after coverage ends. PEBB health plan coverage begins the first day of the month after exchange coverage ends.

(e) A subscriber who defers enrollment while enrolled ((~~as a retiree or dependent of a retiree~~)) in CHAMPVA will have a one-time opportunity to enroll in a PEBB health plan

by submitting the required forms and evidence of continuous enrollment to the PEBB program:

(i) During the PEBB annual open enrollment period. The required forms must be received by the PEBB program no later than the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or

(ii) When CHAMPVA coverage ends. The required forms and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after coverage ends. PEBB health plan coverage begins the first day of the month after CHAMPVA coverage ends.

(f) A subscriber who defers enrollment may enroll in a PEBB health plan if they receive formal notice that the authority has determined it is more cost-effective to enroll them or their eligible dependents in PEBB medical than a medical assistance program.

(g) If a subscriber elects to enroll a dependent in PEBB health plan coverage, the dependent must be enrolled in the same PEBB medical and PEBB dental plan as the subscriber.

Exception: If a subscriber selects a medicare supplement plan, nonmedicare enrollees will be enrolled in the Uniform Medical Plan (UMP) Classic. If a subscriber selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees.

(7) An enrolled retiree or a survivor who requests to voluntarily terminate their enrollment in a PEBB health plan must do so in writing. The written termination request must be received by the PEBB program. A retiree or a survivor who voluntarily terminates their enrollment in a PEBB health plan also terminates enrollment for all eligible dependents. Once coverage is terminated, a retiree or a survivor may not enroll again in the future unless they reestablish eligibility for PEBB insurance coverage by becoming newly eligible. Enrollment in a PEBB health plan will terminate 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, enrollment in a PEBB health plan will terminate on the last day of the previous month.

Exception: When a subscriber or their dependent is enrolled in a medicare advantage plan, then enrollment in a PEBB health plan will terminate on the last day of the month when the medicare advantage plan disenrollment form is received.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-207 When can a retiree or an eligible dependent's public employees benefits board (PEBB) insurance coverage be terminated by the health care authority (HCA)? A retiree or an 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 applicable premium surcharges when due as described in WAC 182-08-180 (1)(c);

(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 18-20-117, filed 10/3/18, effective 1/1/19)

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 eligible school employees who participate in school employees benefits board (SEBB) life insurance as an employee and meet qualifications for PEBB retiree insurance coverage as provided in WAC 182-12-171 or 182-12-180, are eligible for retiree term life insurance. They must submit the required forms to the PEBB program. Forms for a retiring employee or a retiring school employee as described in WAC 182-12-171, must be received by the PEBB program no later than sixty days after the date their PEBB or SEBB employee life insurance ends. Forms for an official leaving public office as described in WAC 182-12-180, must be received by the PEBB program no later than sixty days after the official leaves public office.

(1) Employees or school 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 or SEBB employee life insurance, they may choose:

(a) To continue to self-pay premiums and keep retiree term life insurance, the employee or the school employee must pay retiree term life insurance premiums directly to the contracted vendor during the period they are eligible for PEBB or SEBB employee life insurance; or

(b) To stop self-paying retiree term life insurance premiums during the period they are eligible for PEBB or SEBB employee life insurance and reelect retiree term life insurance when they are no longer eligible for the employer contribution toward PEBB or SEBB employee life insurance.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-211 May an employee or a school employee who is determined to be retroactively eligible for disability retirement enroll or defer enrollment in public employees benefits board (PEBB) retiree insurance coverage? (1) An employee or a school 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 or the school employee submits the required form and a copy of the formal determination letter they received from the Washington state department of retirement systems (DRS) or the appropriate higher education authority;

(b) The employee's or the school employee's form and a copy of their 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 or the school employee immediately begins to receive a monthly pension benefit or a supplemental retirement plan benefit under their higher education retirement plan (HERP), with exceptions described below from WAC 182-12-171(2):

(i) A retiring employee of a state agency, ((~~Washington state school district, Washington state educational service district, Washington state charter school, or~~)) an employer group participating under a Washington state sponsored retirement plan, or a retiring school 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 of a state agency, ((~~Washington state school district, Washington state educational service district, Washington state charter school, or~~)) an employer group participating under a Washington state sponsored retirement plan, or a retiring school employee who is a member of a Plan 3 retirement plan, also called a separated employee (defined in RCW 41.05.011(25)), must meet their Plan 3 retirement eligibility criteria. The employee or the school employee does not have to receive a retirement plan payment to enroll in PEBB retiree insurance coverage; or

(iii) 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 their HERP plan's retirement eligibility criteria, or be at least age fifty-five with ten years of state service.

(2) ((~~Premiums and applicable premium surcharges are due from the effective date of enrollment in PEBB retiree insurance coverage.~~)) The employee or the school employee, at their option, must indicate the ((~~effective~~)) date of enrollment or deferment in PEBB retiree insurance coverage on the form. The employee or the school 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 of PEBB retiree insurance coverage ((~~begins~~)) described in subsection (2)(a) and (b) of this section; however, such request must demonstrate extraordinary circumstances beyond the control of the retiree.

(4) Premiums and applicable premium surcharges are due from the effective date of enrollment in PEBB retiree insurance coverage.

(5) If a retiring employee or a retiring school employee elects to enroll a dependent in PEBB health plan coverage, the dependent must be enrolled in the same PEBB medical and PEBB dental plan as the retiring employee or the retiring school employee.

Exception: If a retiring employee or a retiring school employee selects a medicare supplement plan, nonmedicare enrollees will be enrolled in the Uniform Medical Plan (UMP) Classic. If a retiring employee or a retiring school employee selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-260 Who are eligible dependents? To be enrolled in ((~~a health plan~~)) PEBB benefits, 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 reserves the right to review a dependent's eligibility at any time. 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~~)) PEBB benefits if the PEBB program is unable to verify a dependent's eligibility within the PEBB program enrollment timelines.

The subscriber must ((~~notify the PEBB program~~)) provide notice, in writing, when their dependent is not eligible under this section((~~. The notification must be received by the PEBB program no later than sixty days after the date their dependent is no longer eligible under this section. See~~)) as described in 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) Legal spouse. A former spouse((~~s are~~)) is not an eligible dependent((~~s~~)) 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.~~)) A former state registered domestic partner((~~s are~~)) is not an eligible dependent((~~s~~)) 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 (((~~h~~))) (g) of this subsection. Children are defined as the subscriber's:

(a) Children based on establishment of a parent-child relationship as described in RCW 26.26A.100, except when parental rights have been terminated;

(b) Children of the subscriber's spouse, based on the spouse's establishment of a parent-child relationship, except when parental rights have been terminated. The stepchild's relationship to ((~~a~~)) the subscriber (and eligibility as a dependent) ends on the same date the marriage with the spouse ends through divorce, annulment, dissolution, termination, or death;

(c) ((~~Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of the child;~~

~~(d)~~)) Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child;

(((~~e~~))) (d) Children of the subscriber's state registered domestic partner, based on the state registered domestic partner's establishment of a parent-child relationship, except when parental rights have been terminated. The child's relationship to the subscriber (and eligibility as a dependent) ends on the same date the subscriber's legal relationship with the state registered domestic partner ends through divorce, annulment, dissolution, termination, or death;

(((~~f~~))) (e) Children specified in a court order or divorce decree for whom the subscriber has a legal obligation to provide support or health care coverage;

(((~~g~~))) (f) Extended dependent 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. Extended dependent child does not include a foster child unless the subscriber, the subscriber's spouse, or the subscriber's state registered domestic partner has assumed a legal obligation for total or partial support in anticipation of adoption; and

(((~~h~~))) (g) Children of any age with a developmental or physical disability 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 of twenty-six:

(i) The subscriber must provide proof of the disability and dependency within sixty days of the child's attainment of age twenty-six;

(ii) The subscriber must ((~~agree to~~)) notify the PEBB program, in writing, ((~~no later than sixty days after the date that~~)) when the child is no longer eligible under this subsection as described in WAC 182-12-262 (2)(a);

(iii) A child with a developmental or physical disability who becomes self-supporting is not eligible under this subsection as of the last day of the month in which they become capable of self-support;

(iv) A child with a developmental or physical disability age twenty-six and older who becomes capable of self-support does not regain eligibility under (i) of this subsection if they later become incapable of self-support; and

(v) The PEBB program with input from the applicable contracted vendor will periodically verify 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, which may require renewed proof from the subscriber.

(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 18-20-117, filed 10/3/18, effective 1/1/19)

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 their dependent except as provided in WAC 182-12-205 (3)(c). Subscribers must satisfy the enrollment requirements as described in subsection (4) of this section and 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~~)) subscriber enrolls a newborn child in ((~~optional~~)) supplemental dependent life insurance and accidental death and dismemberment (AD&D) insurance. The newborn child's dependent life insurance and AD&D 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((~~.~~)); or

(c) **During special open enrollment.** Subscribers may enroll dependents during a special open enrollment as described in subsection (3) 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 depen-**

dent meets the eligibility criteria as described in WAC 182-12-250 or 182-12-260. ((~~Employees~~)) Subscribers must ((~~notify their employing agency~~)) provide notice when a dependent is no longer eligible due to divorce, annulment, dissolution, or qualifying event of a dependent ceasing to be eligible as a dependent child, as described in WAC 182-12-260(3). The notice must be received within sixty days of the last day of the month the dependent loses eligibility for health plan coverage. Employees must notify their employing agency when a dependent is no longer eligible, except as required under WAC 182-12-260 (3)(g)(ii). All other subscribers must notify the PEBB program ((~~when a dependent is no longer eligible~~)). Consequences for not submitting notice within the required 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 as described in WAC 182-12-270;

(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 eligible 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 (see WAC 182-12-171, 182-12-180, or 182-12-211), survivors (see WAC 182-12-180, 182-12-250, or 182-12-265), and ((~~enrollees with~~)) PEBB continuation coverage ((~~as described in~~)) enrollees (see 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. 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 or on the last day of the month specified in the subscriber's written notice, whichever is later. 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 eligible 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~~)) PEBB benefits 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 the later of the event date as described in WAC 182-08-198(2) or 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 and proof of the event 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~~)) PEBB benefits coverage will begin or end as follows:

• For the newly born child, ((~~health plan~~)) PEBB benefits coverage will begin the date of birth;

• For a newly adopted child, ((~~health plan~~)) PEBB benefits 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~~)) PEBB benefits 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~~)) supplemental dependent life insurance and AD&D insurance coverage purchased by the employee becomes effective.

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

(b) Subscriber acquires a new dependent due to:

(i) Marriage or registering ((~~for~~)) a state registered 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.

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

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

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

((~~**Exception:**~~)) **Note:** ((~~For the purposes of special open enrollment~~)) As used in (e) of this subsection, "employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 54.9801-6.

(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;

(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 and that change in residence resulted in the dependent losing their health insurance;

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

(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;

(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~~)) An employee must submit the required forms to their employing agency((~~. All other~~)), a subscriber((~~s~~)) on continuation coverage or PEBB retiree insurance coverage must 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. All required forms and documents must be received within the required time frames.

(a) If a subscriber wants to enroll their 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~~)) and submit them within the ((~~relevant~~)) required time frame described in WAC 182-08-197, 182-08-187, 182-12-171, 182-12-180, 182-12-211, 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 forms as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the required forms must be received no later than ((~~twelve months~~)) sixty days 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 the 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, the required forms must be received no later than sixty days after the event that creates the special open enrollment.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-263 National Medical Support Notice (NMSN). (1) When a National Medical Support Notice (NMSN) requires a subscriber to provide health plan coverage for a dependent child the following provisions apply:

((~~(1)~~)) (a) The subscriber may enroll their dependent child and request changes to their health plan coverage as described under subsection ((~~(3)~~)) (c) of this section. Employees submit the required forms to their employing agency. ((~~All other~~)) Subscribers on continuation coverage or PEBB retiree insurance coverage submit the required forms to the public employees benefits board (PEBB) program.

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

((~~(a)~~)) (i) The child's other parent; or

((~~(b)~~)) (ii) Child support enforcement program.

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

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

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

((~~(c)~~)) (iii) The subscriber's selected health plan will be changed if directed by the NMSN;

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

~~(e)~~)); or

(v) If the subscriber is eligible for and elects Consolidated Omnibus Budget Reconciliation Act (COBRA) or other continuation coverage, the NMSN will be enforced and the dependent must be covered in accordance with the NMSN.

((~~(4)~~)) (d) Changes to health plan coverage or enrollment as described in ((~~subsection (3)(a)~~)) (c)(i) through ((~~(c)~~)) (iii) of this ((~~section~~)) subsection will begin the first day of the month following receipt by the employing agency of the NMSN. If the NMSN is received by the employing agency on the first day of the month, the change to health plan coverage

or enrollment begins on that day. A dependent will be removed from the subscriber's health plan coverage as described in ((~~subsection (3)(d)~~)) (c)(iv) of this ((~~section~~)) subsection the last day of the month the NMSN 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.

((~~(5) The subscriber may be eligible to make changes to their health plan enrollment and salary reduction elections related to the NMSN as described in WAC 182-08-198(2), 182-08-199(3), 182-12-128(4), or 182-12-262(3).~~)) (2) When a NMSN requires a spouse, former spouse, or other individual to provide coverage for a dependent enrolled in PEBB coverage and that coverage is in fact provided, the dependent may be removed from the subscriber's PEBB insurance coverage prospectively.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-265 What options for continuing health plan enrollment are available to a surviving spouse, state registered domestic partner, or child, if ((~~the~~)) an employee, a school employee, or a retiree dies? The survivor of an eligible employee, an eligible school employee, or a retiree who meets the eligibility criteria and submits the required forms as described in subsection (1), (2), or (3) of this section is eligible to enroll or defer enrollment as a survivor under public employees benefits board (PEBB) retiree insurance coverage. If enrolling in PEBB retiree insurance coverage, the survivor's first premium payment and applicable premium surcharges ((~~is~~)) are due to the health care authority (HCA) no later than forty-five days after the election period ends as described in subsection (1), (2), or (3) of this section. Following the survivor's first premium payment, premiums and applicable premium surcharges must be paid as described in WAC 182-08-180 (1)(c).

(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. The required forms to enroll or defer enrollment must be received by the PEBB program no later than sixty days after the later of the date of the employee's death or the date the survivor's PEBB insurance coverage ends.

(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, they are not eligible to enroll as a survivor under PEBB retiree insurance coverage. However, they 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,~~)) an educational service district((~~, or charter school~~)).

Eligibility for the surviving spouse, surviving state registered domestic partner, or surviving child of an elected and full-time appointed official of the legislative and 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. The required forms to enroll or defer enrollment must be received by the PEBB program no later than sixty days after the retiree's death.

(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 survivor is eligible to enroll or defer enrollment as a survivor under PEBB retiree insurance coverage. The required forms to enroll or defer enrollment 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 survivor must provide evidence of continuous enrollment in medical coverage as described in WAC 182-12-205 from the most recent open enrollment for which the survivor 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,~~)) an educational service district((~~, or charter school~~)).

(3) ((~~The~~)) A school employee's spouse, state registered domestic partner, or child ((~~of a deceased school district, educational service district, or a charter school employee is eligible to~~)) who loses eligibility due to the death of an eligible school employee may enroll or defer enrollment as a survivor under PEBB retiree insurance coverage at the time of the school employee's death, provided the employee died on or after October 1, 1993. The survivor must immediately begin receiving a retirement benefit allowance under chapter 41.32, 41.35 or 41.40 RCW. The required forms to enroll or defer enrollment must be received by the PEBB program no later than sixty days after the later of the date of the school employee's death or the date the survivor's ((~~school district coverage,~~)) educational service district coverage, or ((~~char-ter~~)) school employees benefits board (SEBB) insurance coverage ends.

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

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

Note: If a spouse, state registered domestic partner, or child of an eligible school employee is not eligible for a retirement benefit allowance, they are not eligible to enroll as a survivor under PEBB retiree insurance coverage. However, a spouse, state registered domestic partner, or child of an eligible school employee enrolled in SEBB insurance coverage may continue health plan enrollment as described in WAC 182-31-090.

(4) If ((a)) premiums and applicable premium surcharges received by the HCA ((is)) are sufficient as described in WAC 182-08-180 (1)(d)(ii) to maintain PEBB health plan enrollment after the ((employee's)) employee, school employee, or retiree's death, the PEBB program will consider the payment as notice of the survivor's intent to continue enrollment.

If the survivor's enrollment ended due to the death of the employee, school employee, or retiree, the PEBB program will reinstate the survivor's enrollment without a gap subject to payment of premium and applicable premium surcharges.

(5) If a survivor elects to enroll a dependent in PEBB health plan coverage, the dependent must be enrolled in the same PEBB medical and PEBB dental plan as the survivor.

Exception: If a survivor selects a medicare supplement plan, nonmedicare enrollees will be enrolled in the Uniform Medical Plan (UMP) Classic. If a survivor selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees.

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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 surcharges ((is)) are due to the HCA no later than forty-five days after the election period ends as described in WAC 182-12-146, 182-12-180, 182-12-250, or 182-12-265, whichever applies. Following the ((employee's)) dependent's first premium payment, the dependent must pay premium and applicable premium surcharge amounts associated with PEBB insurance coverage as premiums and applicable premium surcharges become due. If the monthly premium or applicable premium surcharges 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 applicable premium surcharges ((was)) were paid as described in WAC 182-08-180 (1)(c). The 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.

Note: Based on RCW 26.60.015 and public employees benefits board policy resolution that extended PEBB coverage for dependents not otherwise eligible for COBRA, ((an employee's)) a subscriber's state registered domestic partner and the state registered partner's children may continue PEBB insurance coverage on the same terms and conditions as spouses and other eligible dependents under COBRA.

(3) No 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 18-20-117, filed 10/3/18, effective 1/1/19)

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 as described in RCW 41.05.080(3), are eligible to participate in the PEBB wellness incentive program.

(2) Effective January 1, ((2016)) 2020, to receive 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)) following deadline:

(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)) through September, the deadline is ((September)) November 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)) through December, the deadline is December 31st.

(3) Subscribers who do not complete the requirements according to subsection (2) 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~~)) contracted vendor 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. Once earned, subscribers must claim the incentive on or before December 31st of the same calendar year it was earned.

(5) 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.

Chapter 182-16 WAC

APPEALS PRACTICE AND PROCEDURE

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-010 Purpose. This chapter describes the general rules and procedures that apply to the health care authority's brief adjudicative proceedings and formal administrative hearings for the public employees benefits board program.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

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

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

"Appellant" means a person ((~~or entity~~)) who requests a ((~~review by~~)) brief adjudicative proceeding with the PEBB appeals unit ((~~or a formal administrative hearing~~)) about the action of the employing agency, the HCA, or its contracted vendor.

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

"Brief adjudicative proceeding" means the process described in RCW 34.05.482 through 34.05.494 and in WAC 182-16-2000 through 182-16-2160.

"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 state holidays as set forth in RCW 1.16.050.

"Continuance" means a change in the date or time of when a brief adjudicative proceeding or formal administrative hearing will occur.

"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, contracted vendor, 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 under ((~~this~~)) chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 129 or other sections of the Internal Revenue Code.

"Director" means the director of the authority.

"Dispositive motion" means a motion made to a presiding officer, review officer, or hearing officer to decide a claim or case in favor of the moving party without further proceedings.

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

"Employee" for the public employees benefits board program includes all employees of the state, whether or not covered by civil service; elected and appointed officials of the executive branch of government, including full-time members of boards, commissions, or committees; justices of the supreme court and judges of the court of appeals and the superior courts; and members of the state legislature. Pursuant to contractual agreement with the authority, "employee" may also include: (a) Employees of a county, municipality, or other political subdivision of the state and members of the legislative authority of any county, city, or town who are elected to office after February 20, 1970, if the legislative authority of the county, municipality, or other political subdivision of the state submits application materials to the author-

ity 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) through December 31, 2019, employees of a school district or represented employees of an educational service district if the authority agrees to provide any of the school districts' or educational service districts' insurance programs by contract with the authority as provided in RCW 28A.400.350; (d) employees of a tribal government, if the governing body of the tribal government seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(f) and (g); (e) employees of the Washington health benefit exchange if the governing board of the exchange established in RCW 43.71.020 seeks and receives approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(g) and (n); ((~~and~~)) (f) through December 31, 2019, employees of a charter school established under chapter 28A.710 RCW; and (g) through December 31, 2023, nonrepresented employees of an educational service district. "Employee" does not include: Adult family home providers; unpaid volunteers; patients of state hospitals; inmates; employees of the Washington state convention and trade center as provided in RCW 41.05.110; students of institutions of higher education as determined by their institution; and any others not expressly defined as employees under RCW 41.05.011 or by the authority under this chapter.

"Employer-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 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, and through December 31, 2019, school districts and charter schools, and through December 31, 2023, educational service districts obtaining employee benefits through a contractual agreement with the authority to participate in benefit plans developed by the public employees benefits board as described in WAC 182-08-245.

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

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

"File" or "filing" means the act of delivering documents to the office of the presiding officer, review officer, or hearing officer. A document is considered filed when it is received by the authority or its designee.

"Final order" means an order that is the final ((~~PEBB program~~)) health care authority decision.

"Formal administrative hearing" means a proceeding before a hearing officer that gives an appellant an opportunity for an evidentiary hearing as described in RCW 34.05.413 through 34.05.476 and WAC 182-16-3000 through 182-16-3200.

"HCA hearing representative" means a person who is authorized to represent the PEBB program in a formal administrative hearing. The person may be an assistant attorney general or authorized HCA employee.

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

"Hearing officer" means an impartial decision maker who presides at a formal administrative hearing, and is:

• 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 OAH.

"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~~)) means basic life insurance ((~~and accidental death and dismemberment (AD&D) insurance~~)) paid for by the employing agency, as well as ((~~optional~~)) supplemental 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.

"Long-term disability insurance" or "LTD insurance" ((~~includes~~)) means basic long-term disability insurance paid for by the employing agency and supplemental long-term disability insurance offered to and paid for by the employee((~~s on an optional basis~~)).

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby eligible 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 established under ((~~this~~)) chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"PEBB" means the public employees benefits board.

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

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

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

"Prehearing conference" means a proceeding scheduled and conducted by a hearing officer to address issues in preparation for a formal administrative 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 under chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

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

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

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

"Presiding officer" means an impartial decision maker who conducts a brief adjudicative proceeding and is a director-designated HCA employee.

"Public employee" has the same meaning as employee.

"Review officer or officers" means one or more delegates from the director that consider appeals relating to the administration of PEBB benefits by the PEBB program.

"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 dependent care assistance program (((~~DCAP~~))), medical flexible spending arrangement (((~~FSA~~))), or premium payment plan offered pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"Service" or "serve" means the process described in WAC 182-16-058.

"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.

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

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

"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 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-055 Mailing address changes. (1) During the appeal process if the appellant's mailing address changes, the appellant must notify the public employees benefits board (PEBB) appeals unit as soon as possible.

(2) If the appellant does not notify the PEBB appeals unit of a change in the appellant's mailing address and the PEBB appeals unit continues to serve notices and other important documents to the appellant's last known mailing address, the documents will be deemed served on the appellant.

(3) This requirement to provide notice of an address change is in addition to WAC ((~~182-08-198, 182-08-199, 182-12-128, and 182-12-262~~)) 182-08-191 that require a subscriber to update their address.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-064 Applicable rules and laws. (1) An employing agency must apply public employees benefits board (PEBB) program rules adopted in the Washington Administrative Code (WAC) and follow instructions from the authority.

(2) A presiding officer, review officer or officers, or hearing officer must first apply the applicable ((~~public employees benefits board (~~))PEBB((~~)~~)) program rules adopted in the ((~~Washington Administrative Code (~~))WAC((~~)~~)). If no PEBB program rule applies, the presiding officer, review officer or officers, or hearing officer must decide the issue according to the best legal authority and reasoning available, including federal and Washington state constitutions, statutes, regulations, significant decisions indexed as described in WAC 182-16-130, and court decisions.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-066 Burden of proof, standard of proof, and presumptions. (1) The burden of proof is a party's responsibility to provide evidence regarding disputed facts and persuade the presiding officer, review officer or officers, or hearing officer that a position is correct based on the standard of proof. Unless stated otherwise in rules or law, the appellant has the burden of proof in a brief adjudicative proceeding or formal administrative hearing.

(2) Standard of proof refers to the amount of evidence needed to prove a party's position. Unless stated otherwise in rules or law, the standard of proof in a brief adjudicative proceeding or formal administrative ((~~in a~~)) hearing is a preponderance of the evidence, meaning that something is more likely to be true than not.

(3) Public officers and agencies are presumed to have properly performed their duties and acted as described in the law, unless substantial evidence to the contrary is presented. A party challenging this presumption bears the burden of proof.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-120 Computation of time. (1) In computing any period of time prescribed by this chapter, the day of the event from which the time begins to run is not included. (For example, if an initial order is served on ((~~Tuesday~~)) Friday and the party has twenty-one days to request a review, start counting the days with ((~~Wednesday.~~)) Saturday.)

(2) ((~~Except~~)) As provided in subsection (3) of this section, the last day of the period so computed is included unless it is a Saturday, Sunday, or legal holiday as defined in RCW 1.16.050, in which case the period extends to the end of the next business day.

(3) When the period of time prescribed or allowed is ((~~less than~~)) ten days or less, intermediate Saturdays, Sundays and legal holidays shall be excluded in the computation.

(4) The deadline is 5:00 p.m. on the last day of the computed period.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-130 Index of significant decisions. (1) A final decision may be relied upon, used, or cited as precedent by a party only if the final order has been indexed in the authority's index of significant decisions in accordance with RCW 34.05.473 (1)(b).

(2) An index of significant decisions is available to the public on the health care authority's (HCA) web site. As decisions are indexed they will be available on the web site.

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

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

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

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2000 Brief adjudicative proceedings. Pursuant to RCW 34.05.482, the authority will use brief adjudicative proceedings for issues identified in this chapter when doing so would not violate law, or when protection of the public interest does not require the authority to give notice and an opportunity to participate to persons other than the parties, or the issue and interests involved in the controversy do not warrant use of the procedures of RCW 34.05.413 through ((~~34.05.479~~)) 34.05.476 which govern formal administrative hearings.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2010 ((~~Where to appeal~~)) Appealing a decision regarding public employees benefits board (PEBB) 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 their dependent aggrieved by a decision made by the state agency with regard to public employees benefits board (PEBB) eligibility, enrollment, or premium surcharges may appeal that decision to the state agency by the process ((~~outlined~~)) described in WAC 182-16-2020.

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

(2) Any current or former employee of an employer group or their dependent who is aggrieved by a decision made by an employer group with regard to PEBB eligibility, enrollment, or premium surcharges 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~~)) unit by the process described in WAC 182-16-2030.

(3) Any subscriber or dependent aggrieved by a decision made by the PEBB program with regard to PEBB eligibility, enrollment, premium payments, premium surcharges, 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 unit by the process described in WAC 182-16-2030.

(4) Any ((~~PEBB~~)) enrollee aggrieved by a decision regarding the administration of a health plan, life insurance, accidental death and dismemberment (AD&D) insurance, or long-term disability insurance may appeal that decision by following the appeal provisions of those plans, with the exception of:

(a) Enrollment decisions;

(b) Premium payment decisions other than life insurance or AD&D 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 182-16-2050.

(7) Any subscriber aggrieved by a decision made by 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 182-16-2040.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2020 ((~~How can a current or former employee or an employee's dependent appeal~~)) Appealing a decision made by a state agency about eligibility, premium surcharges, or enrollment in benefits((~~?~~)). (1) An eligibility, premium surcharges, or enrollment decision made by a state agency may be appealed by submitting a written request for administrative review to the state agency. The state agency must receive the request for administrative review no later than thirty days after the date of the denial notice. The contents of the request for administrative review are to be provided as described in WAC 182-16-2070.

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

(b) The state agency ((~~shall~~)) must render a written decision within thirty days of receiving the request for administrative review. The written decision ((~~shall~~)) must be sent to the employee or employee's dependent who submitted the request for administrative review and must include a description of appeal rights. The state agency ((~~shall~~)) must also send a copy of the state agency's written decision to the state agency's administrator (or designee) and to the public employees benefits board (PEBB) appeals unit. If a state agency fails to render a written decision within thirty days of receiving the written request for administrative review, the request for administrative review may be considered denied as of the thirty-first day and the original underlying state agency decision may be appealed to the PEBB appeals unit by following the process in this section.

(c) The state agency may reverse eligibility, premium surcharges, or enrollment decisions ((~~based only on circumstances that arose due to delays caused by the state agency or errors made by the state agency~~)) as permitted by WAC 182-08-187.

(2) Any current or former employee or employee's dependent who disagrees with the state agency's decision in response to a written request for administrative review, as described in subsection (1) of this section, may request a brief adjudicative proceeding to be conducted by the authority by submitting a written request to the PEBB appeals unit.

(a) The PEBB appeals unit must receive the request for a brief adjudicative proceeding no later than thirty days after the date of the state agency's written decision on the request for administrative review. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(i) The PEBB appeals unit ((~~shall~~)) must notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(ii) Once the PEBB appeals unit receives a request for a brief adjudicative proceeding, the PEBB appeals unit will send a request for documentation and information to the applicable state agency. The state agency will then have two business days to respond to the request and provide the requested documentation and information. The state agency will also send a copy of the documentation and information to the ((~~employee, former employee, or the employee's dependent~~)) appellant.

(iii) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(b) If an employee fails to timely request a brief adjudicative proceeding to appeal the state agency's written decision within thirty days by following the process in (a) of this subsection, the state agency's prior written decision becomes the health care authority's final decision without further action.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2030 Appealing a public employees benefits board (PEBB) program decision regarding eligibility, enrollment, premium payments, premium surcharges, a PEBB wellness incentive, or certain decisions made by an employer group((~~?~~)). (1) A decision made by the public employees benefits board (PEBB) program regarding eligibility, enrollment, premium payments, premium surcharges, a PEBB wellness incentive, may be appealed by submitting a request to the PEBB appeals unit for a brief adjudicative proceeding to be conducted by the authority.

(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 request to the PEBB appeals unit for a brief adjudicative proceeding to be conducted by the authority.

(3) The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(4) The request for a brief adjudicative proceeding from a current or former employee or employee's dependent must be received by the PEBB appeals unit no later than thirty days after the date of the denial notice.

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

(6) The PEBB appeals unit ((~~shall~~)) must notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(7) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(8) Failing to timely request a brief adjudicative proceeding to appeal a decision made under this section within the applicable time frame described in subsections (4) and (5) of this section, will result in the prior PEBB program decision becoming the authority's final decision without further ((~~employing agency~~)) action.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2040 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 public employees benefits board (PEBB) wellness incentive program contracted vendor.

(2) Any subscriber who disagrees with a decision in response to an appeal filed with the PEBB wellness incentive program contracted vendor may appeal the decision by submitting a request for a brief adjudicative proceeding to the PEBB appeals unit.

(a) The request for a brief adjudicative proceeding from a current or former employee must be received by the PEBB appeals unit no later than thirty days after the date of the denial notice. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(b) The request for a brief adjudicative proceeding from a retiree or self-pay subscriber must be received by the PEBB appeals unit no later than sixty days after the date of the denial notice. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(3) The PEBB appeals unit ((~~shall~~)) must notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(4) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(5) If a subscriber fails to timely request a brief adjudicative proceeding of a decision made under subsection (1) of this section within thirty days by following the process in WAC 182-16-2020(2), the decision of the PEBB wellness incentive program contracted vendor becomes the authority's final decision.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2050 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 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 administrative review to their state agency. The state agency must receive the written request for administrative review no later than thirty days after the date of the denial. The contents of the written request for administrative review are to be provided as described in WAC 182-16-2070.

(a) Upon receiving the written request for administrative review, the state agency ((~~shall~~)) must perform a complete review of the denial by one or more staff who did not take part in the decision resulting in the denial.

(b) The state agency ((~~shall~~)) must render a written decision within thirty days of receiving the request for administrative review. The written decision ((~~shall~~)) must be sent to the employee who submitted the written request for review and must include a description of appeal rights. The state agency ((~~shall~~)) must also send a copy of the state agency's written decision to the state agency's administrator (or designee) and to the PEBB appeals unit. If a state agency fails to render a written decision within thirty days of receiving the written request for administrative review, the request for administrative review may be considered denied as of the thirty-first day and the original underlying state agency decision may be appealed to the PEBB appeals unit by following the process in this section.

(2) Any employee who disagrees with the state agency's decision in response to a written request for administrative review, as described in this section, may request a brief adjudicative proceeding to be conducted by the authority by submitting a written request to the PEBB appeals unit.

(a) The PEBB appeals unit must receive the request for a brief adjudicative proceeding no later than thirty days after the date of the state agency's written decision on the request for administrative review. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(i) The PEBB appeals unit ((~~shall~~)) must notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(ii) Once the PEBB appeals unit receives a request for a brief adjudicative proceeding, the PEBB appeals unit will send a request for documentation and information to the applicable state agency. The state agency will then have two business days to respond to the request and provide the documentation and information requested. The state agency will also send a copy of the documentation and information to the employee.

(iii) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(b) If an employee fails to timely request a brief adjudicative proceeding to appeal a decision made under this section within thirty days by following the process described in this subsection, the state agency's prior written decision becomes the authority's final decision without further ((~~state agency~~)) action.

(3) Any employee aggrieved by a decision regarding a claim for benefits under the medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP) offered under the ((~~state's~~)) salary reduction plan may appeal that decision to the authority's contracted vendor by following the appeal process of that contracted vendor.

(a) Any employee who disagrees with a decision in response to an appeal filed with the contracted vendor that administers the medical FSA and DCAP under the ((~~state's~~)) salary reduction plan may request a brief adjudicative proceeding by submitting a written request to the PEBB appeals unit. The PEBB appeals unit must receive the request for a brief adjudicative proceeding no later than thirty days after the date of the contracted vendor's appeal decision. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(i) The PEBB appeals unit ((~~shall~~)) must notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(ii) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(b) If an employee fails to timely request a brief adjudicative proceeding to appeal a decision made under this section within thirty days by following the process described in this subsection, the contracted vendor's prior written decision becomes the authority's final decision.

(4) Any employee aggrieved by a decision regarding the administration of the premium payment plan offered under the ((~~state's~~)) salary reduction plan may request a brief adjudicative proceeding to be conducted by the authority by submitting a written request to the PEBB appeals unit for a brief adjudicative proceeding.

(a) The PEBB appeals unit must receive the request for a brief adjudicative proceeding no later than thirty days after the date of the denial notice by the PEBB program. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(i) The PEBB appeals unit ((~~shall~~)) must notify the appellant in writing when the notice of appeal has been received.

(ii) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(b) If an employee fails to timely request a brief adjudicative proceeding to appeal a decision made under this section within thirty days by following the process described in this subsection, the PEBB program's prior written decision becomes the authority's final decision.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2060 How can an entity or organization appeal a decision of the health care authority to deny an employer group application? (1) An entity or organization whose employer group application is denied by the authority may appeal the decision by submitting a request for a brief adjudicative proceeding to the public employees benefits board (PEBB) appeals unit. For rules regarding eligible entities, see WAC 182-12-111.

(2) The PEBB appeals unit must receive the request for a brief adjudicative proceeding no later than thirty days after the date of the denial notice. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(3) The PEBB appeals unit ((~~shall~~)) must notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(4) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(5) Failing to timely request a brief adjudicative proceeding to appeal a decision made under this section within thirty days by following the process described in subsection (2) of this section, will result in the prior PEBB program decision becoming the authority's final decision.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2080 Who can appeal or represent a party in a brief adjudicative proceeding? (1) The appellant may act as their own representative or may choose to be represented by another person, except that employees of the health care authority (HCA) or HCA's authorized agents may not represent an appellant, unless approved by a presiding officer or review officer.

(2) If the appellant is represented by a person who is not an attorney admitted to practice in Washington state, the representative must provide the presiding officer and other parties with the representative's name, address, and telephone number. In cases involving confidential information, the nonattorney representative must provide the PEBB appeals unit and other parties with a signed, written consent permitting release to the nonattorney representative of the appellant's ((~~personal~~)) health information protected by state or federal law.

(3) An attorney admitted to practice law in Washington state representing the appellant must file a written notice of appearance containing the attorney's name, address, and telephone number with the presiding officer's office and serve all parties with the notice. In cases involving confidential information, the attorney must provide the PEBB appeals unit and other parties with a signed, written consent permitting release to the attorney of the appellant's ((~~personal~~)) health information protected by state or federal law. If the appellant's attorney representative no longer represents the appellant, then the attorney must file a written notice of withdrawal of representation with the presiding officer or review officer or officers' office and serve all parties with the notice.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2085 Continuances. The presiding officer or review officer or officers may grant, in their sole discretion, a request for a continuance on motion of the appellant, the authority, or on ((~~its~~)) their own motion. The continuance may be up to thirty calendar days.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2090 Initial order. Unless a continuance has been granted, within ten days after the PEBB appeals unit receives a request for a brief adjudicative proceeding, the presiding officer shall render a written initial order that addresses the issue or issues raised by the appellant in their appeal. The presiding officer ((~~shall~~)) must serve a copy of the initial order on all parties and the initial order ((~~shall~~)) must contain information on how the appellant may request review of the initial order.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2100 How to request a review of an initial order resulting from a brief adjudicative proceeding. (1) An appellant who has received an initial order upholding an employing agency decision, public employees benefits board (PEBB) program decision, or a decision made by PEBB program contracted vendor, may request review of the initial order by the authority. The appellant must file a written request for review of the initial order or ((~~by making~~)) make an oral request for review of the initial order with the ((~~public employees benefits board (~~))PEBB((~~)~~)) appeals unit within twenty-one days after service of the initial order. The written or oral request for review of the initial order must be ((~~provided~~)) made by using the contact information included in the initial order. If the appellant fails to request review of the initial order within twenty-one days, the order becomes the final order without ((~~any~~)) further action by the authority.

(2) Upon timely request by the appellant, a review of an initial order will be performed by one or more review officers designated by the director of the authority.

(3) If the ((~~parties have~~)) appellant has not requested review, the authority may review an order resulting from a brief adjudicative proceeding on its own motion, and without notice to the parties, but it may not take action on review less favorable to any party than the initial order without giving that party notice and an opportunity to explain that party's view of the matter.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2105 Withdrawing the request for a brief adjudicative proceeding or review of an initial order. (1) The appellant may withdraw the request for a brief adjudicative proceeding or review of an initial order for any reason, and at any time, by contacting the public employees benefits board (PEBB) appeals unit. The PEBB appeals unit will present the withdrawal request to the presiding officer or review officer or officers.

(2) The request for withdrawal must be made in writing.

(3) After a withdrawal request is received, the presiding officer or review officer or officers must enter and serve a written order dismissing the ((~~appeal~~)) brief adjudicative proceeding or review of an initial order.

(4) If an appellant withdraws a request for a brief adjudicative proceeding or review of an initial order, the appellant may not reinstate the request for a brief adjudicative proceeding or review of an initial order unless time remains on their original appeal period.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2120 Request for reconsideration. (1) A request for reconsideration asks the review officer or officers to reconsider the final order because the party believes the review officer or officers made a mistake of law, mistake of fact, or clerical error.

(2) A request for reconsideration must state in writing why the party wants the final order to be reconsidered.

(3) Requests for reconsideration must be filed with the review officer or officers who entered the final order.

(4) If a party files a request for reconsideration:

(a) The review officer or officers must receive the request for reconsideration on or before the tenth business day after the service date of the final order.

(b) The party filing the request must send copies of the request to all other parties.

(c) Within five business days of receiving a request for reconsideration, the review officer or officers must serve all parties a notice that provides the date the request for reconsideration was received.

(5) The other parties may respond to the request for reconsideration. The response must state in writing why the final order should stand. Responses are optional. If a party chooses not to respond, that party will not be prejudiced because of that choice.

(a) Responses to a request for reconsideration must be received by the review officer or officers no later than seven business days after the service date of the review officer's or officers' notice as described in subsection (4)(c) of this section, or the response will not be considered.

(b) Service of responses to a request for reconsideration must be made to all parties.

(6) If a party needs more time to file a request for reconsideration or respond to a request for reconsideration, the review officer or officers may extend the required time frame if the party makes a written request providing a good reason for the request within the required time frame.

(7) Unless the request for reconsideration is denied as untimely filed under WAC 182-16-2120 (4)(a), the same review officer or officers who entered the final order, if reasonably available, will also consider the request as well as any responses received.

(8) The decision on the request for reconsideration must be in the form of a written order denying the request, granting the request in whole or in part and issuing a new written final order, or granting the petition and setting the matter for further hearing.

(9) If the review officer or officers do not send an order on the request for reconsideration within twenty calendar days of the date of the notice described in subsection (4)(c) of this section, the request is deemed denied.

(10) If any party files a request for reconsideration of the final order, the reconsideration process must be completed before any judicial review may be requested. However, the

filing of a petition for reconsideration is not required before requesting judicial review.

(11) An order denying a request for reconsideration is not subject to judicial review.

(12) No evidence may be offered in support of a motion for reconsideration, except newly discovered evidence that is material for the party moving for reconsideration and that the party could not with reasonable diligence have discovered and produced ((~~at the hearing or before the ruling on a dispositive motion~~)) prior to the final order being issued.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2130 Judicial review of final order. (1) Judicial review is the process of appealing a final order to a court.

(2) The appellant may appeal a final order by filing a written petition for judicial review that meets the requirements of RCW ((~~34.05.546. The~~)) 34.05.510 through 34.05.598. Neither the public employees benefits board (PEBB) program nor the employing agency may ((~~not~~)) request judicial review.

(((~~(3) The appellant should consult RCW 34.05.510 through 34.05.598 for further details and requirements of the judicial review process.~~)))

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2140 Presiding officer—Designation and authority. The designation of a presiding officer ((~~shall~~)) must be consistent with the requirements of RCW 34.05.485 and the presiding officer ((~~shall~~)) must not have personally participated in the decision made by the employing agency or PEBB program.

(1) The presiding officer will decide the issue based on the information provided by the parties during the presiding officer's review of the appeal.

(2) A presiding officer is limited to those powers granted by the state constitution, statutes, rules, or applicable case law.

(3) A presiding officer may not decide that a rule is invalid or unenforceable.

(4) In addition to the record, the presiding officer may employ ((~~authority~~)) the authority's expertise as a basis for the decision.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2150 Review officer or officers—Designation and authority. (1) The designation of a review officer or officers shall be consistent with the requirements of RCW 34.05.491 and the review officer or officers shall not have personally participated in the decision made by the employing agency or PEBB program.

(2) The review officer or officers shall review the initial order and the record to determine if the initial order was correctly decided.

(3) The review officer or officers will issue a final order that will either:

(a) Affirm the initial order in whole or in part;

(b) Reverse the initial order in whole or in part; or

(c) Refer the matter for a formal administrative hearing; or

(d) Remand to the presiding officer in whole or in part.

(4) A review officer or officers are limited to those powers granted by the state constitution, statutes, rules, or applicable case law.

(5) A review officer or officers may not decide that a rule is invalid or unenforceable.

(6) In addition to the record, the review officer or officers may employ ((~~authority~~)) the authority's expertise as a basis for the decision.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2160 Conversion of a brief adjudicative proceeding to a formal administrative hearing. (1) The presiding officer or the review officer or officers, in their sole discretion, may convert a brief adjudicative proceeding to a formal administrative hearing at any time on motion by the subscriber or enrollee or their representative, the authority, or on the presiding officer or review officer or officers' own motion.

(2) The presiding officer or review officer or officers must convert the brief adjudicative proceeding to a formal administrative hearing when it is found that the use of the brief adjudicative proceeding violates any provision of law, when the protection of the public interest requires the authority to give notice and an opportunity to participate to persons other than the parties, or when the issues and interests involved in the controversy warrant the use of the procedures or RCW 34.05.413 through ((~~34.05.479~~)) 34.05.476 that govern formal administrative hearings.

(3) When a brief adjudicative proceeding is converted to a formal administrative hearing, the director ((~~may become the hearing officer or may~~)) designates a ((~~replacement~~)) hearing officer to conduct the formal administrative hearing upon notice to the subscriber or enrollee and the authority.

(4) When a brief adjudicative proceeding is converted to a formal administrative hearing, WAC 182-16-010 through 182-16-130 and 182-16-3000 through 182-16-3200 apply to the formal administrative hearing.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-3000 Formal administrative hearings. (1) When a brief adjudicative proceeding is converted to a formal administrative hearing consistent with WAC 182-16-2160, the director designates a hearing officer to conduct the formal administrative hearing.

(2) Formal administrative hearings are conducted consistent with the Administrative Procedure Act, RCW 34.05.413 through ((~~34.05.479~~)) 34.05.476.

(3) ((~~This~~)) Part III describes the general rules and procedures that apply to public employees benefits board (PEBB) benefits formal administrative hearings.

(a) ((~~This~~)) Part III 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 hereby adopted for use by the authority in public employees benefits board (PEBB) benefits formal administrative hearings. Other procedural rules adopted in chapters 182-08, 182-12, and 182-16 WAC are supplementary to the model rules of procedure.

(b) In the case of a conflict between the model rules of procedure and this part, the procedural rules adopted in this part ((~~shall~~)) must govern.

(c) If there is a conflict between this part and specific PEBB program rules, the specific PEBB program rules prevail. PEBB program rules are found in chapters 182-08 and 182-12 WAC.

(d) Nothing in this part 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.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-3010 Requirements to appear and represent a party in the formal administrative hearing process. (1) All parties must provide the hearing officer and all other parties with their name, address, and telephone number.

(2) The appellant may act as their own representative or have another person represent them, except that employees of the health care authority (HCA) or HCA's authorized agents may not represent an appellant, unless approved by a hearing officer.

(3) If the appellant is represented by a person who is not an attorney admitted to practice in Washington state, the representative must provide the hearing officer and all other parties with the representative's name, address, and telephone number. In cases involving confidential information, the nonattorney representative must provide the HCA hearing representative with a signed, written consent permitting release to the nonattorney representative of ((~~personal~~)) health information protected by state or federal law.

(4) An attorney admitted to practice law in Washington state, who wishes to represent the appellant, must file a written notice of appearance containing the attorney's name, address, and telephone number with the hearing officer's office and serve all parties with the notice. In cases involving confidential information, the attorney representative must provide the HCA hearing representative with a signed, written consent permitting release to the attorney representative of the appellant's ((~~personal~~)) health information protected by state or federal law. If the appellant's attorney representative no longer represents the appellant, then the attorney must file a written notice of withdrawal of representation with the hearing officer's office and serve all parties with the notice.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-3030 Authority of the hearing officer. (1) A hearing officer must hear and decide the issues ((~~de novo (anew)~~)) based on the evidence and oral or written arguments presented during a formal administrative hearing and admitted into the record.

(2) A hearing officer has no inherent or common law powers, and is limited to those powers granted by the state constitution, statutes, or rules.

(3) A hearing officer may not decide that a rule is invalid or unenforceable. If the validity of a rule is raised during a formal administrative hearing, the hearing officer may allow only argument to preserve the record for judicial review.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-3080 Time requirements for service of notices made by the hearing officer. (1) The hearing officer or their designee must serve a notice of a formal administrative hearing to all parties and their representatives at least twenty-one calendar days before the hearing date. The parties may agree to, but the hearing officer cannot impose, a shorter notice period.

(2) If a prehearing conference or dispositive motion hearing is scheduled, the hearing officer must serve a notice of the prehearing conference or dispositive motion hearing to the parties and their representatives at least seven business days before the date of the prehearing conference or dispositive motion hearing except:

(a) The hearing officer may change any scheduled formal administrative hearing into a prehearing conference or dispositive motion hearing and provide less than seven business days' notice of the prehearing conference or dispositive motion hearing; and

(b) The hearing officer may give less than seven business days' notice if the only purpose of the prehearing conference is to consider whether to grant a continuance.

(3) The hearing officer must reschedule a formal administrative hearing if necessary to comply with the notice requirements in Part III of this ((~~section~~)) chapter.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-3100 Rescheduling and continuances for formal administrative hearings. (1) Any party may request the hearing officer to reschedule a formal administrative hearing if a rule requires notice of a hearing and the amount of notice required was not provided.

(a) The hearing officer must reschedule the hearing under circumstances identified in ((~~subsection (1) of~~)) this ((~~section~~)) chapter if requested by any party.

(b) The parties may agree to shorten the amount of notice required by any rule.

(2) Any party may request a continuance of a formal administrative hearing either orally or in writing.

(a) In each formal administrative hearing, the hearing officer must grant each party's first request for a continuance. The continuance may be up to thirty calendar days.

(b) The hearing officer may grant each party up to one additional continuance of up to thirty calendar days because of extraordinary circumstances ((~~established at a proceeding~~)).

(c) After granting a continuance, the hearing officer or their designee must:

(i) Immediately telephone all other parties to inform them the hearing was continued; and

(ii) Serve an order of continuance on the parties no later than fourteen days before the new formal administrative hearing date. All orders of continuance must provide a new deadline for filing documents with the hearing officer. The new filing deadline can be no less than ten calendar days prior to the new formal administrative hearing date. If the continuance is granted pursuant to (b) of this subsection, then the order of continuance must also include findings of fact that state with specificity the extraordinary circumstances for which the hearing officer granted the continuance.

(3) Regardless of whether a party has been granted a continuance as described in subsection ((~~(1)~~)) (2)(b) of this section, the hearing officer must grant a continuance if a new material issue is raised during the formal administrative hearing and a party requests a continuance.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-3120 Dispositive motions. (1) A dispositive motion could dispose of one or all the issues in a formal administrative hearing, such as a motion to dismiss or motion for summary judgment.

(2) To request a dispositive motion hearing a party must file a written dispositive motion with the hearing officer and serve a copy of the motion to all other parties. The hearing officer may also set a dispositive motion hearing, and request briefing from the parties, to address any possible dispositive issues the hearing officer believes must be addressed before the hearing.

(3) The deadline to file a timely dispositive motion ((~~shall~~)) must be ten calendar days before the scheduled hearing.

(4) Upon receiving a dispositive motion, a hearing officer:

(a) Must convert the scheduled hearing to a dispositive motion hearing when:

(i) The dispositive motion is timely filed with the hearing officer at least ten calendar days before the date of the hearing; and

(ii) The party filing the dispositive motion has not previously filed a dispositive motion.

(b) May schedule a dispositive motion hearing in all instances other than described in (a) of this subsection.

(5) The hearing officer may conduct the dispositive motion hearing in person or by telephone conference. For dispositive motion hearings scheduled to be held in person, the HCA hearing representative may choose to attend and participate in person or by telephone conference call.

(6) The party requesting the dispositive motion hearing must attend and participate in the dispositive motion hearing in person or by telephone. If the party requesting the motion hearing does not attend and participate in the dispositive motion hearing, the hearing officer will enter an order ((~~of default~~)) dismissing the dispositive motion.

(7) During a dispositive motion hearing, the hearing officer can only consider the filed dispositive motions, any response to the motions, evidence submitted to support or oppose the motions, and argument on the motions. Prior to rescheduling any necessary hearings, the hearing officer must serve a written order on the dispositive motions.

(8) The hearing officer must serve the written order on the dispositive motions to all parties no later than eighteen calendar days after the dispositive motion hearing is held. Orders on dispositive motions are subject to motions for reconsideration or petitions for judicial review as described in WAC 182-16-2120 and 182-16-2130.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-3130 Subpoenas. (1) Hearing officers, the HCA hearing representative, and attorneys for the parties may prepare subpoenas as described in Washington state civil rule 45, unless otherwise prohibited by law. Any party may request the hearing officer prepare a subpoena on their behalf.

(2) The hearing officer may schedule a prehearing conference to decide whether to issue a subpoena.

(3) If a party requests the hearing officer prepare a subpoena on its behalf, the party is responsible for:

(a) Service of the subpoena; and

(b) Any costs associated with:

(i) Compliance with the subpoena; and

(ii) Witness fees as described in RCW 34.05.446(7).

(4) Service of a subpoena must be made by a person who is at least eighteen years old and not a party to the hearing. Service of the subpoena is complete when the person serving the subpoena:

(a) Gives the person or entity named in the subpoena a copy of the subpoena; or

(b) Leaves a copy of the subpoena with a person over the age of eighteen at the residence or place of business of the person or entity named in the subpoena.

(5) To prove service of a subpoena on a witness, the person serving the subpoena must file with the hearing officer's office a signed, written, and dated statement that includes:

(a) The name of the person to whom service of the subpoena occurred;

(b) The date the service of the subpoena occurred;

(c) The address where the service of the subpoena occurred; and

(d) The name, age, and address of the person who provided service of the subpoena.

(6) A ((~~party~~)) person or entity subject to or affected by the subpoena may request the hearing officer quash (set aside) or change a subpoena request at any time before the deadline given in the subpoena.

(7) A hearing officer may quash (set aside) or change a subpoena if it is unreasonable.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-3140 Orders of dismissal—Reinstating a formal administrative hearing after an order of dismissal. (1) An order of dismissal is an order from the hearing officer ending the matter. The order is entered because the party who made the appeal withdrew from the proceeding, the appellant is no longer aggrieved, the hearing officer granted a dispositive motion dismissing the matter, or the hearing officer entered an order of default because the party who made the appeal failed to attend or refused to participate in a prehearing conference or the formal administrative hearing.

(2) The order of dismissal becomes a final order if no party files a request to vacate the order as described in subsections (3) through (7) of this section.

(3) If the hearing officer enters and serves an order dismissing the formal administrative hearing, the appellant may file a written request to vacate (set aside) the order of dismissal. Upon receipt of a request to vacate an order of dismissal, the hearing officer must schedule and serve notice of a prehearing conference as described in WAC 182-16-3080. At the prehearing conference, the party asking that the order of dismissal be vacated has the burden to show good cause according to subsection (8) of this section for an order of dismissal to be vacated and the matter to be reinstated.

(4) The request to vacate an order of dismissal must be filed with the hearing officer and the other parties. The party requesting that an order of dismissal be vacated should specify in the request why the order of dismissal should be vacated.

(5) The request to vacate an order of dismissal must be filed with the hearing officer no later than twenty-one calendar days after the date the order of dismissal was entered. If no request is received within that deadline, the dismissal order becomes ((~~a final order and the final order will stand~~)) the health care authority's final decision without further action.

(6) If the hearing officer finds good cause, as described in subsection (8) of this section, for the order of dismissal to be vacated, the hearing officer must enter and serve a written order to the parties setting forth the findings of fact, conclusions of law, and reinstatement of the matter.

(7) If the order of dismissal is vacated, the hearing officer will conduct a formal administrative hearing at which the parties may present argument and evidence about issues raised in the original appeal. The formal administrative hearing may occur immediately following the prehearing conference on the request to vacate only if agreed to by the parties and the hearing officer, otherwise a formal administrative hearing date must be scheduled by the hearing officer.

(8) Good cause is a substantial reason or legal justification for failing to appear, act, or respond to an action using the provisions of Superior Court civil rule 60 as a guideline. This good cause exception applies only to this chapter. This good cause exception does not apply to any other chapter or chapters in Title 182 WAC.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-3160 Withdrawing a formal administrative hearing. (1) The appellant may withdraw a formal administrative hearing for any reason, and at any time, by contacting the health care authority (HCA) hearing representative who will coordinate the withdrawal with the hearing officer.

(2) The request for withdrawal must generally be made in writing. An oral withdrawal by the appellant is permitted during a formal administrative hearing when both the hearing officer and HCA hearing representative are present.

(3) After a withdrawal request is received, the hearing officer must cancel any scheduled hearings and enter and serve a written order dismissing the case.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-3170 Final order deadline—Required information. (1) Within ninety days after the formal administrative hearing record is closed, the hearing officer ((~~shall~~)) must serve a final order that ((~~shall~~)) must be the final decision of the authority. The hearing officer shall serve a copy of the final order to all parties.

(2) The hearing officer must include the following information in the written final order:

(a) Identify the order as a final order of the public employees benefits board (PEBB) program;

(b) List the name and docket number of the case and the names of all parties and representatives;

(c) Enter findings of fact used to resolve the dispute based on the evidence admitted in the record;

(d) Explain why evidence is, or is not, credible when describing the weight given to evidence related to disputed facts;

(e) State the law that applies to the dispute;

(f) Apply the law to the facts of the case in the conclusions of law;

(g) Discuss the reasons for the decision based on the facts and the law;

(h) State the result and remedy ordered; and

(i) Include any other information required by law or program rules.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-3180 Request for reconsideration and response—Process. (1) A request for reconsideration asks the hearing officer to reconsider the final order because the party believes the hearing officer made a mistake of law, mistake of fact, or clerical error.

(2) A request for reconsideration must state in writing why the party wants the final order to be reconsidered.

(3) Requests for reconsideration must be filed with the hearing officer who entered the final order.

(4) If a party files a request for reconsideration:

(a) The hearing officer must receive the request for reconsideration on or before the tenth business day after the service date of the final order((.));

(b) The party filing the request must serve copies of the request ((to)) on all other parties((.)) on the same day the request is served on the hearing officer; and

(c) Within five business days of receiving a request for reconsideration, the hearing officer must serve to all parties a notice that provides the date the request for reconsideration was received.

(5) The other parties may respond to the request for reconsideration. The response must state in writing why the final order should stand. Responses are optional. If a party chooses not to respond, that party will not be prejudiced because of that choice.

(a) Responses to a request for reconsideration must be received by the hearing officer no later than seven business days after the service date of the hearing officer's notice as described in subsection (4)(c) of this section, or the response will not be considered.

(b) Service of responses to a request for reconsideration must be made to all parties.

(6) If a party needs more time to file a request for reconsideration or respond to a request for reconsideration, the hearing officer may extend the required time frame if the party makes a written request providing a good reason for the request within the required time frame.

(7) No evidence may be offered in support of a motion for re-consideration, except newly discovered evidence that is material for the party moving for reconsideration and that the party could not ((with reasonable diligence)) have reasonably discovered and produced at the hearing or before the ruling on a dispositive motion.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-3190 Decisions on requests for reconsideration. (1) Unless the request for reconsideration is denied as untimely filed under WAC 182-16-3180, the same hearing officer who entered the final order, if reasonably available, will also dispose of the request as well as any responses received.

(2) The decision on the request for reconsideration must be in the form of a written order denying or granting the request in whole or in part and if the request is granted issuing a new written final order.

(3) If the hearing officer does not send an order on the request for reconsideration within twenty calendar days of the date of the notice described in WAC ((182-16-2120)) 182-16-3180 (4)(c), the request is deemed denied.

(4) If any party files a request for reconsideration of the final order, the reconsideration process must be completed before any judicial review may be requested. However, the filing of a request for reconsideration is not required before requesting judicial review.

(5) An order denying a request for reconsideration is not subject to judicial review.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-3200 Judicial review of final order. (1) Judicial review is the process of appealing a final order to a court.

(2) The appellant may appeal a final order by filing a written petition for judicial review that meets the requirements of RCW ((34.05.546)) 34.05.510 through 34.05.598. The public employees benefits board (PEBB) program may not request judicial review.

(3) The appellant should consult RCW 34.05.510 through 34.05.598 for further details and requirements of the judicial review process.

WSR 19-17-074
PERMANENT RULES
OFFICE OF THE INSURANCE COMMISSIONER

[Insurance Commissioner Matter R 2019-01—Filed August 20, 2019, 2:17 p.m., effective September 20, 2019]

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

Purpose: Amend existing rules to conform to changes in the federal law to medicare supplemental policies by the Medicare Access and CHIP Reauthorization Act of 2015 and chapter 38, Laws of 2019.

Citation of Rules Affected by this Order: [New WAC 284-66-071]; and amending WAC 284-66-064, 284-66-067, 284-66-068, and 284-66-130.

Statutory Authority for Adoption: RCW 48.02.060, 48.66.041, and 48.66.165.

Adopted under notice filed as WSR 19-12-061 on May 31, 2019.

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

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

Number of Sections Adopted on the Agency's own Initiative: New 1, Amended 4, Repealed 0.

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

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 1, Amended 4, Repealed 0.

Date Adopted: August 20, 2019.

Mike Kreidler
Insurance Commissioner

AMENDATORY SECTION (Amending WSR 11-17-077, filed 8/16/11, effective 9/16/11)

WAC 284-66-064 Benefit standards for policies or certificates issued or delivered on or after June 1, 2010.

No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a medicare supplement policy or certificate unless it complies with these benefit standards. Benefit standards applicable to medicare supplement policies or certificates issued before June 1, 2010, remain subject to the requirements of WAC 284-66-060 and 284-66-063.

(1) General standards. The following standards apply to medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(a) A medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than three months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within three months before the effective date of coverage.

(b) A medicare supplement policy or certificate must provide that benefits designed to cover cost sharing amounts under medicare will be changed automatically to coincide with any changes in the applicable medicare deductible, copayment or coinsurance amounts. Premiums may be modified to correspond with such changes.

(c) No medicare supplement policy or certificate may provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured other than the nonpayment of premium.

(d) Each medicare supplement policy shall be guaranteed renewable and:

(i) The issuer may not cancel or nonrenew the policy solely on the ground of health status of the individual; and

(ii) The issuer may not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(iii) If the medicare supplement policy is terminated by the group policyholder and is not replaced as provided under (d)(v) of this subsection, the issuer shall offer certificate holders an individual medicare supplement policy which, at the option of the certificate holder:

(A) Provides for continuation of the benefits contained in the group policy; or

(B) Provides for benefits that otherwise meet the requirements of this subsection.

(iv) If an individual is a certificate holder in a group medicare supplement policy and the individual terminates membership in the group, the issuer must:

(A) Offer the certificate holder the conversion opportunity described in (d)(iii) of this subsection; or

(B) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(v) If a group medicare supplement policy is replaced by another group medicare supplement policy purchased by the same policyholder, the issue of the replacement policy must offer coverage to all persons covered under the old group policy on its date of termination.

(vi) Termination of a medicare supplement policy or certificate must be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of medicare Part D benefits will not be considered in determining a continuous loss.

(vii)(A) A medicare supplement policy or certificate must provide that benefits and premiums under the policy or certificate are suspended at the request of the policyholder or certificate holder for the period not to exceed twenty-four months in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within ninety days after the date the individual becomes entitled to assistance.

(B) If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted, effective as of the date of termination of entitlement within ninety days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(C) Each medicare supplement policy must provide that benefits and premiums under the policy must be suspended for any period that may be provided by federal regulation at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act. If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy must be automatically reinstituted effective as of the date of loss of coverage if the policyholder provides notice of loss of coverage within ninety days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

(viii) Reinstitution of coverages as described in this section:

(A) Must not provide for any waiting period with respect to treatment of preexisting conditions;

(B) Must provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and

(C) Must provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

(2) Every issuer of medicare supplement insurance benefit plans A, B, C, D, F, F with high deductible, G, M, and N must make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other medicare supplement insurance plans in addition to the basic core package, but not in lieu of it.

(a) Coverage of Part A medicare eligible expenses for hospitalization to the extent not covered by medicare from

the 61st day through the 90th day in any medicare benefit period.

(b) Coverage of Part A medicare eligible expenses incurred for hospitalization to the extent not covered by medicare for each medicare lifetime inpatient reserve day used;

(c) Upon exhaustion of the medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent of the medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system rate or other appropriate medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days. The provider must accept the issuer's payment as payment in full and may not bill the insured for any balance;

(d) Coverage under medicare Parts A and B for the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations;

(e) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of medicare eligible expenses under Part B regardless of hospital confinement, subject to the medicare Part B deductible.

(f) Coverage of cost sharing for all Part A medicare eligible hospice care and respite care expenses.

(3) The following additional benefits must be included in medicare supplement benefit plans B, C, D, F, F with high deductible, G, M, and N as provided by WAC 284-66-066:

(a) Coverage for one hundred percent of the medicare Part A inpatient hospital deductible amount per benefit period.

(b) Coverage for fifty percent of the medicare Part A inpatient hospital deductible amount per benefit period.

(c) Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a medicare benefit period for posthospital skilled nursing facility care eligible under medicare Part A.

(d) Coverage for one hundred percent of the medicare Part B deductible amount per calendar year regardless of hospital confinement.

(e) Coverage for all of the difference between the actual medicare Part B charges as billed, not to exceed any charge limitation established by the medicare program or state law, and the medicare-approved Part B charge.

(f) Coverage to the extent not covered by medicare for eighty percent of the billed charges for medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by medicare if provided in the United States and which care began during the first sixty consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars and a lifetime maximum benefit of fifty thousand dollars. For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.

(4)(a) Every issuer of a standardized medicare supplement plan B, C, D, F, F with high deductible, G, K, L, M, or N issued on or after June 1, 2010, must issue to an individual who was eligible for both medicare hospital and physician services prior to January 1, 2020, without evidence of insurability, coverage under a 2010 plan B, C, D, F, F with high deductible, G, G with high deductible, K, L, M, or N to any policyholder if the medicare supplement policy or certificate replaces another medicare supplement policy or certificate B, C, D, F, F with high deductible, G, G with high deductible, K, L, M, or N or other more comprehensive coverage, including any standardized medicare supplement policy issued prior to June 1, 2010.

(b) Every issuer of a standardized medicare supplemental plan B, D, G, G with high deductible, K, L, M, or N issued on or after January 1, 2020, must issue to an individual who was eligible for both medicare hospital and physician services on or after January 1, 2020, without evidence of insurability, coverage under a 2010 plan B, D, G, G with high deductible, K, L, M, or N to any policyholder if the medicare supplemental policy or certificate replaces another medicare supplemental policy or certificate B, D, G, G with high deductible, K, L, M, or N or other more comprehensive coverage.

(c) Every issuer of a standardized medicare supplement plan A issued on or after June 1, 2010, must issue, without evidence of insurability, coverage under a 2010 plan A to any policyholder if the medicare supplement policy or certificate replaces another medicare supplement plan A issued prior to June 1, 2010.

AMENDATORY SECTION (Amending WSR 09-24-052, filed 11/24/09, effective 1/19/10)

WAC 284-66-067 Standard medicare supplement plans issued for delivery on or after June 1, 2010. No policy or certificate delivered or issued for delivery in this state on or after June 1, 2010, as a medicare supplement policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to medicare supplement policies and certificates issued before June 1, 2010, remain subject to the requirements of WAC 284-66-066.

(1)(a) An issuer must make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic or core benefits, as defined in WAC 284-66-064.

(b) If an issuer makes available any of the additional benefits described in WAC 284-66-064 or offers standardized benefit plan K or L as described in subsection (5) of this section, then the issuer shall make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the basic or core benefits as described in (a) of this ((~~section~~)) subsection, a policy form or certificate form containing either standardized benefit plan C or standardized benefit plan F.

(2) No groups, packages or combinations of medicare supplement benefits other than those listed in this section may be offered for sale in this state, except as may be permitted in WAC 284-66-064 and 284-66-073.

(3) Benefit plans must be uniform in structure, language, designation and format to the standard benefit plans listed in this section and conform to the definitions in this chapter. Each benefit must be structured in accordance with the format found in WAC 284-66-064 or in the case of plans K or L, in subsection (5) of this section, and list the benefits in the order shown. For purposes of this section, "structure, language and format" means style, arrangement and overall content of a benefit.

(4) In addition to the benefit plan designations required in subsection (3) of this section, an issuer may use other designations to the extent permitted by law.

(5) Make-up of 2010 standardized benefit plans:

(a) Standardized medicare supplement benefit plan A may include only the basic core benefits as defined in WAC 284-66-064.

(b) Standardized medicare supplement benefit plan B may include only the basic core benefit as defined in WAC 284-66-064 plus one hundred percent of the medicare Part A deductible as defined in WAC 284-66-064.

(c) Standardized medicare supplement benefit plan C may include only the basic core benefit as defined in WAC 284-66-064 plus one hundred percent of the medicare Part A deductible, skilled nursing facility care, one hundred percent of the medicare Part B deductible and medically necessary emergency care in a foreign country as defined in WAC 284-66-064.

(d) Standardized medicare supplement benefit plan D may include only the basic core benefits as defined in WAC 284-66-064 plus one hundred percent of the medicare Part A deductible, skilled nursing facility care and medically necessary emergency care in a foreign country as defined in WAC 284-66-064.

(e) Standardized medicare supplement regular plan F may include only the basic core benefit as defined in WAC 284-66-064 plus one hundred percent of the medicare Part A deductible, the skilled nursing facility care, one hundred percent of the medicare Part B deductible, one hundred percent of the medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in WAC 284-66-064.

(f) Standardized medicare supplement plan F with high deductible may include only one hundred percent of covered expenses following the payment of the annual deductible set forth in (f)(ii) of this subsection.

(i) The basic core benefit as defined in WAC 284-66-064 plus one hundred percent of the medicare Part A deductible, skilled nursing facility care, one hundred percent of the medicare Part B deductible, one hundred percent of the medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in WAC 284-66-064.

(ii) The annual deductible in plan F with high deductible must consist only of out-of-pocket expenses, other than premiums, for services covered by regular plan F and must be in addition to any other specific benefit deductibles. The basis for the deductible must be one thousand five hundred dollars and will be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the consumer price index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars.

(g) Standardized medicare supplement benefit plan G may include only the basic core benefit as defined in WAC 284-66-064, plus one hundred percent of the medicare Part A deductible, skilled nursing facility care, one hundred percent of the medicare Part B excess charges and medically necessary emergency care in a foreign country as defined in WAC 284-66-064. Effective January 1, 2020, the standardized benefit plans described in WAC 284-66-068 (1)(d) (redesignated plan G high deductible) may be offered to any individual who was eligible for medicare prior to January 1, 2020.

(h) Standardized medicare supplement benefit plan K is mandated by the Medicare Prescription Drug Improvement and Modernization Act of 2003, and may include only the following:

(i) Coverage of one hundred percent of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any medicare benefit period;

(ii) Coverage of one hundred percent of the Part A hospital coinsurance amount for each medicare lifetime inpatient reserve day used from the 91st through the 150th day in any medicare benefit period;

(iii) Upon exhaustion of the medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent of the medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system rate or other appropriate medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days. The provider must accept the insurer's payment as payment in full and may not bill the insured for any balance;

(iv) Coverage for fifty percent of the medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in (h)(x) of this subsection;

(v) Skilled nursing facility care coverage for fifty percent of the coinsurance amount for each day used from the 21st day through the 100th day in a medicare benefit period for posthospital skilled nursing facility care eligible under medicare Part A until the out-of-pocket limitation is met as described in (h)(x) of this subsection;

(vi) Coverage for fifty percent of cost sharing for all Part A medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in (h)(x) of this subsection;

(vii) Coverage for fifty percent under medicare Part A or B of the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells as defined under federal regulations unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in (h)(x) of this subsection;

(viii) Except for coverage provided in (h)(ix) of this subsection, coverage for fifty percent of the cost sharing otherwise applicable under medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in (h)(x) of this subsection;

(ix) Coverage of one hundred percent of the cost sharing for medicare Part B preventive services after the policyholder pays the Part B deductible; and

(x) Coverage of one hundred percent of all cost sharing under medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under medicare Parts A and B of four thousand dollars in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(i) Standardized medicare supplement plan L as mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 may include only the following:

(i) The benefits described in (h)(i) through (vi) and (ix) of this subsection; and

(ii) The benefit described in (h)(i) through (vi) and (vii) of this subsection but substituting seventy-five percent for fifty percent; and

(iii) The benefit described in (h)(x) of this subsection but substituting two thousand dollars for four thousand dollars.

(j) Standardized medicare supplement plan M may include only the basic core benefit as defined in WAC 284-66-064, plus fifty percent of the medicare Part A deductible, skilled nursing facility care and medically necessary emergency care in a foreign country as defined in WAC 284-66-064.

(k) Standardized medicare supplement plan N may include only the basic core benefit as defined in WAC 284-66-064, plus one hundred percent of the medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in subsection (3) of this section, with copayments in the following amounts:

(i) The lesser of twenty dollars or the medicare coinsurance or copayment for each covered health care provider office visit, including visits to medical specialists Part B; and

(ii) The lesser of fifty dollars or the medicare Part B coinsurance of copayment for each covered emergency room visit, however this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a medicare Part A expense.

(6) An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include only benefits that are appropriate to medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of medicare supplement simplification. New or innovative benefits may not include an outpatient prescription drug benefit. New or innovative benefits may not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

AMENDATORY SECTION (Amending WSR 09-05-004, filed 2/4/09, effective 3/7/09)

WAC 284-66-068 ((~~Prohibition against use of genetic information and requests for genetic testing.~~)) Standard medicare supplemental plans issued for delivery to individuals newly eligible for medicare on or after January 1, 2020. ((~~Effective May 21, 2009, except as provided in subsection (3) of this section:~~

~~(1) An issuer of a medicare supplement insurance policy or certificate must not deny or condition the issuance of effectiveness of the policy or certificate and must not discriminate in the pricing of the policy or certificate of an individual on the basis of the genetic information with respect to any individual. This includes the imposition of any exclusion of benefits under the policy based on a preexisting condition or adjustment of premium rates based on genetic information. This subsection shall not be construed to limit the ability of an issuer, to the extent otherwise permitted by law from:~~

~~(a) Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium based on the manifestation of a disease or disorder of the insured or applicant; or~~

~~(b) Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy. The manifestation of a disease or disorder in one individual must not be used as genetic information about other group members or to increase the premium for the group.~~

~~(2) An issuer of a medicare supplement insurance policy or certificate must not request or require an individual or a family member of the individual to undergo a genetic test. This subsection shall not be construed to preclude an issuer from obtaining and using the results of a genetic test in making a determination regarding payment consistent with subsection (1) of this section. For purposes of this section, "payment" has the meaning set forth in Part C of Title XI and Section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time. An issuer may request only the minimum information necessary to accomplish the intended purpose.~~

~~(3) An issuer may request, but must not require, that an individual or a family member of the individual undergo a genetic test only if all of the following conditions are met:~~

~~(a) The request is made for research that complies with Part 46 of Title 45, Code of Federal Regulations, or its equivalent, or any other applicable state or local law or rule for the protection of human subjects in research;~~

~~(b) The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of the child, to whom the request is made that:~~

~~(i) Compliance with the request is voluntary; and~~

~~(ii) Noncompliance will have no effect on enrollment status or premium or contribution amounts;~~

~~(c) Genetic information collected or acquired under this subsection must not be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate;~~

~~(d) The issuer notifies the secretary of the United States Department of Health and Human Services in writing that the issuer is conducting activities pursuant to the exception provided for under this subsection, including a description of the activities conducted;~~

~~(e) The issuer complies with all other conditions required by regulation by the secretary of the United States Depart-~~

~~ment of Health and Human Services for activities conducted under this subsection;~~

~~(4) An issuer must not request, require, or purchase genetic information for underwriting purposes;~~

~~(5) An issuer shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment; and~~

~~(6) If an issuer obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, the request, requirement, or purchase will not be considered a violation of subsection (5) of this section only if the request, requirement, or purchase is not in violation of subsection (4) of this section.~~

~~(7) For purposes of this section:~~

~~(a) "Issuer" has the meaning set forth in WAC 284-66-030(4) and includes any third-party administrator or other person acting for or on behalf of the issuer.~~

~~(b) "Family member" means any individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of the individual.~~

~~(c) "Genetic information" means information about the individual's genetic tests, the genetic tests of family members of the individual, and the manifestation of a disease or disorder in family members. The term includes any requests for or receipt of genetic services or participation in clinical research which includes genetic services by the individual or a family member. Any reference to genetic information concerning an individual or family member who is a pregnant woman includes genetic information of any fetus carried by the pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. Genetic information does not include information about the gender or age of any individual.~~

~~(d) "Genetic services" means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.~~

~~(e) "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes. The term genetic test does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.~~

~~(f) "Underwriting purposes" means:~~

~~(i) Rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy;~~

~~(ii) The computation of premium or contribution amounts under the policy;~~

~~(iii) The application of any preexisting condition exclusion under the policy; and~~

~~(iv) Other activities related to the creation, renewal, or replacement of a policy of health insurance or health benefits.~~)) The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires the following standards are applicable to all medicare supplemental policies or certificates delivered or issued for delivery in the state to individuals newly eligible for medicare on or after January 1, 2020. No policy or certificate that provides coverage of the medicare Part B deductible may be advertised, solicited, delivered or issued for delivery in this state as a medicare supplemental policy or certificate to individuals newly eligible for medicare on or after January 1, 2020. All policies must comply with the following benefit standards. Benefit plan standards to medicare supplemental policies and certificates issued to individuals eligible for medicare before January 1, 2020, remain subject to the requirements of WAC 284-66-067.

(1) Benefit requirements. The standards and requirements of WAC 284-66-067 shall apply to all medicare supplemental policies or certificates delivered or issued for delivery to those newly eligible for medicare on or after January 1, 2020, with the following exceptions:

(a) Standardized medicare supplemental benefit plan C is redesignated as plan D and must provide the benefits contained in WAC 284-66-067 (5)(c) but shall not provide coverage for one hundred percent or any portion of the medicare Part B deductible;

(b) Standardized medicare supplemental benefit plan F is redesignated as plan G and must provide the benefits contained in WAC 284-66-067 (5)(e) but shall not provide coverage for one hundred percent or any portion of the medicare Part B deductible;

(c) Standardized medicare supplemental plans C, F, and F with high deductible may not be offered to individuals newly eligible for medicare on or after January 1, 2020;

(d) Standardized medicare supplemental benefit plan F with high deductible is redesignated as plan G with high deductible and must provide the benefits contained in WAC 284-66-067 (5)(f) but shall not provide coverage for one hundred percent or any portion of the medicare Part B deductible; provided further that, the medicare Part B deductible paid by the beneficiary shall be considered an out-of-pocket expense in meeting the annual high deductible; and

(e) The reference to plans C or F contained in WAC 284-66-067 (1)(b) is deemed a reference to plans D or G for purposes of this section.

(2) Applicability to certain individuals. This section applies only to individuals that are newly eligible for medicare on or after January 1, 2020:

(a) By reason of attaining age sixty-five on or after January 1, 2020; or

(b) By reason of entitlement to benefits under Part A under section 226(b) or 226A of the Social Security Act, or who is deemed to be eligible for benefits under section 226(a) of the Social Security Act on or after January 1, 2020.

(3) Offer of redesignated plans to individuals other than newly eligible. On or after January 1, 2020, the standardized benefit plans described in subsection (1)(d) of this section may be offered to any individual who was eligible for medicare prior to January 1, 2020, in addition to the standardized plans described in WAC 284-66-067.

NEW SECTION

WAC 284-66-071 Prohibition against use of genetic information and requests for genetic testing. Effective May 21, 2009, except as provided in subsection (3) of this section:

(1) An issuer of a medicare supplement insurance policy or certificate must not deny or condition the issuance of effectiveness of the policy or certificate and must not discriminate in the pricing of the policy or certificate of an individual on the basis of the genetic information with respect to any individual. This includes the imposition of any exclusion of benefits under the policy based on a preexisting condition or adjustment of premium rates based on genetic information. This subsection shall not be construed to limit the ability of an issuer, to the extent otherwise permitted by law from:

(a) Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium based on the manifestation of a disease or disorder of the insured or applicant; or

(b) Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy. The manifestation of a disease or disorder in one individual must not be used as genetic information about other group members or to increase the premium for the group.

(2) An issuer of a medicare supplement insurance policy or certificate must not request or require an individual or a family member of the individual to undergo a genetic test. This subsection shall not be construed to preclude an issuer from obtaining and using the results of a genetic test in making a determination regarding payment consistent with subsection (1) of this section. For purposes of this section, "payment" has the meaning set forth in Part C of Title XI and Section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time. An issuer may request only the minimum information necessary to accomplish the intended purpose.

(3) An issuer may request, but must not require, that an individual or a family member of the individual undergo a genetic test only if all of the following conditions are met:

(a) The request is made for research that complies with Part 46 of Title 45, Code of Federal Regulations, or its equivalent, or any other applicable state or local law or rule for the protection of human subjects in research;

(b) The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of the child, to whom the request is made that:

(i) Compliance with the request is voluntary; and

(ii) Noncompliance will have no effect on enrollment status or premium or contribution amounts;

(c) Genetic information collected or acquired under this subsection must not be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate;

(d) The issuer notifies the secretary of the United States Department of Health and Human Services in writing that the issuer is conducting activities pursuant to the exception provided for under this subsection, including a description of the activities conducted;

(e) The issuer complies with all other conditions required by regulation by the secretary of the United States Department of Health and Human Services for activities conducted under this subsection;

(4) An issuer must not request, require, or purchase genetic information for underwriting purposes;

(5) An issuer shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment; and

(6) If an issuer obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, the request, requirement, or purchase will not be considered a violation of subsection (5) of this section only if the request, requirement, or purchase is not in violation of subsection (4) of this section.

(7) For purposes of this section:

(a) "Issuer" has the meaning set forth in WAC 284-66-030(4) and includes any third-party administrator or other person acting for or on behalf of the issuer.

(b) "Family member" means any individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of the individual.

(c) "Genetic information" means information about the individual's genetic tests, the genetic tests of family members of the individual, and the manifestation of a disease or disorder in family members. The term includes any requests for or receipt of genetic services or participation in clinical research which includes genetic services by the individual or a family member. Any reference to genetic information concerning an individual or family member who is a pregnant woman includes genetic information of any fetus carried by the pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. Genetic information does not include information about the gender or age of any individual.

(d) "Genetic services" means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.

(e) "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes. The term genetic test does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(f) "Underwriting purposes" means:

(i) Rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy;

(ii) The computation of premium or contribution amounts under the policy;

(iii) The application of any preexisting condition exclusion under the policy; and

(iv) Other activities related to the creation, renewal, or replacement of a policy of health insurance or health benefits.

AMENDATORY SECTION (Amending WSR 11-01-159, filed 12/22/10, effective 1/22/11)

WAC 284-66-130 Requirements for application forms and replacement of medicare supplement insurance coverage. (1) Application forms must include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has another medicare supplement, medicare advantage, medicaid coverage, or another health insurance or other disability policy or certificate in force or whether a medicare supplement insurance policy or certificate is intended to replace any other policy or certificate of a health care service contractor, health maintenance organization, disability insurer, or fraternal benefit society presently in force. A supplementary application or other form to be signed by the applicant and insurance producer containing the questions and statements, may be used: If the coverage is sold without an insurance producer, the supplementary application must be signed by the applicant.

[Statements]

(1) You do not need more than one medicare supplement policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) If you are sixty-five or older, you may be eligible for benefits under medicaid and may not need a medicare supplement policy.

(4) If, after purchasing this policy, you become eligible for medicaid, the benefits and premiums under your medicare supplement policy can be suspended if requested during your entitlement to benefits under medicaid for twenty-four months. You must request this suspension within ninety days of becoming eligible for medicaid. If you are no longer entitled to medicaid, your suspended medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within ninety days of losing medicaid eligibility. If the medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for, and have enrolled in a medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health benefit plan. If you suspend your medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of medicare supplement insurance and concerning medical assistance through the state medicaid program, including benefits as a "Qualified Medicare Beneficiary" (QMB) and a "Specified Low-Income Medicare Beneficiary" (SLMB).

[Questions]

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. **PLEASE ANSWER ALL QUESTIONS.**

[Please mark Yes or No below with an "X"]

To the best of your knowledge.

(1)(a) Did you turn age 65 in the last 6 months?

Yes □ No □

(b) Did you enroll in medicare Part B in the last 6 months?

Yes □ No □

(c) If yes, what is the effective date?

(2) Are you covered for medical assistance through the state medicaid program?

[NOTE TO APPLICANT; If you are participating in a "Spend - Down Program" and have not met your "Share of Cost," please answer NO to this question.]

Yes □ No □

If yes,

(a) Will medicaid pay your premiums for this medicare supplement policy?

Yes □ No □

(b) Do you receive any benefits from medicaid OTHER THAN payments toward your medicare Part B premium?

Yes □ No □

(3)(a) If you had coverage from any medicare plan other than original medicare within the past 63 days (for example, a medicare advantage plan, or a medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START / / END / /

(b) If you are still covered under the medicare plan, do you intend to replace your current coverage with this new medicare supplement policy?

Yes □ No □

(c) Was this your first time in this type of medicare plan?

Yes □ No □

(d) Did you drop a medicare supplement policy to enroll in the medicare plan?

Yes □ No □

(4)(a) Do you have another medicare supplement policy in force?

Yes □ No □

(b) If so, with what company and what plan do you have [optional for Direct Mailers]?

_____

_____

_____

(c) If so, do you intend to replace your current medicare supplement policy with this policy?

Yes □ No □

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan.)

Yes □ No □

(a) If so, with what company and what kind of policy?

_____

_____

_____

(b) What are your dates of coverage under the other policy?

START / / END / /

(If you are still covered under the other policy, leave "END" blank.)

_____

(2) Insurance producers must list any other medical or health insurance policies sold to the applicant.

(a) List policies sold that are still in force.

(b) List policies sold in the past five years that are no longer in force.

(3) Immediately adjacent to the section of the application on which the applicant chooses the plan type for which they are applying, the company must include the following language, in bold type: "Only those applicants who are initially eligible for Medicare before January 1, 2020 may apply for plans C, F, and high deductible F, if offered."

(4) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, must be returned to the applicant by the insurer upon delivery of the policy.

(((~~(4)~~))) (5) Upon determining that a sale will involve replacement of medicare supplement coverage, an issuer, other than a direct response issuer, or its appointed insurance producer, must furnish the applicant, before issuing or delivering the medicare supplement insurance policy or certificate, a notice regarding replacement of medicare supplement insurance coverage. One copy of the notice, signed by the applicant and the insurance producer (except where the coverage is sold without an insurance producer), must be provided to the applicant and an additional signed copy must be kept by the issuer. A direct response issuer must deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of medicare supplement insurance coverage.

(((~~(5)~~))) (6) The notice required by subsection (((~~(4)~~))) (5) of this section for an issuer, must be provided in substantially the form set forth in WAC 284-66-142 in no smaller than twelve point type, and must be filed with the commissioner before being used in this state.

(((~~(6)~~))) (7) The notice required by subsection (((~~(4)~~))) (5) of this section for a direct response insurer must be in substantially the form set forth in WAC 284-66-142 and must be filed with the commissioner before being used in this state.

(((~~(7)~~))) (8) A true copy of the application for a medicare supplement insurance policy issued by a health maintenance organization or health care service contractor for delivery to a resident of this state must be attached to or otherwise physically made a part of the policy when issued and delivered.

(((~~(8)~~))) (9) Where inappropriate terms are used, such as "insurance," "policy," or "insurance company," a fraternal benefit society, health care service contractor or health maintenance organization may substitute appropriate terminology.

(((~~(9)~~))) (10) Paragraphs 1 and 2 of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

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 19-17-086
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Economic Services Administration)

[Filed August 21, 2019, 9:46 a.m., effective September 21, 2019]

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

Purpose: The department is amending by permanent adoption WAC 388-444-0030 Are able-bodied adults without dependents (ABAWD) subject to additional work requirements and time limits to be eligible for basic food? This amendment reflects the annual update to Washington's supplemental nutrition assistance program state plan concerning ABAWD time-limits, work requirements, and current United States Department of Agriculture Food and

Nutrition Services approved waivers for certain geographic areas of Washington state.

Citation of Rules Affected by this Order: Amending WAC 388-444-0030.

Statutory Authority for Adoption: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.510, 74.08.090, 74.08A.120.

Other Authority: Title 7 C.F.R. Part 273.24.

Adopted under notice filed as WSR 19-10-045 on April 29, 2019.

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

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

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

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

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

Date Adopted: August 20, 2019.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 18-02-037, filed 12/22/17, effective 1/22/18)

WAC 388-444-0030 Are able-bodied adults without dependents (ABAWD) subject to additional work requirements and time limits to be eligible for basic food? (1) An able-bodied adult without dependents (ABAWD) is a person who:

(a) Is age eighteen through forty-nine;

(b) Is fit for work and not exempted under WAC 388-444-0035; and

(c) Does not receive food assistance in an assistance unit (AU) that includes a minor child (we will consider the AU to include a minor child even if the minor child is not eligible to receive food assistance).

(2) If you are an ABAWD, you must participate in work activities under subsection (4) of this section.

(3) Nonexempt ABAWDs who live outside of King County or on the Muckleshoot Tribal Reservation may continue to receive food assistance until December 31, ((~~2018~~)) 2019 even if they fail to participate in work-related activities.

(4) A nonexempt ABAWD is not eligible to receive food assistance for more than three full months (which do not have to be consecutive months), not including any partial benefit months in a thirty-six month period, unless the ABAWD:

(a) Works an average of eighty hours per month, including:

(i) Work in exchange for money;

(ii) Work in exchange for goods or services ("in kind" work);

(iii) Unpaid work that is verified according to department requirements; or

(iv) Any combination of (a)(i) through (iii) of this subsection;

(b) Participates in one of the following work programs and is meeting the requirements of that work program:

(i) The Workforce Innovation and Opportunity Act of 2014;

(ii) Section 236 of the Trade Act of 1974;

(iii) A state-approved employment and training program at least an average of eighty hours per month; or

(c) Participates in an unpaid work program as provided in WAC 388-444-0040.

WSR 19-17-089

PERMANENT RULES

LIQUOR AND CANNABIS BOARD

[Filed August 21, 2019, 10:30 a.m., effective September 21, 2019]

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

Purpose: The revised rules allow consideration of tribal enrollment cards from federally recognized Indian tribes located outside of Washington as acceptable forms of identification to verify a person's age for alcohol sales, service, consumption, and possession. The revisions include language that clarifies requirements for all acceptable identification types.

Citation of Rules Affected by this Order: Amending WAC 314-11-025 What are the acceptable forms of identification?

Statutory Authority for Adoption: RCW 66.08.030 and chapter 66.44 RCW.

Adopted under notice filed as WSR 19-13-039 on June 12, 2019.

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

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

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

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

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

Date Adopted: August 21, 2019.

Jane Rushford
Chair

AMENDATORY SECTION (Amending WSR 18-08-094, filed 4/4/18, effective 5/5/18)

WAC 314-11-025 What are the ((~~forms of~~)) acceptable forms of identification? (1) ((~~Following are the~~)) Acceptable forms of identification ((~~that are acceptable~~)) to verify a person's age for the purpose of selling, serving, or allowing a person to possess or consume alcohol must include:

(a) The identification holder's photo;

(b) The identification holder's date of birth; and

(c) The identification holder's signature, except on federally issued identification where a visible signature is not required.

(2) If the identification has an expiration date, it cannot be used to verify age after the expiration date.

(3) Acceptable forms of identification include:

(a) A driver's license, instruction permit, or identification card of any state, ((~~or~~)) province of Canada, ((~~from a~~)) U.S. territory, or the District of Columbia, or an "identicard" issued by the Washington state department of licensing per RCW 46.20.117;

(b) A United States armed forces identification card issued to active duty, reserve, and retired personnel and the personnel's dependents((~~, which may include an embedded, digital signature in lieu of a visible signature~~));

(c) A passport, passport card, or NEXUS card;

(d) A Merchant Marine identification card issued by the United States Coast Guard; ((~~and~~)) or

(e) An enrollment card issued by the governing authority of a federally recognized Indian tribe ((~~located in Washington~~)), if the enrollment card incorporates reasonable security features ((~~comparable~~)) sufficient to deter counterfeiting, which may include features similar to those ((~~implemented~~)) used by the department of licensing for standard Washington driver's licenses.

(((~~(2) If the identification document has an expiration date, a person may not use the document after the expiration date to verify his or her age.~~)))

(i) An enrollment card must be approved by the board's enforcement division prior to use as an acceptable form of identification. The tribe may request approval by submitting the following for review and inspection:

(A) A letter requesting approval and describing the security features of the enrollment card;

(B) A physical sample of an enrollment card; and

(C) For tribes located outside of Washington, a contact phone number where enforcement officers may call at any time to verify the validity of the enrollment card.

(ii) After review and inspection, the board's designee will send a letter approving or denying the enrollment card as an acceptable form of identification.

(iii) The board may rescind approval if the enrollment card no longer meets the requirements of this section.